Ahsip, Tommy

MRN: 1000014397

Robert Stanley Arthur Hayward, MD
Physician
General Internal Medicine

Discharge Summary
Signed

Creation Time: 22/09/21 1420

General Internal Medicine Inpatient Discharge Summary

Encounter dates:	Admitted 01 Aug 2019; Discharged 09 Sep 2021 (783 hospital days)
Disposition:	Transferred to acute care facility with planned repatriation
Goals of care:	GCD-M1 (Source: Patient;Alternate Decision Maker; Clarification: Family conference outcome)
MyAHS Connect:	Pending

Overview

This 83 y.o.man was brought from temporary lodging to the EDM WMC University of Alberta Hospital because of 1 week worsening exertional dyspnea, was admitted for respiratory support, and is discharged to home (family care) for stabilization to a new baseline.

Most Responsible Diagnosis

Respiratory failure with hypoxia

Hospital Problems

Principal Problem:
- Respiratory failure with hypoxia

Active Problems:
- Type 2 diabetes mellitus
- CKD (chronic kidney disease)
- COPD (chronic obstructive pulmonary disease)
- HFrEF (heart failure with reduced ejection fraction)
- Hypertension
- GERD (gastroesophageal reflux disease)

Resolved Problems:
- Stroke
- Diabetes mellitus

COVID-19 Status

COVID-19 (most recent NAT): no result in 1Y

COVID-19 Immunizations

Administered	Date(s) Administered
• COVAUVec Vaccine (AstraZeneca)	12/04/2021

Patient-reported immunization status: Full

Hospital Course

This 82 y.o. man was brought from home (family care) to the EDM WMC University of Alberta Hospital because of 1 week worsening ertional dyspnea and was admitted for respiratory support. Key hospital milestones include:

- Stabilized with fluid, electrolyte and glucose management (brief ketoacidosis), coupled with short term speculative antibiotics
- Recovered baseline organ function within 48 hours while mild delirium cleared within 72 hours
- Remainder of hospitalization focused on re-calibration of medications and reactivation for deconditioning

Discharge Assessment & Plan

*** Respiratory failure with hypoxia**
Multifactorial acute respiratory failure on baseline borderline exercise tolerance related to COPD, HFrEF and increasing pulmonary hypertension.

Presentation and imaging consistent with non-specific COPD/CHF with no findings consistent with ischemia or sepsis.

- Transition to low flow supplementation and wean O2
- No further loop diuretics until volume stabilized.

HFrEF (heart failure with reduced ejection fraction)
Followed by: Heart function clinic, Dr. Wirzba
Status: key CHF (HFrEF <41%) events include prior MI; causes include hypertension; and complications include serosal effusions.
Function: NYHA class III-A, with last ejection fraction of 28% (noted on 2020) classified as Severely reduced (< 31%)
Interventions: ICD
Therapies: ACE, Loop diruetics
Course: improving

Co-managed with respiratory failure.

COPD (chronic obstructive pulmonary disease)
Followed by: Ron Damant
Status: key risks include never intubated, 2 hosp/yr; causes include 50 py smoking; complications include pulmonary hypertension
Function: outcome markers include FEV1 0.8L, follows own peak flow
Interventions: has attended pulmonary rehabilitation
Therapies: triple puffers, compliant
Course: stable

Stable without evidence of exacerbation. At baseline.

- No new interventions or investigations and no change in physical findings

CKD (chronic kidney disease)
Followed by: Nephrology (KEC)
Function: outcome markers include baseline creatinine ~150
Course: stable

Worsening renal failure indicators likely transient with expectation of return to baseline.
- ACE inhibitor held till Cr within 10% of baseline

Type 2 diabetes mellitus
Followed by: internal medicine
Status: key problem-related risks/events include 3 prior admissions for hypoglycemia, brittle control; causes include metabolic syndrome and history of pancreatitis; and complications include vasculopathy, retinopathy and gastroparesis.
Function: problem-associated functional impacts include medication and diet supervision.
  - Edmonton Frailty Score (1 Y look-back) 12 (Severe Frailty)
  - ADL/IADLs moderate assistance

Interventions: cannot manage more than daily cap glucose check
Therapies: insulin dependent
Course: stable

Hyperglycemia with mild ketoacicosis likely multifactorial triggered by stress, medication (short term steroid) and hydration.
- Fluid and metabolic resuscitation, with improvement apparent while temp hold of metformin.
- Resume home hypoglycemic/insulin regimin.

GERD (gastroesophageal reflux disease)
Stable on intermittent PPI. Followed by family physician.

Hypertension
Stable with lifestyle and diuretic management (overview)

Follow Up Arrangements

- *Primary care provider:* Aidevo Sandra Adebo
- *Attending provider at discharge:* Fraser W. Armstrong
- *Other follow-up provider(s):* Robert Hayward (General Internal Medicine)
- *Follow-up acccountabilities:* Tom is advised to check in with his primary care provider for continuing care after discharge. Results for tests ordered in hospital but resulted post-discharge are routed to the discharge attending. In addition Dr. Hayward will review cardiac function tests scheduled post-discharge. Medications prescribed at discharge will be followed and refilled by primary care.
- *Follow-up appointments:* KEC GIM Clinic in 2 weeks time (clinic to call)

Community Supports

Tom returns to the same type and level of community supports as pre-admission.

Medications

Adverse Reactions: Penicillin g and Avocado

Discharge Medications

Scheduled:
• cetirizine 5 mg tablet; 5 mg, oral, daily
• flu vacc qs 2019-20 (6mos up)(PF) 60 mcg (15 mcg x 4)/0.5 mL syringe injection; 0.5 mL, intramuscular, during hospitalization
• furosemide 20 mg tablet; 20 mg, oral, 2 times per day
• insulin aspart-aspart protamin 100 unit/mL (30-70) cartridge; Commonly known as: NovoMix 30 Penfill U-100 Insul; 15 mg, subcutaneous, 2 times per day
• insulin lispro-insulin lispro protamine (HumaLOG Mix 25) injection 100 unit/mL cartridge injection cartridge; Commonly known as: Humalog Mix25 U-100 Insulin; 4 units, subcutaneous, 2 times per day
• metFORMIN 500 mg tablet; 1,000 mg, oral, 2 times per day, with breakfast and supper

Medication Reconciliation (Continued, Changed, New, Discontinued)

Continued

- cetirizine (REACTINE) 5 mg tablet
- insulin aspart-aspart protamin (NOVOMIX 30 PENFILL U-100 INSUL) 100 unit/mL (30-70) cartridge
- metFORMIN 500 mg tablet

New

- flu vacc qs 2019-20, 6mos up,,PF, 60 mcg (15 mcg x 4)/0.5 mL syringe injection
- furosemide 20 mg tablet
- insulin lispro-lispro protamin (HUMALOG MIX25 U-100 INSULIN) 100 unit/mL (25 %-75 %) cartridge

Discontinued

- enalapril maleate 10 mg tablet

Rationale for changes: Balancing renal, pulmonary and cardiac function with new consideration of patient compliance challenges.

Interventions

No clinically significant procedural interventions occurred during this admission.

Other History

Pertinent medical, surgical, family, social, device and immunization history is included in the admitting history and physical report of 15 September 2021.

Electronically signed by Robert Stanley Arthur Hayward, MD at 22/09/21 1423

Admission (Current) on 1/8/2019