Case notes

Name:	N.P.
Gender:	M ☐ F ☒
Date of birth:	20/06/1926
Date of admission:	13/09/2013

1605

Presenting complaint

Admitted from medical clinic with palpitations, chest pain and shortness of breath. Unwell for past few weeks with increasing shortness of breath, episodes of fast, irregular palpitations and lower leg oedema.

Recent short-stay admission to hospital one month ago with same complaints. Investigations then showed an ECG with ectopics; troponin normal. Sent home for planned review in medical clinic. Since that time BP had been high (SBP 170–190mmHg) and GP (Dr A) had increased her lercanidipine from 10mg mane, 5mg nocte to 10mg bd.

Past history

1. Hypertension more than 40 years.
2. Hypothyroidism – on thyroxine.
3. Osteoarthritis many years.
4. Gastroespohageal reflux disease 2007.
5. Pancreatitis 2012.
6. Kidney lump – annual follow-up by urologist.
7. Surgery for shoulder, L inguinal hernia.
8. Allergic to thiazide.

Social history

Born in Serbia. Sponsored by brother-in-law and sister-in-law (died last week) to come to Australia in 1948. Worked in family business until retirement 15 years ago. Lives with husband who has heart disease (IHD, AF and heart failure) who has been in failing health for past year. They are well supported by two daughters and families who live nearby.

Current therapy

Metoprolol 12.5mg bd
Candesartan 16mg mane
Lercanidipine 10mg bd
Esomeprazole 20mg nocte
Thyroxine 100microg twice a week (M, Th); 50microg other days
Ostelin Vit D 1000U mane
Aspirin (Astrix) 100mg mane

Physical examination

- Elderly woman not unduly distressed; iv in situ L forearm, ECG monitored and on O2 via nasal prongs.
- Short of breath on minimal effort.
- BP sitting 162/89mmHg (machine reading); HR ~120
- JVP 2–3cm; HS irregular, no murmurs.
- Chest – bibasal crackles.
- Pitting oedema to mid calves.
- Abdomen – no masses or ascites.

Assessment

AF with chest pain ? coronary ischaemia.

Plan

1. Admit to Cardiology ward
2. Troponins/CXR/U&E

RA JMO #1123

13.09.13 1845 PM Nursing

Pt arrived on ward @ 1630. Pt A & O. Afebrile. Nil c/o pain. Obs BP 171/83, HR 78 AF. Peripheries warm/perfused. NCOOB. SpO2 100% at RA.

Bloods sent to pathology as ordered by Cardiology HMO on ph #4569; first troponin normal; HMO informed regarding R/V. Metoprolol 25mg given as charted. Skin integ D & I. Pt monitored. Independent of ADLs PVIT. Tolerating food/fluids well. AH CNS.

13.09.13 1920 JMO

Review of recently admitted patient. 87yo F in AF with RVR at Clinic today.

O/E

BP 171/83, HR 78 RR 20 SpO2 100% RA

Heart – HS irregular, Lungs – clear

Pitting oedema ankles

ECG: RBBB (old) and AF with RVR (on admit to ward)

Plan

1. Chase pending bloods
2. Liaise with Reg re anticoagulation.

RA #1123

14.09.13 0320 Nursing ND

ID bands ✓, safety checks ✓ GCS 15 Pt c ongoing chest discomfort & reports 2–3/10 dull ache L side. ECG completed. Pt pain self-resolved. Paged Dr M & had phone order for anginine. Pt reports pain free by time organised. R/V pt at 0400 re clexane pt still pain free and aware to

inform nurse if any CP. Dr M charted prn anginine. Neurovasc: P, W & D. CVS: pt monitored SR with occasional atrial ectopics with compensatory pauses. ECG printed. Afebrile. RESP: SpO2 rest 100% RA/ RR 18 No SOB or incr WOB. RENAL: Pt I voiding no witnessed voiding so far. Pt given oral Magmin to replace magnesium. All other pathology as chart. Vital signs as charted BP 145/76, come down from previous. HR 86. Nil further issues at TOR. NIC aware pt path results. Nil further orders to be R/V in AM. LB RN1

Indwelling Vascular Advice
Type: 22G
Site: R hand
Main reason for insertion: Ongoing CP
Insertion date: 14.09.13
Inserted by: AB

