MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID--------------SEX---UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

Adm 22/11/00 ICU MATER
Transferred Logan Hospital c aspiration pneumonitis and pancreatitis
History - admitted Logan 20/11 c abdo pain 21/11 NG inserted + gastrografin → into (L) lung **
HT ↓ SaO_2 ↓ HR ↑ Renal - oliguric
intubated prior to transfer, sedated — no medical/surgical history, nonsmoker, occ. drinker
Abdo distended ++
NG, CVL, ART, inotropes adrenaline + dopamine, lasix, AB's + Dobutamine
FiO_2 100%
- HT ↓ 60/- SaO_2 91% on FiO_2 100%
ARDS 2° pancreatitis + aspiration, oliguric renal failure, acute pancreatitis
23/11 vascath for haemofiltration CVVHD NJ feeding tube
O.T. #1 necrosectomy - necrotic pancreas.
24/11 multi organ failure, severe resp + cardiac failure, coagulopathy
abnormal liver function
wean ? adrenaline
25/11 Feeding tube blocked / unblocked.
Bronchoscopy - thick sputum, noradrenaline
27/11 CVL + art resited. Bronchoscopy
(O.T #2) Laparotomy + debridement — still inotrope dependent
29/11 (OT # 3) Cholecystectomy + debridement — ventilated, poor gases
30/11 some improvement. — critically ill.
(OT #4) necrosectomy performed
colonic lavage
2/12 (OT #5) TRACHY under bronchs
3/12 (OT #6) mesh closure ? abdo
NJ inserted (L) subclav CVL.
4/12 reflux - NG inserted — febrile to 40°
5/12 ↓ sedation weaning inotropes
7/12 norad + dobut ceased. NG blocked, removed (NJ still in).
sedation [illegible] + morph 2mg/hr
9/12 regular lasix. — d'arcee + F.C. Device
10/12 midaz ceased × moved toes (to his parents) — ↳ ? AB related / C. difficile
For stool cultures. ? C. difficile. — Awake ? confusion / short term memory loss intermittently
(L) foot - cold, no pulse ↓ circ. — Agitated + anxious Bp ↑ 190/- c stress.
11/12 OT #7 Mesh fixed up
16/12 Commenced T-piece
19. Bronchoscopy

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27-29 CULGOA CRESCENT 14-06-1957
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NO RELIGION SELF EMPLOYED

(Affix Patient Identification Label Here)

________________ HOSPITAL

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
17.1.00	Surg Reg.
0500	
	Sudden deterioration at 4 o'clock → [illegible]
	w/ tachypnoea 34
	dyspnoea sats 84% 6L →
	90% [illegible]
	PO2 59 PCO2 26 pH [illegible]
	tachycardia 174
	U.O. (a) last 4 hrs now
	17 mls + conc. last hr.
	[illegible]
	[illegible].
	[illegible] - [illegible] [illegible]
	24 hr [illegible] w/ CT [illegible]
	of [illegible] [illegible]
	[illegible] or [illegible] [illegible] [illegible] USS
	initial WCC 21.0
	Ca [illegible] (N) [illegible]
	pH (a) (a) LFTs (N) Cr/[illegible]
	Today [illegible] 3rd [illegible]
	to (L) lower lobe [illegible] [illegible]
	NGT [illegible] 10.00 am w/ [illegible]
	↓ sats to 88% on air [illegible]
	recovered well on O2 + was [illegible]
	but tachycardic 130 until [illegible]

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22/1/00 ICU/CCU Reg

Admission of a 42 year old gentleman transferred from Logan with aspiration pneumonitis & pancreatitis.

HxPC: Admitted to Logan Hospital on 20/1/00 with central abdo pain after eating.
Ultimately idiopathic pancreatitis.
-Initially:

Amylase	1931
WCC	23
Hb	167
pH	7.34
pO_2	127 on oxygen.

BGL: 12.6

-R conservatively.

Yesterday NGT placed and 400 mls Gastrografin Contrast given (Unchecked NGT's was put in L) lung.
-Initially well with ↓AE both bases ↓ breaths L) base
-Became unwell last night
-Hypotensive
-Hypoxic
-Tachycardic
-Oliguric.
No ICU beds at Logan or PAH so transferred here.
Intubated just prior to transfer.
Oliguric last 3-4 hours only.
Previously well before admission to hospital.
No previous episodes of pancreatitis
Not a big drinker according to family - only drinks occasionally.

PMHx: Nil known PMHx. ?HTN/HD/Asthma.

PSHx: Nil

Non smoker
Occasional drinker.

