CDI Clinical Scenario 11

CLINICAL DOCUMENTATION IMPROVEMENT:

An Introduction Into The Field of CDI

MARSI

MEDICAL AUDIT RESOURCE SERVICES, INC.

CODING HOSPITAL

123 Main Street
Anywhere, USA

HISTORY AND PHYSICAL EXAMINATION

ADMITTED:

MEDICAL RECORD NUMBER:

CHIEF COMPLAINT: Chest Pain

HPI:
This man with extensive history of coronary artery disease. He had coronary artery bypass grafting in, 1982, with subsequent redo. He had a PTCA on three or four occasions. He obtained his primary cardiac care down at the VA Medical Center. He has had myocardial infarctions. Just about a month ago, he had chest pain, and was hospitalized there. Had work up and was told, in his words, "that he had mild heart attack, but no muscle damage." He had a cardiac catheterization there, had multiple areas of involvement, was told that medical management was the best option, with the other option being a repeat bypass grafting, though, of course, that would be complicated by his history of two bypasses already. Thus, he was managed medically. Also, a couple of months ago, he went to the VA for routine visit, had been having trouble with increasing shortness of breath, edema, and orthopnea. They told him he was "full of fluid", admitted him for eight days, and he dropped his weight from 254 to 212 pounds during that time, and he felt markedly improved, "a total makeover" since then. They increased his Lasix to 100 mg bid and added Metolazone 5 mg every other day. He was a smoker, but has quit within the past few years. He also has a history of cerebrovascular disease with mild stroke when he was visiting about two years ago. Had transient left-sided weakness, but has no residual.

PMH:
Is as noted above. He also had dual chamber pacemaker that has been replaced once. He is a Type II diabetic on oral therapy. He does home blood sugars, and they have been excellent. He was baffled when it was over 300 here in the emergency room, but I presume that is associated with the stress of his current presentation.

He was feeling fine when he went to bed last night. He got up at about 2:15 to void and had some precordial chest pressure possibly radiating a little bit to the left arm. He sat on the edge of the bed, the pain got worse, got to about a 6/10 in intensity. He took a

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nitroglycerin. The first one helped promptly. Then the pain got worse. He took another, and ten minutes later there was no improvement, so he took a third, which, as well, did not help. Therefore, he presented to the hospital for evaluation. Associated with this chest pain, there was no shortness of breath or diaphoresis, possibly felt a little lightheaded, but no nausea or vomiting. On presentation to the emergency room, he tells me his pain was 6/10. There, Dr. Smith evaluated him. He received another sublingual nitroglycerin, O2 was placed. His pain resolved, and he is entirely pain free at this time. His SA 02 were noted to be 96 percent on room air. He was noted to b hypokalemic with potassium level of 2.7 and therefore we added 40 mEq of potassium per liter of IV fluids, and he did not tolerate that due to a lot of burning pain in the arm, so the attempt is being made to replace it orally. Currently, is without chest pain or pressure, no dyspnea or orthopnea.

PMH:
As noted above. Surgeries: He has had bilateral cataract extraction. He recently had some sort of last procedure to the left eye. He is being fitted for glasses. He had a right inguinal hernia repaired in 1999. TURP in the past. He does have hyperlipidemia. Allergy noted to Lisinopril.

Habits: Nonsmoker.
Current Medications: Isosorbide 40 mg tid, Forusemide 100 mg bid, Glyburide 5 mg daily, Lansoprazole (Prevacid) 15 mg daily, Metolazone 5 mg every other day, Metoprolol 50 mg bid, Simvastatin 10 mg q pm, Plavix 75 mg daily, Diazepam 5 mg prn, Quinine sulfate 250 mg at hs prn for leg cramps, nitroglycerin .4 mg sublingually prn, and potassium chloride is 8 mEq tablets 2 taken tid.

FAMILY HISTORY:
Father died in age 82 of coronary artery disease, having had first MI at approximately age 60. Mother had hardening of the arteries. Sister has some sort of cancer.

SOCIAL HISTORY:
Apparently on SSD for coronary artery disease and takes primary medical care at the VA. Lives with his wife.

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REVIEW OF SYSTEMS:
Otherwise negative.

PHYSICAL EXAMINATION:
Pleasant man. He had been given some Valium in the ER because of pain in his arm and was resting comfortable with snoring when I came in. I awakened him. He awakened him. He is in absolutely no distress. He is pain free. Vital signs are stable with temp 98.3, pulse 61 and regular, respirations 20 and unlabored, blood pressure 115/63. Skin is clear, warm and dry. No cyanosis. HEENT: Normocephalic, atraumatic. PERRL. EOMI. He has had bilateral cataract extractions. TMs are fine. Pharynx is clear. Upper and lower dentures. Neck is supple. Carotids normal symmetrical. I do not hear bruits, and there is no JVD or HJR. Lungs are clear throughout. Heart is regular distant heart sounds with very soft Grade I/VI rumbly low-pitched systolic murmur. Abdomen is soft and nontender without hepatosplenomegaly or other masses. Normal bowel sounds. I hear no bruits. Extremities: He has no edema. He has an easily palpable right dorsalis pedis pulse, none palpable on the left, though feel are warm. Neurological: Cranial nerves 2-12 are intact. Motor and sensory are normal.

