Markenzie Jean-baptiste

H & P

Emergency Medicine Rotation

08/27/2020

**Identifying Data:**

Full Name: AL

Address: Harlem, NY

Age: 89

Date & Time: July 29, 2020 @ 4:30 PM

Location: Metropolitan Hospital

Religion: None

Reliability: Reliable

Source of Information: Patient’s son

Source of Referral: Patient’s son

Mode of Transport: EMS

**Chief Complaint**:  “ urinary retention and fatigue x 1 day”

**History of Present Illness**:

Mr L is a 89 y/o M with PMH Afib, pacemaker HTN, ischemic CVA with left sided residual weakness and hypothyroid, who was brought to ED by son due to urinary retention and fatigue. PT has a history of BPH/lower urinary tract infection s/p greenlight TURP in 2015 (India) in which he had repeated episodes of urinary retention requiring Foley exchange every 6 weeks. PT last saw urologist 7/17 and was given 5 days Bactrim for UTI. Urine cx grew proteus mirabilis resistant to Bactrim. PT’s son also reported that pt has had increasing weakness of right extremities x 1 week.

**Past Medical History:**

Present illness:

1. BPH with obstruction/lower urinary tract infection symptoms, - has an indwelling catheter
2. Atypical mycobacterial infection s/p 8-month treatment
3. CVA (cerebral vascular accident) with left sided hemiparesis
4. hypertension
5. Dementia
6. Depression
7. Hypothyroidism
8. Prostate Disease

Hospitalizations: unknown

Immunizations: unknown

Past Surgical History:

Cardiac pacemaker placement

Prostate surgery 2015

Medications:

Apixaban(ELIQUIS) 5 mg- take 1 tab by mouth BID

Atorvastatin 40 mg QD

Metoprolol 100 mg QD

Donepezil 10 mg QD

Finasteride 5 mg QD

Levothyroxine 75 MCG tablet QD

Tamsulosin (FLOMAX) 0.4 MG

Trazadone 50 MG

Allergies:

Denies drug allergies, food allergies or environmental allergies.

Family History:

Mother- unknown

Father- unknown

Social History:

Habits:  No known hx of smoking or drinking alcohol.

Travel: no recent travel

Marital History: single

Home: lives in home cared for by home health aide

**Review of Systems: (Unable to Perform due to acuity of condition)**

**Physical**

Vital Signs:

Blood Pressure: 104/65

Heart Rate: 155 bpm

Respiration Rate: 22

Temperature: 99.2F

O2 Sat: 98% room air

General: 89 y/o male, he is obtunded. He appears malnourished and frail. **Chronically ill, Foley not draining.**

Skin: skin is warm and dry, non-icteric, no rashes or lesions,

Head: normocephalic, atraumatic

Eyes: PERRL. Cataract in left eye

Mouth and Pharynx:

Lips: pink, moist, no evidence of cyanosis or lesion. Nontender to palpation

Mucosa: pink; well hydrated. No masses. Lesions noted. Non-tender to palpation. No evidence of leukoplakia

Oropharynx: Well hydrated no evidence of injection; exudate, masses, lesions, foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema lesions.

Neck: No JVD present. No Carotid Bruits. Trachea midline. No masses, lesions, scars, pulsation noted. no thyromegaly. No thyroid bruits noted.

Cardiovascular: **Afib with rapid ventricular response, distal pulses intact.**

Chest: Symmetrical, no deformities, no signs of trauma. Respiration unlabored/ no parodoxic respiration or use of accessory muscles noted.

Lungs: No rales/rhonchi/wheezes, no tactile fremitus, normal percussion.

Abdomen: Soft. Bowel sounds are present in all 4 quadrants. No distension

Musculoskeletal: muscle wasting in all extremities. No edema or tenderness.

Genitourinary: **Foley not producing urine. Another Foley was placed. 400 ml of turbid yellow purulent urine came out.**

*Neurological*: He is alert but not oriented to person, place and time. He displays normal reflexes. Unable to follow commands. Decreased sensation.