All: Nil

CLINICAL EXAMINATION

DATE:

OE: On arrival here.
looks unwell. Cool peripheries
Sedated, intubated & ventilated.
Temp: 38.3

CVS: PR 135 bpm sinus tachy.
BP 90/50 mmHg - noninvasive.
JVPNE
HSx2
0SOM

Resp: FiO_2 O_2 sats 98%.
FiO_2 70% O_2 Sats 95% (NBM)
AE ↓ bd both bases.
PN resonant.
BS: Occ crep.

abdo: Distended +++.
Tense.
Occ bowel sound only.

CVP: 20

No results as yet.
CXR shows RML collapse.
& ETT not quite down far enough.
↓Expansion both lungs.

Imp: Very sick 43yr old man with ① pancreatitis
② Gastrografin aspiration
③ Hypotensive & shut down.
④ Oliguric.

Plan: ABG lactate CVL.
Dr Whiting is on his way in.
Being seen by Dr Cannbody.
Plans as per Dr Whiting & Dr Cannody.
Rpt bloods this pm.
BSLs.

K Johnson.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

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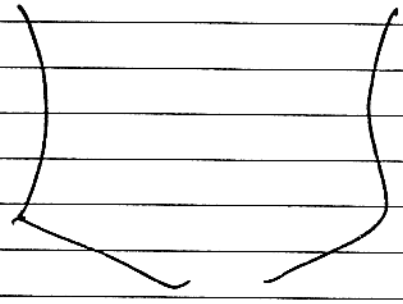
22/1/00

10am Admitted Logan. early hours of 21/1/00.
c pancreatitis. Given 1L fluid load.

Now has severe pancreatitis manifest by.

ARDS combined gastrogastritis / pancreatitis.
Relative hypoperfusion of pancreas on CT. – all looks viable.
No acute fluid collects
↑glucose.



Stay Light.

BP = 90/60 pulse = 115.

UO ↓↓.

No indication to take to OT at this stage.

Recommend - naso-jejunal feeding.
- imipenem IV.
- maximum ventilatory support

? Is there a role for bromocriptine.

M. Cannon.

22.1.00: WHITING:

Hypo c Severe pancreatitis
Onset 36/24 ago
Vomiting → epigastric distension
Amylase 1900
Wcc 0-10 yesterday Wcc 23.0

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

Ventilated
Currently: Cool periphery / mottled
BP 100/60
HR 130/min Sinus tachy
U/O 20 ml/hr
Creat 0.10

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

Urine → dark coloured with ↑ bile

Plan (1) Art line + CV line
(2) Start inotropes - adrenaline 0.02 mg/kg/min + try to improve peripheral perfusion
(3) Dopamine 2.5 μg/kg/min
(4) Monitor CVP.
(5) Volume load as necessary
(6) If ~~no U/O~~ U/O < 100 ml/hr then give frusemide 40 mg + 8 mg/hr
(7) Imipenem 500 mg TDS

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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Nurses notes 22.11.00. 1300hrs.
Received pt @ 0845 from Logan Hospital - paralysed and ventilated.
Past history as per medical notes above.
Since admission ~~above~~ arterial and central lines inserted.
CNS - GCS 3/15 - on midazolam + morphine 5mg + 5mg each/hr having had vecuronium 8mg + 4mg earlier. Pupils size 3 + reacting
CVS - ECG - S tachycardic - rate to 140. - 12 lead ECG ST ↑ L1 V5 + V6. Very cool, mottled peripheries but core T° 39°. Blood cultures x1 taken. Currently requiring 0.02 ug/kg/min adrenaline to keep BP 121/71.
Also on 2.5 ug/kg/min dopamine.
CVP +13
Resp - SIMV 12 x 900 Peep 7.5 PS 20cm. Small amounts dirty brown sputum aspirated via ETT. AE ↓ bibasally.
GIT - BS active passing flatus.
Endocr - BSL 9.9. for 4/24 BSL's.
Renal - urine 9 - 32 mls/hr. on 2.5 ug/kg/min dopamine.
~~ADDIT~~ 1400hrs: T° to 39.3.
GCS 10/15 - morphine + midazolam ↑ to 7.5 mg/hr + 7.5 mg/hr.
Wife + x2 brothers ~~son~~ in law in attendance.
Mother + father are flying up from Wollongong ~ 1600hrs. Wife has spoken to Drs Carmody + Whiting. - (Houghton) [signature] RN

22/11/00 ICU/CCU Reg

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

Has been unwell all shift.
Admitted this am at ~0930hrs
Art line + CVL inserted by Dr Whiting
Ventilated, initially on 100% oxygen.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

Resp: Ventilated.
FiO2 90% PEEP 10cmH2O RR 12
AE good both lungs
PO2 66 mmHg last ABG.

CVS: On 0.04 ug/kg/min Adrenalin
CVP/ 9/16cm.
BP 103/60 mmHg
NSx2 HR 137 bpm sinus tachy.

Neuro: Sedated with morphine + midazolam 7.5+7.5mg
Pearl.
Responding when rolled – kicks.

Renal: On 2.5ug/kg/min of Dopamine + frusemide infusion.
UO 15ml/h in last hour. Remains oliguric.

Abdo: Distended ++
BS Very quiet.

ECG: ST↑ 1mm I, II, V3-V6 – Previously ↑0.5-1.0mm on baseline.
HR 90 bpm.
No TW/Qs.

CXR: ETT ~~NG~~ just above carina.

Plan: Keep CVL ~12cm.
Try to keep SBP > 95 mmHg

Plan for Weaning: Happy with PO2 of >60mmHg.
Continue current support.
~~Has asked for the surgeons~~ Has ask for surgical RV again this pm.
Try to keep CVL >12cm

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITAL

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22/1/00 ↓HR to 90
1715HM ↓BP to 80/40
↓SaO_2 to 85

↑Adrenaline to titrate to BP - keep SBP 100mmHg
↓Tidal Volume → ↑Sats + ↑BP
Give $NaHCO_3$.
Check bloods regularly overnight. Check K+ next hour.
Rpt ABGs
Correct acidosis.

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

Kylie Johnson
Reg

22/1/2000
Surg Reg
· Deteriorating

CVS Hypotensive to 60 systolic
Bradycardic (relatively) to 80.
→ Adrenaline ↑ 12 mcg/kg/min

Resp - Hypoxic - sats 91% on 100% FiO2

Renal UO poor - 5-10 mls/hr
renal dose dopamine
Lasix infusion

Imp Deteriorating

Not for ... waiting (ICU consultant)
⇒ ? needs OT

MHPH 45-1 1/92 Chart B

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

D/w Dr Carmody (surgeon)
→ OT is of little benefit as
he probably has severe end of the disease
→ Recheck

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Under Section 91 and Section 141
of the Health Rights Commission Act 1991.

22/1 8:20pm

Thanks.

Necrosectomy at this stage will not reverse this acute deterioration or tomorrow if sustains this level of illness

Dr McSweeney

22/1/00 Evening
Rmo. Problems

(1) Acute severe pancreatitis - unheralded.
- amylase 1931 initially.
- seen this a.m.
- abdo distended ++ BS avid
- S/B surgeons as per above note

(2) ARDS 2° to pancreatitis + gastrografin aspiration
- Gas exchange poor
- Currently on FiO_2 95% + PEEP 10 and oxygenating ~90%.
- High pressures up to ~40 mm Hg.
- CXR appearances deteriorating.

(3) Oliguric renal failure - UOP ~5-15 ml/hr. despite lasix infusion 5 mg/hr.
- ~~FHG~~ - nil response to fluid loading.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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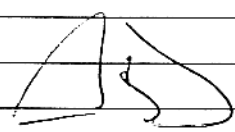
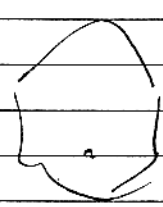
(4) Metabolic acidosis 2° to (1) (5).
pH 7.25 at 17.15h, BE -10.1
→ 200 mL of $NaHCO_3$ over 2/24.
- currently 9²/24 ABG
- aiming to B.E. > -5.0 (ie [≤ 5⊟] + [< 0]).

(5) Haemodynamic instability
Difficulty maintaining SBP ≥ 90
- currently high 80's despite escalation of Adrenaline — 0.26 mcg/kg/min.

OE/ T 39.5 PR 85 BP 83/50 CVP 16 RR 18.
GCS 2+T.

Chest

bronchial breathing (L) base
↓ AE generally
TML.
VC SIMV 700 x 14 PAP ~ 35-40.
PEEP 10. F.O_2 now 100%
SaO_2 79%.

His
Abds

tense
BS minimal

Feet pale ++
Cap refill ~ 5 seconds

GCS 2+T

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

- Acute deterioration at 1500h + 2150h
↓ SaO_2 to ~ 70%, ↓ BP to 50/, ↓ HR to 50/min.
Requiring escalating adrenaline, now 34 mcg/~~kg/min~~/min.
Requiring ↑ F.O_2 to 100%.
Currently oxygenating 79% only.
Remains hypotensive 85/

Plan - D/w DD writing x3 - most recent ~ 2230h:
(*) Feels that prognosis grave, current Rx is maximal
(*) Not for further escalation adrenaline.
(*) invid Not benefit from a change in ventilation parameters.

PTO

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE: 22·1·2000

Nursing Note

CVS: ✓ Haemodynamically unstable. Inotrope dependant with Adrenaline at .34 mcg/kg/min; not maintaining satisfactory BP. Monitored in ✓ sinus rhythm/tachy. CVP 14-20. Given haemacel + albumex boluses (500mls + 500mls) for ↓BP with little effect. RESP: SIMV 14 x 700 mls FiO: 1.0, SaO: 70 - 94%. Minimal thin yellow/brown endotracheal secretions. Cough reflex present. Spontaneous effort - 0 - 20 b/m (≈ 400mls). CNS: Occassional eye opening to stimuli & weak localising. Morphine & Midaz running at 10mg/hr. GIT: ✓ faint intermittent bowel sounds, ✓ No increase in girth measurements. Small amount of blood stained NG loss. RENAL: Minimal urine output - 0 - 15mls/hr. Dopamine at 2.5 mcg/kg/min & commenced frusemide infusion at 5mg/hr. ✓ METABS: BSL - 10.3 Temp 39.4. SKIN: Grossly intact, peripherals cool with fair - poor perfusion. SOCIAL: Visited by family.

(Oxley Nursing Ay) BEATON

Rmo (cont'd).

- (X) Would not benefit from addition of other inotropes.
- (✓) Advises treatment of acidosis ē NaHCO3 100 mls prn for Base excess ≤ -5
- (X) Does not feel that any more invasive monitoring would be of benefit
- (X) Given critical + multi-system progressive nature of illness, resuscitative efforts in the event of arrest are unlikely to be fruitful. - per Dr Whiting. Final decision regarding resuscitation left with resident staff - indicated that I would be inclined to attempt resuscitation given (P)'s age - Dr whiting happy ē this.

FWid boluses as required for ↓BP depending on CVP

Family in attendance.

B Shepherd

SHO

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 Hours	Colour	S.G.	pH	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

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NO RELIGION	SELF EMPLOYED	

23/01/00 RMO Clayden.

~0215h – UO ↓↓ since ~2000h.
nil for past 1h.
Creat now 0·36

CVP 15-16

-ao d/w Dr Whiting : (0215 h)
needs CVP ~ 16-18.

→given NSA 500 ml bolus.

⇒ CVP 17-18 BP 91/52.

→awaiting if any ↑ UO.

addit- ao d/w Dr Whiting, ↑ Lasix unlikely any benefit.
but is an option to try if infusion
no ↑ U.O. RClayden.

23/01/00. Terence remains in an unstable condition. He has been hypotensive all shift. He remains on inotropic support, adrenaline and Dopamine. He has also required 1 L of Human Albumin Solution. He also has midazolam and morphine running at 10 ml/hr. Patient is also remains on Frusimide infusion.
Ventilation is as follows SIMV Resp rate 14 100% FiO2, PS 20, SaO2 71-81%. Dr ward. Pressure areas intact and family unto visit throughout the night. R.N.T. Hitch.

23.1.00; WHITINGS
Very ill
Stable on inotropes.
Adrenalin ~ 0.3 µg/kg/hr.

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

BP 97/46

HR 85

Peripheral perfusion OK

Congestion OK

U/O poor

Temp 39.9°C

On [illegible]

Plan 1) Could add some dobutamine now that HR ↓ to 85 — Stop [illegible]

2) Continue dopamine / adrenaline

3) Vas cath + begin haemofiltration

4) Try to get HR ↑ to ≥ 100–110 /min c̄ dobutamine

5) Haemofiltration → BF 100 ml/min
CVVHD → Dialysate 1000 ml/h
→ Heparin 500 u/hr
→ Antithrombin 100 ml/h

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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M 778512

14-06-1957
M

SELF EMPLOYED

AFFIX PATIENT IDENTIFICATION

Dobutamine.
await CXRs

RClayden.

23/1

Severe pancreatitis progresses.
Maximum support
Critically ill.

Current literature suggests early necrosectomy patients have slightly improved survival

long talks Danielle re conservative vs operative approaches

OT today. for necrosecting.

23/01/00 0945 Pt R/V by Dr Carmody

O'Donnell (JHO) - planned for OT this am : Necrosectomy
- then for dialysis this pm

Plan — ✓x matched 6 x units PRC

Dr Carmody will insert a N-J feeding tube.

Note — Dr Carmody advised that this procedure would not NECESSARILY improve pts condition

he has d/w Danielle Lindsay (pts WIFE) @ length re risks/benefits of OT

will need consent

(O'Donnell)

CLINICAL EXAMINATION (Cont.)
DATE:

23/11/00 ICU Reg

R/V by Dr Whiting

Problems:

1) ~~Aspiration~~ Acute lung injury
Sats poor on 100% oxygen

2) Renal failure with oliguria.
77mls urine output since arrival.
For haemodialysis late this am.
If tolerates it haemodynamically take off 100mls per hour, if not just leave as isovolumetric

3) Hypotensive despite adrenaline 0.45 mcg/kg/min + dobutamine
BP only 90/60 mmHg
Peripherally perfused.
Ca output ~~hypotension~~ adrenaline up to 0.5mcg/kg/min if needs Rx.

4) BSLW lung. Need to keep up to 5-10's may need 50% dextrose infusion for this, to keep 5-10 mmol

5) Metabolic acidosis
Seems to be improving
PH 7.34 now
Has had 300mls of $NaHCO_3$.
Keep BE > -5.0 ~~-~~ if needs further $NaHCO_3$.

Has been seen by Dr Cannody.
- For surgery this morning.
- 6U blood cross matched
- Await haemodialysis for after the surgery.
- Have notified Dr Whiting of theatre.
- Family aware & agreeable!
- Currently trying to contact the med super for consent.

Kylie Johnson
(Reg)

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(all up) + see how the gas - [illegible] how he is going at
~ 1 [illegible]

PRIVILEGED AND CONFIDENTIAL

Under Section 91 and Section 141
of the Health Rights Commission Act 1991.

23/01/00
0850h
RMO Claydon

Night Shift Summary
d/x severe pancreatitis

<u>main issues</u> - Remains Critically Ill

① <u>Resp</u> - gas exchange worsened → PO_2 38 o/n. on FiO_2 100%

currently: pH 7.37 (∴ no further HCO_3 given)
PCO_2 36
PO_2 41 *
HCO_3 20
BE -3.7
Sats 80%

on SIMV: rate 14
FiO_2 100
peep 10
TV 700.

Sats 72-79% o/n.

② CVS - remained hypotensive; but no further declines o/n
- systolic av. ~ 80-85.
(↓↓ BP c̄ turns. - responded to 500ml NSA.)
CVP 18-20 this am

MHPH 45-1 1/92 Chart B

CLINICAL EXAMINATION (Cont.)
DATE:

relatively bradycardic HR ~ 80

~~__~~ Renal - oliguric.
0-4 ml uo/h.

Creat ↑ to 0.45. *.

- no response to lasix, fluid loading.

→ Dr Whiting inserted vascath this am to commence CVVHD
- lasix ceased.

other metabolic -
↓ing BSL^s.
currently 4.2.

K+ remains 4.7
(Mg 0.9)

Coags ↑^d PT 18.3 APTT 73.3
no clinical evidence of bleeding
(d/w Dr Whiting - acceptable to observe &
usually worse c̄ pancreatitis)

febrile o/n 39⁹.

→ needs BC^s this am.

addit d/w ~~family~~ o/n re. grave situation
Day team will speak c̄ them again re CVVHD & situation
Plan - CVVHD
- other as per Dr Whiting:
currently adding in

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID---------- SEX--- UR NO--

LINDSAY TERENCE — M — 778512

27-29 CULGOA CRES LOGAN VILLAGE 4207 — 14-06-1957 — M

Ph(H) 0755 468256

Ph(B) 0419655702

NO RELIGION — SELF EMPLOYED

23/01/00 1400 hrs O'Donnell (JHO) — Pt returned from OT

New art line in (R) wrist – not working.

(R) haemodynamically stable:

BP 97/55 MAP 71 (NBP)

pulse 83 — Currently No Art line functioning.

CVP 17

(R) Resp on SIMV 100% FiO2.

PS 20 PEEP 10

Sats 87 – 93%.

PRIVILEGED AND CONFIDENTIAL

Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

Currently on:

Dobutamine 12ml/h (10µg/kg/min)

Dopamine 7.5ml/h (~~200mg~~ 15µg/hr)

Adrenaline 25ml/h (50µg/min)

Morphine 100mg } 10mg/h.
Midazolam 50mg } 5mg/h.

as per Dr Whiting:

nil maintenance fluid – as pt is to be started on CVVHD
→ aiming for neutral balance if ↓BP and reas. ABGs

OR aiming for (–) 100ml/h. if ~BP and poor ABG's

(R) ABGs 1410 hrs

pH	7.36	pO_2	56
pCO_2	37	sO_2	90
HCO_3	20	BE	–4.1

(improved on pre-op ABGs)

∴ run a NEUTRAL balance on CVVHD

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

⊛ Abdo : lge transverse elliptical incision

Open wound : covered ī clear dressings

N-J. feeding tube in place

⊛ UO currently 2-4 ml/h. To start CVVHD

Plan will D/W Dr Whiting re insertion

↳ feeding plan : hold off on feeds today and consider starting tomorrow.

(O'Donnell)

1500hrs 23.1.00. Nurses notes

Remains critically ill.

CNS - 3-7/15. Morphine @ 10 mg/hr Midazolam @5 mg/h.

CVS - v. cold peripheries on inotropes: adrenaline @ .5 µg/kg/min, dopamine 15 mg/hr dobutamine 10 µg/kg/min and BP still only ~85 systolic. T to 40°.

HR 80's - ECG - SR. CVP +17.

Resp - ventilation unchanged - SIMV 14 x 700 on FiO_2 100 Peep 10cm. Brown fluid via ETT aspd

RUIT - naso jejunal inserted by Dr Carmody - wants to start feeds but Dr Whiting says not yet.

Renal - commenced CVVHD @ 1430 hrs - even balance at this stage ↓ low BP

Endocr - BSL 8.8 - 5.1

To Surgery as above.

Family in attendance

(Mudgway) Staff Gr

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATIOI

--ID----------	SEX	UR NO--
LINDSAY	M	778512
TERENCE		
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NO RELIGION	SELF EMPLOYED	

BSL 8.5

Art line replaced

Plan ① Try & keep SBP — do not wean inotrops unless hypotensive

② Contin CVVHD

③ O_2 could do if paO_2 >65 mmHg

23/1/00 NURSING – 2130hrs

Remains ventilated – FIO2 100% PS 20 Peep 10 Rate 14 + spontaneous breath up to 20 (total) HF/Hribibasally Sats 77-84%. Minimal secretions suctioned. S/B done writing refer above notation. FIO2 (may be reduced if paO_2 >65mmHg.

Haemodynamically unstable requiring inotropic support. remains hypotensive. BP 90-110/42-60

Peripherally cool & temp @ 38.7 – 39.00

GCS 3-4. minimal response to stimuli. PEARL (2+)

Input. ① Adrenaline @ 49 mcg/min ② Dobutamine 10mcg/kg/min ③ Dopamine 15mg/hr ④ Morphine & Midaz @ 10mg/5mg/hr respectively. Remains well sedated & sore.

Output: U/O poor 2-8mls/hr Smd NG aspirate as charted. Wound drainage moderate to large 725mls noted so far this shift. Wound dressing reinforced. due to samp. CVVHD continues & clear balance

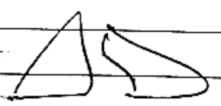
CLINICAL EXAMINATION

maintained. Heparin @ 2mls/hr c̄ clotting times 35-40 mins. Access pressures satisfactory.
Critical / however relatively stable c̄ no significant events noted.
Arterial line reinserted
Visited by family. — [signature] (RN) D HILL...

23/1/00 Problems - Evening
Reg

2325h. ① Acute severe pancreatitis - necrosectomy today
② ARDS 2° to above ± gastrografin aspiration
- maintaining SaO_2 generally >85%, occas. desat^n to low 80's, down to 70's c̄ turns.
- ventilation parameters unchanged
- on 100% FiO_2.
- VCS, MV 700 x 14 p-support 20, total rate 17-23
③ Haemodynamic instability
- generally maintaining BP ≥95/
- adrenaline 49 mcg/min - do not attempt to wean.
dobutamine 10 mcg/kg/min } leave as is
Dopamine 15 mg/hr.
④ Acute oliguric RF on CVVHD
- aiming + achieving neutral balance
- per Dr Whiting add 1L N.saline/24 hr to this end + 500 ml NSA.
⑤ Coagulopathy APTT 92 → titrate CVVHD heparin.
INR 1.5

OE/ T38.5 PR 110 BP 138/74 RR 22
Chest



↓AE Ⓛ > Ⓡ
occas. creps.

CNS GCS 6+T
Morph / midaz
⑩ ⑤

H ,, ,,

Abdo Open wound looks clean
BS nil
- Not for feeding for now per Dr Whiting
Plan - Try to maintain as is in neutral balance
Increase adren. if required
Otherwise leave unchanged
[signature] - SHO

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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23/01/00 Shift Summary (update from 1400hrs)
1610 hrs
O'Donnell
(JHO)

* unable to insert art line in either foot (as instr. by Dr Whiting)

→ he is happy for non-invasive BP measurements

O/E pt reas. stable

GCS 3 on M : M infusion (10 : 5)

pulse 67 Continues on :
Ad, Dobut, Dopamine inf

BP 116/55

CVP 16

Resp on SIMV 100% FiO2. Still quite acidotic - ABG's still poor but improving

PS 20 PEEP 10

Sats 89 - 91% ie pO2 56 @ 1400

Renal on CVVHD
- currently 25ml/h

UO est ~ 4ml/h

Aiming for neutral FB

Abdo drain on (L) side of wound ~ 40 ml/h.

nil feeds down N-J tube @ present.

Open wound : clean

CLINICAL EXAMINATION (Cont.)
DATE:

Surgeon's plan is to take pt back to OT on Wed / Thurs to close wound and for likely cholecystectomy

Nrk OT report : only small amt of necrotic tissue
→ this was all removed / washed out.

→ nil other abNs found in

Plan · continue IV infusions of ionotropes as written up

· continue IV ABs

· will R/V mane re viability of peripheral venepuncture for ABG's. (recent ones from (L) Fem A)

· continue CVVHD

(*) if BP remains good, pt may tolerate a ↓ in Ad

Aim for SBP ~ 100 mm Hg.

23/1/00 : WRITING: 1830

Somewhat improved but still v. ill

PaO_2 56 on 90% PEEP 10

BP 117/66

Peripheries warm.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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Aiming for -500 to -800 FB / day
(if CVS - BP, allows)

(3) Sedation ↓ to 7.0 mg morph
2.5 mg midaz.

(4) CVS - BP more stable today ~ 110-120 s

currently on —
DA 10 — 2.5 µg/kg/min
Dobutamine - 12ml/h (60mg/h)
NAdr - 0.17 µg/kg/min

Adr ceased.

[illegible]

(5) Bloods - all short. +

Lipids: TG 4.3 (0.5-2.0)
Chol 2.2
HDL 0.1 (0.8-1.8)
Lipid Risk 3.0.

no ↑in lipase / amylase ∴ NG fed o/n.

∴ as d/w Surgeons — cont NG feeds.

Further Plans: see Dr Leditchke's notes to follow after review

RClayden

CLINICAL EXAMINATION (Cont.)
DATE:

25/1/2000 1930 LEDITSCHKE

- Still very ill.
- Adrenaline successfully weaned.
  BP: MAP ~ 80 on 17 Noad. 10mg/L Dobutamine "Renal" Dopamine
  HR ~ 88.
- Now warm & reasonable perfusion
- Oedematous
- VOP 50 → 300 ml/h, with 10-20 mg/hr frusemide.
- Has commenced NG feeding as per Dr Kennedy.

Gas exchange remains problematic on 100% O_2 15 PEEP PCV!

Plan: (1) Paralyse : titrate to 2/4 TOF.
(2) Will conduct further PEEP Trial.
As appears v. sensitive to derecruitment DO NOT BREAK CIRCUIT (ie losing PEEP) without consulting ME, please.
(3). Accept $S_a O_2$ 90% on Blood Gas Decrease FiO_2 as tolerable
(4) Run negative Balance of 500 – 1000 ml/24hrs
– 4 boluses if necessary.
– accept MAP above 65 if passing urine
– frusemide infusion to drop VOP 200 ml/h.

If ongoing problems with gas exchange will consider a trial of prone ventilation

Joel Ledi

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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24/1/00 cont.

O.T.: 23/1 : partial necrosectomy
otherwise (N) laparotomy

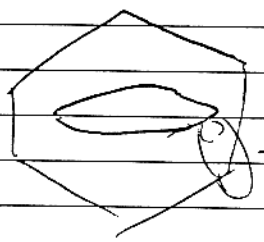
wound left open.

Tracy: temp 35.5. on morph/midaz
GCS 3 adrenaline 50 µg/min
on analysis dopamine
BSL 11 dobutamine

CVS: HR 84 BP 120/60
good peripheral perfusion.

RESP: on 100% O_2 Sats 90%. pH 7.38
O_2 5L
CO_2 40.

ABDO: on no feeds
open wound
still distended
- minimal drainage.