Electrocardiogram, paced rhythm. Chemistries show glucose of 363, sodium 138, potassium 2.7, chloride 88, bicarb 38. His LDH and CK are normal and the troponin is normal at 0.3. BUN 46, creatinine 1.4.

ASSESSMENT:
1. 72 year old man with extensive history of coronary artery disease with previous bypass X2, several angioplasties, recent angiogram, the specifics of which I do not have, but recommendation, apparently, at that time of medical management with possibility of redo bypass consideration if not controlled, presents with nocturnal onset of chest pain, somewhat prolonged. Resolved at present. Unstable angina, rule out infarction.
2. CHF, controlled
3. Hypokalemia, secondary to diuretics
4. Hyperlipidemia
5. Type II Diabetes Mellitus
6. PUD/GERD
7. History of Cerebrovascular Disease with previous CVA

ADMITTED:

MEDICAL RECORD NUMBER:

PLAN:
At this point he is stable and comfortable. He is admitted to the coronary care unit. I think it would be wise to put him on IV Heparin infusion. Will follow his cardiograms and enzymes closely. From a medical management standpoint, he is on fairly maximal therapies. We could increase his beta blocker somewhat, but will need to watch his pulse and blood pressure. We need to replace his potassium, which we will try to do orally. I am simply going to follow his glucose for now. I would like to avoid giving any insulin, as this is simply going to drop his potassium further by forcing it intracellularly. I have discussed all this with the patient.

D:
T:

PROGRESS NOTE

Date/Time

S: No chest pain, no SOB. Feels good. "I thought I could go home today"
O: All vital signs normal. Color good, No JVD, or edema. Lungs clear, Heart regular, abdomen non tender. Extremities show no edema.

Potassium level now 3.0. EKG paced rhythm, PTT 51.4.

A: Unstable angina in setting of severe CAD
Hypokalemia
Diabetes Mellitus – poor control

P: Continue in CCU today
Continue Heparin, PO KCL
Arrange for patient and patient's wife to meet with diabetic nurse for counseling

PROGRESS NOTE

Date/Time

S: Feels fine but with closer questioning did have chills and felt feverish. Denies Cough, SOB, chest pain or UTI symptoms

O: Alert and oriented, temperature 100.3, lungs clear.

A: Stable angina, now with fever

P: Continue previous treatment, add Tylenol for fever

Patient ID

Admit:

PROGRESS NOTES

MR #

Coding Hospital

PROGRESS NOTE

Date/Time

S: Patient complaining of not feeling well and feeling worn out. Temperative 103.4 Will draw blood cultures and continue treating with Tylenol and Keflex IV

O: Alert, oriented, pale. Fever continues despite Tylenol so will start IV antibiotics. Other vital signs stable. Lungs clear, few rales in right base. Cardiovascular, Regular rate and rhythm.

A: Improving, except for problems with fever

P: Continue Rx

PROGRESS NOTES

Admit:
MR #
Coding Hospital

PROGRESS NOTE

Date/Time

S: Patient feel "100%" better today and "ready to go home"

O: All vital signs are normal including temperature at 98.3. Input and output appear Normal as well.

A: Improving, fever resolved.

P: Start patient on oral antibiotics for consideration for discharge tomorrow.

PROGRESS NOTES

Admit:

Coding Hospital

CODING REGIONAL HOSPITAL
Anywhere, USA

RADIOLOGY REPORT

MR#

CLINICAL SUMMARY: Chest Pain

PORTABLE CHEST,

Findings:
Comparison made to study performed 10/05/xx. There has been no change apparent in the chest. As noted previously, there is evidence of open heart surgery with cardiac pacemaker in place. The heart remains mildly enlarged, but unchanged from prior studies. The pulmonary vascularity is normal in appearance. Calcified granulomas and fibrotic changes are seen with no new infiltrates identified.

Impression:
Stable appearing post operative chest with no evidence of active or acute disease

D:
T:

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Anywhere, USA

RADIOLOGY REPORT

MR#

CLINICAL SUMMARY: Angina

PA AND LATERAL CHEST,

Findings:
The heart is borderline in size. Pacemaker is seen with wires extending into the right atrium and ventricle. Pulmonary vasculature is within normal limits. Severe degenerative changes are seen in the spine.

Impression:
No significant acute abnormality seen in the chest

Ddt/mm

D:
T:

CODING REGIONAL
Anywhere, USA

DISCHARGE SUMMARY

ADMITTED:
DISCHARGED:

ADMITTING DIAGNOSIS: Chest Pain

DISCHARGE DIAGNOSES:

1. Unstable angina, rule out infarction.
2. CHF, controlled
3. Hypokalemia, secondary to diuretics
4. Hyperlipidemia
5. Type II Diabetes Mellitus
6. PUD/GERD
7. History of Cerebrovascular Disease with previous CVA

Patient's course was unremarkable except for fever that spiked on the third day of admission. Blood cultures were performed, and the patient was started on IV Keflex and given Tylenol for fever control.

The fever resolved within 24 hours after Tylenol and IV antibiotics were given, and the patient was switched to oral antibiotics for discharge.

Discharge Medications:
Cipro 500 mg bid 7 days
Continue present medications as well.

Patient should follow-up within one week with cardiologist.

D:
T: