[redacted]

PATIENT: MAHER, JOHN

[redacted]

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:
Mr. Maher is a 41-year-old gentleman without prior history of known heart disease. He has risk factors including a very strong family history of premature coronary artery disease at an early age. He has a number of relatives with coronary events prior to age 50 (prior to age 40 in some cases). He also has high cholesterol and does smoke; although, he is in the process of quitting, apparently. He may have been feeling poorly for the past several days but, tonight, felt generally poorly without, apparently, substernal chest pain. He then collapsed and was found unresponsive. His wife promptly called paramedics, who arrived quickly and instituted CPR. He was in ventricular fibrillation and was shocked to atrial fibrillation. He was transported to the ER where he was unresponsive and was intubated. He was saturating well. His blood pressure ranged from the 80's to the 120's in the ER (dopamine). The cath team was activated for cath and possible primary intervention.

PAST MEDICAL HISTORY:
Hyperlipidemia.

MEDICATIONS:
None.

ALLERGIES:
NONE.

FAMILY HISTORY:
Positive for premature coronary artery disease, as above.

SOCIAL HISTORY:
Positive for smoking.

REVIEW OF SYSTEMS:
Review of systems unobtainable.

PHYSICAL EXAMINATION:
VITAL SIGNS: On physical exam on my arrival in the ER, he had a blood pressure in the 90's on dopamine 5.
GENERAL: He is intubated. He is moving all extremities somewhat symmetrically and not in a rhythmic seizure-like activity. He appears to be coughing or gagging on the ventilator. It is unclear if he is posturing or attempting to move. He is not alert at this time.
NECK: Jugular venous pressure estimated at 5.
CARDIAC EXAM: Irregularly irregular rhythm. No murmur. He does have femoral and dorsalis pedis pulses.
EXTREMITIES: Lower extremities without edema.
LUNGS: Coarse breath sounds anteriorly.
ABDOMEN: Nontender, nondistended.

LABORATORY DATA:
PH 7.26, pCO2 of 46.5, pO2 187, O2 saturation 98.9, potassium 3.4, creatinine 1.2, glucose 254, AST 427, ALT 385, CK 515,

Create Date: 2007-7-1

troponin 4.63. White count 12.2, hemoglobin and hematocrit 16 and 47. Platelets 260, INR 1.08.

EKG post defibrillation shows inferior ST elevations with small Q waves. He does not have prominent anterior R waves but does have anterior ST depressions.

IMPRESSION:
1. Cardiac arrest at home. CPR by paramedics on arrival. Defibrillation to atrial fibrillation with electrocardiogram suggesting inferior-posterior infarct. Unresponsive, now intubated. Unclear neurologic status.
2. Family history of early premature coronary artery disease.
3. History of smoking, recently stopping.
4. History of high cholesterol.

PLAN:
Cardiac catheterization and possible percutaneous intervention. I have discussed the situation with his wife. She understands the gravity of the situation. He is hypotensive in the setting of infarct. This alone provides a very grave prognosis, which can be markedly improved if he can undergo cardiac catheterization and percutaneous intervention on a culprit vessel. He remains, however, with unclear neurologic status. She understands and is understandably overwhelmed but agrees to proceed. The cath lab team has already been contacted.

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mdj