

**The (—) Law Offices
Medical Records Summary
Privileged and Confidential**

Case Caption: (—), (—)
(—) File Number:
Date of Injury: (—)
Responsible Attorney: (—)
Date of Records Review: 1/4/09
Reviewed by: (—)

Medical Records From:

(—) Fire EMS PCR
(—) University Hospital

Overview: Seventy year old (—) was working as a janitor on (—), 2008 when he began to complain of chest pain to his co-worker. It got progressively more severe over the next twenty minutes before an ambulance arrived on the scene. He was found by EMS slumped in a chair, unresponsive and with agonal respirations. As he was being placed on a stretcher for transport to a hospital, he stopped breathing and went into cardiac arrest. Mr. (—) was resuscitated by EMS and transferred to the emergency department of (—) University Hospital where he arrested again and was once again resuscitated, although he remained comatose and was placed on a ventilator. A neurologic examination showed that Mr. (—) had suffered irreversible brain injury due to lack of oxygen. Physicians met with the family and a decision was reached to provide comfort measures only until arrangements were made for organ donation. Subsequently, he was taken off of the ventilator and passed away at 12:41 am on (—), 2008.

Mr. (—)'s medical history is remarkable for the fact that he had been admitted to the hospital three months earlier after experiencing dizziness followed by loss of consciousness while on the job. At a subsequent visit to the ED of the same hospital less than a month later complaining of increased dizziness with headaches, he reported having fallen and sustained a concussion at that time, although records do not back that up, save for a 2 cm laceration noted to the back of his head. He also had a history of chronic cough, shortness of breath and a CT of the chest revealed some lung damage secondary to asbestos exposure.

Chronology/ Summary of Records:

8/22/08: (—) Fire EMS PCR:

History of Present Illness: Mr. (—) was assessed. Assisted breathing and cardiac monitoring was initiated. When the monitor indicated cardiac arrest, CPR was begun and a breathing tube was inserted into his airway.

Medications: Epinephrine (1:10,000) 1 mg was given IV followed by Atropine 1 mg IV. An additional 1 mg of Epinephrine was given IV with some improvement. (p.2)

8/22/08-8/26/08: (---) University Hospital:

Primary Diagnosis: Anoxic brain injury secondary to ventilator-dependent respiratory failure, benign positional vertigo, sinusitis, and pulseless electrical activity (PEA) code X 2 (p.18)

Treatment: Mr. (---) arrived at the emergency department by ambulance with treatment in progress. While in the ED, he was shocked twice for a too rapid heart rate and started on amiodarone. He arrested once again and was resuscitated for the third time. A central venous catheter was placed in the femoral artery, a urinary catheter was placed, as well as a nasogastric tube, and he was also connected to a ventilator. When stable, he was transferred to the Medical Intensive Care Unit where he was monitored and treated for cardiac arrhythmia and aspiration pneumonia. (At some point he experienced “seizure-like activity,” vomited and aspirated.) After further assessment and treatment, a poor prognosis was presented to the family, at which time it was decided to withdraw further care and discontinue the ventilator.

Tests: Neurological assessment (p.129), EEG (p. 239), cardiac assessment (p. 118), ECG (p. 252 – 258), CT scan of the brain (p. 247), CT angiogram of chest & abdomen (p. 249) chest x-rays (p. 240 - 246), sputum culture (p. 259 – 260), ultrasound of lower extremities (p. 251)

Medications: On admission to ED, a 300 mg bolus of Amiodarone followed by IV drip to correct heart rhythm. Upon cardiac arrest in ED, was given 1 mg Epinephrine followed by 1 mg Atropine. Morphine 3 mg given for “agitation” and Lasix 40mg to reduce fluid in lungs. (p. 29) After admission, he was given 30mg Amiodarone IV push (p. 35), 40mg Lasix IV push, Morphine 3mg IV push, Neosynephrine 80 mcg per min IV, and Ativan 2mg IV push (p. 36), antibiotics Levaquin, Flagyl, Vancomycin for lung infection (p.55), a Morphine IV drip (p.96), Keppra 500mg IV twice a day and Dilantin 100mg every 8 hours for seizure-type activity, Tylenol 650 mg for recurrent fever, (p. 122), Heparin 5000 subcutaneously every 8 hours (p. 124), antibiotics Unasyn 3g every 6 hours and Vancomycin 1g every day (p. 126), Insulin as needed for high blood sugar (p. 233)

History of smoking, alcohol consumption and illicit drugs: Smoked 1 pack per day for 35 years, 2 beers per day (p 110), tox screen negative. (pp.18, 490)

Prior family and medical history/prior injuries: Mother died of coronary artery disease at age 70, Father died of coronary artery disease at age 75 (p.110)

5/30/08: (---) University Hospital: Mr. (---) appeared at the emergency department (ED) on the advice of his doctor complaining of headache and dizziness. He said that he had fallen and suffered a head injury on (---) and “had never felt right” afterwards. He reported his headaches and dizziness getting worse. His glucose was 194. (p. 298) The record from (---) shows that he had a “2 cm laceration” on the back of his head at that time. (p. 336) According to nurses notes, Mr. (---) told them he had suffered a concussion on the previous occasion for hospitalization although I found no record of it. (p. 304) He was treated with Reglan, Maclazine and Tylenol. A CT of the brain was ordered which revealed no sign of abnormality and no change from the one done previously. (p. 305) Lab work was normal except for the elevated blood sugar. (p. 309) He was discharged from the ED the same day.

5/6/08 – 5/7/08: (----) University Hospital: Mr. (----) was working at his job as a janitor when he complained of dizziness to a co-worker, sat down in a chair and then lost consciousness. He later reported having experienced a chronic cough with increasing shortness of breath over the course of the four previous months. (p. 391- 392) Mr. (----) was evaluated with the following tests – EEG normal (p.491), CT of the head unremarkable (p.474), ECG “borderline” with left ventricle enlargement, normal sinus rhythm (NSR) with occasional premature ventricular contractions (PVCs) (p.478), CT of the chest reveals “atherosclerotic disease of the coronary arteries; ... infectious or inflammatory process present in both lungs” and prior exposure to asbestos (p. 472) lab results of blood work showed increased white cell count consistent with infection and elevated glucose – 154 (p. 479 – 480) No cause was found for his dizziness and subsequent loss of consciousness. Seizure activity was ruled out. His final diagnosis was syncope and pneumonia. He was discharged with antibiotics and an inhaler. (p.315)

2003: L4 – L5 Laminectomy

Abnormal labs: Initial findings in ED; cardiac troponin levels elevated (0.5-0.8), electrocardiogram (ECG) showed ejection fraction 30% with global hypokinesis, arterial blood gases (ABGs) – pH 7.16, PaCO2 16, PaO2 52, HCO3 390, Base excess 18, O2 sat 99, white cell count 14.4, neutrophils 68%, creatinine 1.7, glucose 330 (p. 18)

Continuously elevating CPK level – 148 – 381, PTT 29.8 (p.125), phosphorus 8.6, magnesium 2.4 (p. 261)

8/23/08: Glucose 142, albumin 2.4, calcium 7.6, phosphorus 1.5, CK 236, troponin 0.5, white cell count (WBC) 11.6, neutrophils 85.5%, red cell count (RBC) 3.67, hemoglobin (Hgb) 11.2, hematocrit (Hct) 32.7,

8/24/08: Glucose 137, calcium 8.1, CK 381, troponin 0.53, WBC 12.9, neutrophils 88%, RBC 3.51, Hgb 11, Hct 31.3 (p. 262 - 263)

8/25/08: WBC 12.0, neutrophils 88.1%, RBC 3.55, Hgb 11.0, Hct 31.6 (p.207), chloride 111, glucose 170 (p.262 - 263)

Interpretation: The heart is not functioning at optimal levels and has sustained some damage. Gas exchange in the lungs is inadequate and life-threatening. Infection is present and he is anemic. Blood sugar is far too high (possibly undiagnosed diabetes). Blood clotting time is delayed, but that is likely due to the heparin that was administered.

Other (Re: Wife): The emergency contact lists only a brother: John (----),(----) Wolf St, (----),(----)(--), Phone: (----) (p.10) Mr. John (----) is also listed as the next of kin. (p.11) It was Mr. John (----) who signed the release to the funeral home (p.12), the donor consent (p.16), as the “surrogate decision maker” (p.25), and the consent for treatment (p. 27)

Nurses notes mentions “family,” but not “wife” specifically (p.101), “Lived alone” (p.110)

Other (Relevant Info): “According to family, patient was experiencing increasing confusion, shortness of breath and headaches during the week preceding this episode” (p. 118)

