

Chief Complaint: Rapid heartbeat

Encounter Type: Initial

Acuity: C Red

NO DICTATION FOUND

CHART:

Physicians caring for patient:

MD

Diagnosis

Tachycardia - unspecific

Notes:

RESOLVED

Disposition

Provider documentation to be completed on HMED.

Copy to:

Disposition - Discharge from ED: home . Condition: stable . The patient is to follow up with Cardiologist, next week . Recheck immediately for new or worsening symptoms. . Return if any new concerns develop, you develop any new symptoms or you are feeling worse

Medication instructions: No changes
Private Physician(s)

Chief Complaint

Chief complaint/quote: Patient states she has debillerator, "my heart has been racing and it has not gone off yet, for about an hour and 10 minutes.

History of Present Illness

General Template

CC: Rapid heart rate

ONSET: About an hour ago while watching TV

TIME COURSE: This is a 54-year-old female that has a defibrillator who presents to the ED for evaluation of a rapid heart rate. She states that she was watching TV when her heart began to race. She states that this episode is different than other episodes and that her defibrillator didn't go off. This episode lasted for approximately an hour. She states that she recently had her defibrillator reprogrammed. She states that she feels back to normal upon arrival to ED.

SEVERITY: Moderate

TREATMENT AT HOME: None

ASSOCIATED POSITIVE SYMPTOMS: Pt reports nausea.

PERTINENT NEGATIVE SYMPTOMS: Pt denies CP, SOB, fever, chills, URI symptoms, abdominal pain, any bladder/bowel abnormalities or any other acute concerns at this time.

RELEVANT UNDERLYING MEDICAL CONDITIONS: Arrhythmia Raynaud's phenomenon

OTHER COMMENTS: Pt denies an history of coronary artery disease.

Review of Systems

Review of systems is as indicated in the HPI. All other systems were reviewed and were negative.

Medications

Home medications: Sotalol HCL PO 80 mg BID
Aspirin PO325 mg every day
Vitamin D PO 1000 every day
Calcium oral 500 mg BID

Allergies

Patient allergies: No known allergies.

Past Medical/Surgical History

PAST MEDICAL/SURGICAL HISTORY Arrhythmia Raynaud's phenomenon
Hysterectomy Caesarean section Automatic internal defibrillator placement
2003

Patient has not been diagnosed with antibiotic resistant infection.

Social History

Living arrangement: Patient lives with spouse/significant other

Family History

There is no significant family history of any medical condition pertinent to the patient's current presentation

VITAL SIGNS

Initials/Date/Time Temp(C) Rt. Pulse Resp Syst Diast Pos. O2 O2
DelPain

Sat

Sc
MLM1 5/17/2008 21:0636.4 0 148 18 110 71 S 100 .R/A
0
MLM1 5/17/2008 21:11 62 16 128 88 S 98 .R/A
0
MLM1 5/17/2008 21:46 60 16 96 59 S 93 .R/A
0
MLM1 5/17/2008 22:10 60 16 101 65 S 97 .R/A
0

Physical Exam

GENERAL: alert; no acute distress, reporting that the symptoms have resolved

HEAD: normocephalic; atraumatic; no otorrhea, rhinorrhea, hemotympanum, Battle's sign, or raccoon eyes.

EYES: sclera clear; extra-ocular muscle movement intact

EARS: normal ear canals; normal right and left tympanic membranes.

OROPHARYNX: oral mucosa moist and pink, no edema or exudate; able to handle saliva without difficulty.

NECK: supple without meningismus; no cervical adenopathy; no tenderness to palpation; there is no stridor with auscultation

CHEST: good chest wall movement without crepitus or subcutaneous emphysema

PULMONARY: lungs clear to auscultation bilaterally

CARDIOVASCULAR: heart with regular rate and rhythm; no murmurs; no gallops; strong peripheral pulses

GASTROINTESTINAL: abdomen soft and non-tender; no abdominal distension or masses; bowel sounds present throughout; no guarding, rebound, or other peritoneal signs.

BACK: no paraspinal or midline pain; no significant muscle spasms.

GENITOURINARY: no costovertebral angle tenderness to percussion; no discomfort in the suprapubic region with deep palpation.

MUSC/SKEL: no focal bony tenderness; no apparent deformity; no peripheral edema

NEURO: normal mental status; no focal motor or sensory deficits

SKIN: normal color; warm; dry; no rashes; no petechiae

RESULTS

Lab

Basic Metabolic Panel; Specimen: blood ; Location: Not applicable
Result 5/17/2008 21:48

Basic Metabolic Panel; Specimen: blood ; Location: Not applicable

| Test | Flag | Value | Units | Ref. Range | Status |
|------------|------|-------|--------|------------|--------|
| SODIUM | | 139 | MMOL/L | 135-148 | F |
| POTASSIUM | | 3.6 | MMOL/L | 3.5-5.5 | F |
| CHLORIDE | | 100 | MMOL/L | 95-108 | F |
| TOTAL CO2 | | 27.6 | MMOL/L | 21.0-32.0 | F |
| GLUCOSE | H | 121 | MG/DL | 60-95 | F |
| BUN | | 24 | MG/DL | 7-25 | F |
| CREATININE | | 1.0 | MG/DL | 0.6-1.0 | F |

| | | | |
|---------------|----------------------------|----------------|---|
| GFR Estimated | >60 | >60 | F |
| GFR Estimated | UNITS = ML/MIN/1.73m2 | >60 | |
| GFR Estimated | If patient is | >60 | |
| | African-American, multiply | | |
| | result by 1.21. | | |
| CALCIUM | 9.4 | MG/DL 8.7-10.5 | F |

Reviewed By: MD 5/18/2008 02:42

CK; Specimen: blood ; Location: Not applicable
Result 5/17/2008 21:48

CK; Specimen: blood ; Location: Not applicable
Test Flag Value Units Ref. Range Status
CK 64 U/L 37 21-215 F

Reviewed By: MD 5/18/2008 02:42
*CARDIAC EVALUATION
Result 5/17/2008 21:52

*CARDIAC EVALUATION
Test Flag Value Units Ref. Range Status
CK MB 2.0 NG/ML 0.0-5.6 F
TROPONIN I H 0.14 NG/ML 0.00-0.09 F

Reviewed By: MD 5/18/2008 02:42
Procedures

12 lead EKG prior to order ; shown to: MD Old EKG at bedside
MLM1 05/17/08 21:19

Progress Notes

Progress Note: because of her tachycardia, I did order cardiac enzymes, as well as a basic metabolic panel to look at her electrolytes, and especially her potassium.

Progress Note: she remained stable throughout her emergency department stay, and I discussed the results of her tests with her and her husband.

Progress Note: I also spoke with Dr. who agreed with my assessment of this patient's episode tonight. It was felt that she could be safely discharged home and to return to the emergency department immediately for any worsening of her condition or change in her symptoms.

Progress Note: at the time of discharge, the patient was re-examined, has had no change in her physical exam, has been stable throughout her emergency department stay, and will be discharged to home and is advised to download her defibrillator results when she arrives home. She has agreed to do so.

Consults

Consultant: Call placed to: "CARDIOLOGIST MD 05/17/08
21:25

Time cardiology call was placed. Saturday, May 17, 2008 21:26 MD
05/17/08
21:26

Consultant: Call received from "CARDIOLOGIST TDA
05/17/08 21:51

Medical Decision-Making

ECG: EKG showed a normal sinus rhythm with a rate of 67, was ST and T-wave

changes that were unchanged from a previous EKG. There is no clear evidence for ischemia or injury when compared to her previous EKG. Cardiac Monitoring (1 to 3 lead)

Rate: initially, 148, but thereafter, in the 60s

Rhythm: normal sinus rhythm

Ectopy: occasional ventricular premature contraction but no evidence for atrial ectopy.

Pulse Ox: 100%

Oxygen: Room Air

Interpretation: Normal

Intervention: None

Medical Decision-making: This patient has a history of right ventricular dysplasia, has an automatic defibrillator placed, developed a significant tachycardia at home, but was back into a normal sinus rhythm without tachycardia shortly after she arrived to the emergency department. The patient did not have chest pain, but felt "clammy", during her tachycardia episode, and did not feel palpitations. Her labs were reviewed and they revealed a basic metabolic panel that was unremarkable showing no evidence of significant electrolyte abnormalities, and while her CK and CK-MB were normal, her component was elevated. Given the patient's reported cardiac catheterization that showed "no evidence for coronary artery disease" (per the patient and her husband) it is felt that the drip on and likely/possibly represents a global ischemia due to the rapid heart rate rather than an injury secondary to coronary artery disease. The patient was also a discharge to home, has been advised to return for any worsening of her condition or change in her symptoms, is to download the episode when she arrives home, and to follow-up with her cardiologist on Monday.

There was no clear evidence for acute coronary syndrome, pulmonary embolism, dissection thoracic aneurysm, ventricular tachycardia, or pleurisy.

Patient Discussion

Test results were discussed with the patient and/or the patient's family.

The diagnosis was discussed with the patient and/or the patient's family.

The treatment plan, as specified under disposition documentation, was discussed with the patient and/or the patient's family. The patient and/or

the patient's family have expressed understanding and comprehension of the plan.

Resident Supervision

Signatures: