[redacted]

DISCHARGE SUMMARY

PATIENT: MAHER, JOHN
[redacted]

DATE OF ADMISSION: 07/01/2007
DATE OF DISCHARGE: 07/14/2007
[redacted]

REASON FOR ADMISSION: Cardiac arrest.

HISTORY: Mr. Maher is a 41-year-old who was admitted to Virginia Hospital Center on July 1, 2007 following cardiac arrest. He was found unresponsive at his home by his wife after complaining for several days of not feeling well. EMS was called and started cardiopulmonary resuscitation. They also performed electrical defibrillation for ventricular fibrillation with conversion to atrial fibrillation. He was transported to Virginia Hospital Center with continued unresponsiveness and was intubated. The patient apparently vomited a large amount with intubation and
there was suspicion that he aspirated at that time. He remained unresponsive and was transported to Virginia Hospital Center.

HOSPITAL COURSE: He underwent emergency cardiac catheterization and was found to have severe three vessel coronary artery disease. He underwent successful percutaneous transluminal coronary angioplasty without
stenting of the right coronary artery at that time. An intraaortic balloon pump was inserted and he was admitted to the Intensive Care Unit.

An echocardiogram on July 2 revealed an ejection fraction of 40 to 45%. A carotid Doppler examination revealed no significant carotid stenosis. A CT scan of the head on July 4 was negative except for some acute sinusitis. An x-ray revealed a right lung infiltrate and a sputum culture was positive for group B Strep agalactiae and Staphylococcus aureus. This was treated with Zosyn. His electrocardiogram revealed inferior ST elevations and
small Q waves. His CK peak was 5063.

He was extubated but had some short term memory loss which gradually improved.

On July 6, 2007, he underwent an endoscopy due to some gastrointestinal bleeding and was noted to have superficial antral erosions with no evidence of bleeding.

On July 9, 2007, he underwent coronary artery bypass graft surgery including a left internal mammary artery graft to the LAD and saphenous vein graft to the first diagonal branch, first obtuse marginal branch, second obtuse marginal branch, and right coronary artery posterior descending branch.

On July 13, 2007, he underwent an electrophysiology study and was found to have easily inducible sustained ventricular tachycardia. He, therefore, underwent insertion of an implantable cardioverter defibrillator.

He was discharged home on July 14, 2007.

DISCHARGE MEDICATIONS: Ecotrin 325 mg daily, stool softener of choice p.r.n., Toprol XL 25 mg daily, Lipitor 80 mg q.p.m., Keppra 500 mg b.i.d., Zestril 2.5 mg daily, Protonix 40 mg daily, Lasix 20 mg daily for three days, K-Dur 10 mEq daily for three days, Vitron-C daily, Tylenol p.r.n. pain and Darvocet-N 100 p.r.n. pain.

DISCHARGE INSTRUCTIONS: Patient education was begun on post op day three in accordance with standards set by the CVT service and continued until discharge. This education included input from dietary and cardiac rehabilitation consultants. A list of instructions was given to the patient at the time of discharge which emphasized permissible activities, diet, discharge medications and emergency contact methods. The

patient was judged by me to be stable at time of discharge. A copy of these instructions is detailed in the patient's hospital record.

The patient is to return to our office for follow-up examination on July 24, 2007 at 10 [redacted]
sternal precautions.

PRINCIPLE DIAGNOSIS: Coronary artery disease.

SECONDARY DIAGNOSES:
1. Cardiac arrest.
2. Anterior wall myocardial infarction.
3. Altered mental status.
4. Pneumonia.

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