S/V by EL

14.09.13 0730 Nursing ND

Additional: 0500 Pt vital signs checked 174/80 HR 74 irregular. Pt c/o 4/10 chest heaviness on L side. Dr paged. ECG taken & printed. Pt given 2 x ½ tablet anginine from phone order chart as per NIC request until Dr A arrived on ward. Anginine prn order incomplete & Dr A rewrote. Sc/iv morphine charted. No further troponin or bloods to be taken as per Dr A requests. Pt to have sc morph. No IVD. Pt given 2.5mg sc morphine to little effect. Pt initially placed on face mask then changed to NP and PO2 kept >95% at all times as per Dr A request. IVB inserted by NIC & further 2.5mg morphine given iv. CP remained. Dr A paged and came to R/V pt; further tablet anginine given. Metoprolol 12.5mg given early at 0200 as per Dr A request. Total 3 × anginine tablets, 5mg morphine & 12.5mg metoprolol given. Pt reluctant to report CP must be reeducated & encouraged to report. Pt handed over to morning staff. All regular observations as per charts. No further issues at NR. To be R/V by Cardiol this AM.

14.09.13 1130 Cardiol WR

#1 AF – now in SR

Years of palps off & on becoming more frequent; when has palps gets chest pressure L sided. Feels better now.

Plan

1. Cease metop. & commence amiodarone for 400mg tds 1/52 then to bd 1/52 then to 200mg daily.
2. Rivaroxaban 15mg/d for stroke prophylaxis.

RA #1123

14.09.13 1300 AM Nursing

Pt A & O Afebrile. Pt c/o chest discomfort early in the shift. Refused anginine/morphine. Pt had 3 episodes of vomit & bradycardia HR 34 at one stage BP 155/60 HR 67 sinus arrhythmia c AVP & A flutter. Rhythm/rate varied during episodes. Frequent ECGs done. Cardiology HMO kept informed regarding incidents. Candesartan & Maxalon given for nausea with good effect. SOBOE SpO2 95% on RA. R arm iv bung inserted. Trop –ve, K 4.0, Mg 0.82 replaced as charted. Skin integ D & I. Pt ambulates to toilet. Tolerating food/fluids well. BNO. Visited by family. Nil other issues. CA CNS

14.09.13 1500 HMO

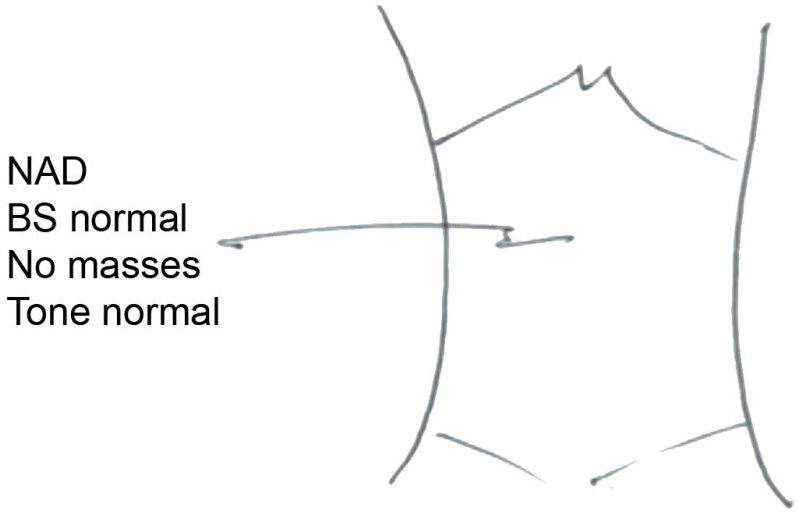
R/V of pt following 2nd episode of vomiting at 1330. 1st episode this am around 0930–1000. Vomiting associated with bradycardia (down to 40) also tachycardia (up to 175). As per Dr M likely 2° to emesis; not concerned.

Vomiting a/w nausea but no dizziness, reflux, waterbrash, vertigo, abdo pain, diarrhoea or infective Sx.

PMHc includes GORD, pancreatitis (2011) however pt denies abdo pain.

Pt feels vomiting may be 2° to morphine which she received twice this AM (but before 0700).

O/E Obs stable. Afeb.



BS present.

Tone normal.

Bloods WCC normal.

Plan

1. Retrospective LFTs & lipase.
2. Monitor for further vomiting.
3. If requires morphine for analgesia, consider giving emetic simultaneously.

AB #4569

15.09.13 Cardiology WR

#1 AF

Back in SR. No major events O/N. Predom SR.

Pt well keen for home
On ~~warfarin~~ rivaroxaban – explained risk bleeding

For:

1. r/v c Cardiologist
2. Cease aspirin
3. D/C today

RA #1123