**Tests:**

Labs

Urinalysis: **turbid, blood-large, protein 100!, nitrite positive, leukocyte large, RBC 10-15, coarse granular cast 10-15..**

**Urine culture- positive for proteus mirabilis**

**Fingerstick glucose- 129**

CBC-**WBC 25.68.,** HGB 14.6, HCT 44.3%, **Neutrophil 93.5, lymphocyte 1.6(low), monocyte 3.1( low)**

Segmented differential band- **14**

BMP- **sodium 128(low), potassium 6.1, chloride 95, CO2 14.0, BUN 59, Cr 2.1,** Calcium 8.9

LFT- **albumin 3.0,** **ALK PHOS 229, ALTSGPT 95, ASTSGOT 120**

TSH- normal

T4,free normal

Mg- 2.0

**Lactate 5.1**

**Troponin *( 0.000-0.010)*  0.032**

**Pro BNP *(1.0-1.25.0)* 10,193.0**

**APTT *( 25.1-36.5)*  45.7**

**PT 15.6 seconds**

**INR *(0.0-1.1)* ratio 1.3**

**CPK (*20-200 U/L)* 240**

**Blood culture : gram negative rods- Proteus Mirabilis**

Cardiac monitor showed A fib with HR of 180 bpm

EKG: showed afib with rapid ventricular response @ 172 bpm, left axis deviation, incomplete right bundle branch block, marked ST abnormality (ST depression in V2 and V3)

**Imaging:**

Portable CXR: Right basilar opacity suspicious for infiltrate/atelectasis

**Assessment**

Mr L. is a 89 y/o M with PMH Afib, pacemaker, HTN, ischemic CVA with left sided residual weakness and hypothyroid, who was brought to ED by son due to urinary retention and fatigue. PT has a history of BPH/lower urinary tract infection s/p greenlight TURP in 2015 (India) in which he had repeated episodes of urinary retention requiring Foley exchange every 6 weeks. PT last saw urologist 7/17 and was given 5 days Bactrim for UTI. Urine cx grew proteus mirabilis resistant to Bactrim. As per family member, pt has new onset of RT sided hemiparesis x 1 week in which there is also concern for CVA. No hx of fall but pt on Eliquis.

Problem list:

1. Urosepsis: elevated lactate, elevated BUN/creatinine, hx of UTI with obstructed bladder/Foley catheter
2. Afib with RVR
3. Acute kidney injury
4. Hyperkalemia
5. Hypotension
6. New onset RT sided hemiparesis

**Plan:**

Continue Eliquis

IV fluids

IV Lopressor 5 mg

IV amiodarone

Labs- repeat labs, CBC, bmp, LFT, TSH, BUN/cr, troponin, pro-bnp, cpk, lactate, blood cultures

CT scan of head, chest and abdomen-pelvis,

Admit to ICU

Follow up:

After Lopressor, HR ended up going down to 100’s. Then patient blood pressure noted to drop to 90/60 requiring placement of right femoral venous central line. The attempt was unsuccessful. PT was given NS AT 150 ML/HR. PT was started on antibiotics. There was also some concern that pt was developing increasing weakness of the right extremities which gave concern to order head ct as well. PT Referred to MICU due to urosepsis, aki with hyperkalemia, hypotension and a fib. PT given broad spectrum antibiotics Vanco/Zosyn.

CT of head: No intracranial hemorrhage, infarction or mass lesion. Findings consistent with small vessel disease.

CT of chest: Consolidation noted in RT lobe suspicious for pneumonia

CT of abdomen pelvis: bladder wall thickening, b/l hydronephrosis and hydroureter to the level of bladder, perinephric strandin. Colonic and small bowel diverticula w/o evidence of acute diverticulitis. Enlarged prostate

Comments from my site rotation evaluator:

**Sepsis in A fib w/ RVR are difficult cases – points to note; rate control was Lopressor likely because patient was already on B-blockade (can use Cardizem also, but generally we reserve for patients who are on CCB). Patient likely given amio was RVR may have returned and blood pressure not high enough to tolerate repeat doses of Lopressor – can also cardiovert if pressure becomes labile. Giving these patients fluids (sepsis fluids) will help with keep up blood pressure. Lactate generally trended before admission,  but patient required pressors so needed ICU regardless.**

**Great case**