U.O. 0-34 mls/hr over past 24hrs

23/1 Hb 99 Na 139 bili 34 INR 1.2.
WCC 16 K 4.3 APTT 67.
Plts 207

Imp: problems as above.
? slightly improving post-op

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE:

Plan - TEOS please
- C.T. Wed/Thurs
- Wash hands
- Wife d/w Dr Carmody re: feeding
- Cont. Imipenem

SL

SMAN

WOUND MANAGEMENT 24/01/2000 0955hrs.
Referral from nursing staff re: pouching system.
Sebaceous both sides of main abdo wound.
Plastic sheet covering intact. Skin surrounding intact. ——— K Cusack RN ———

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Evidence Act 1991.

ICU WARD ROUND Monday, 24 January 2000 **DR A LEDITSCHKE**

Name: Terence Lindsay UR No. 778512

This 42-year-old man has severe pancreatitis with multiple organ failure. Has severe respiratory failure and cardiovascular failure on 50 mcgs of Adrenalin, as well as renal Dopamine and Dobutamine and a coagulopathy. His haematology is currently robust, but he has oliguric renal failure, for which he is on CVVHD, running a neutral balance with a counter current of 1000 mls/hr and he has abnormal liver function test, as one might expect. The underlying aetiology of his pancreatitis is unclear. Apparently there were no documented gallstones and there is no history of alcohol use. His lipids are unknown. He had an necroscectomy yesterday and there has probably been some clinical stabilisation in his condition since then. His abdomen is open with significant drain losses, which are being replaced with Colloid. The plan is to continue his current supportive therapy. He will have a trial of volume loading, limited in view of gas exchange, with further manipulations in his PEEP to try and improve his gas exchange, which is poor, with sets of 90% on 100% and 10 of PEEP currently and to commence some noradrenalin with a view to trying to wean some of his other inotropes and he is to have his Imipenem changed to 500 mgs 8th hourly of Merapenem, in view of his CVVHD. We are liaising with the surgeons about feeding down the naso-jejunal tube and, if this is not feasible today, then he should have TPN.

24/1/00 - NUKS - 1630. Critical / stable. Ventilating non PC/SIMV +/- PC 100% FiO2 20 Rate 14 Resp 5. + nil spont breaths AE ↓ bilat/14 minimal secretions suctioned prn. Sats 98-90% Remains on inotrope support. BP 130/97 for ↓ in adrenaline m/v 6/24. Aim for MAP of 65. Adrenaline presently running @ 38 mcg/min. Monitors BP HR 80

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

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24/01/00 – -84bpm. Cool peripherally, however slowly improving.
GCS – 3. PEARL size 2. Remains sedated of Morphine & Midaz infusion 100/50mg (10mg/5mg) respectively. Pt comfortable of same, however still grimace c turns.
Input unchanged from yest except for reduction in adrenaline and the replacement of wound 100DCS every six hours c colloid.
Output. U/O poor 2 – 18 mls/hr. Wound drainage approx 2000mls/day. CVVHD aiming for even balance. Pt 375 mls positive w/ last 24hrs.
Wound – warm & pink c nil evidence of breakdown or infection. Dressing removed and re attended. Covered c large opsite c 2 x coloplast drainage bags at both sides of wound. Same day intact at this time. Reinforce if req.
Visited by wife and other family members today before considering as to whether to bring in children. TLC +++ (RN) Phillips

PHYSIOTHERAPY 24/1/00.
Remains ventilated
Harsh breath sounds throughout
Sputum M/A thick dirty creamy
For R/V in AM (signature)

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

24/01/00 Shift Summary
1640 hrs
O'Donnell Day 3 Acute severe pancreatitis
(JHO) multi organ failure

pt quite stable this shift, but still critically ill.

Issues. 1. Resp on SIMV - Press Control

FiO_2 0.95
PS 20.

MHPH 45-1 1/92
F0627 Chart B

CLINICAL EXAMINATION

DATE:

PEEP 15
Rate 14
Sats 91%

Recent ABG's
pH 7.40
pCO_2 40
HCO_3 24
BE −0.3
pO_2 51
sO_2 88

quiet end exp wheeze
reas AE

CNS Requiring signif. ionotropic support

Currently on :

Adrenaline 38 µg/min
Dobutamine 10 µg/kg/min.
Dopamine 15mg/h

BP 135/74 Art 124/69 NBP
MAP (89) Aiming for MAP > 65.

pulse 82
CVP 21

Renal on CVVHD running @ 1L/h.

~~replacing~~. Cr 0.53 (slowly worse)
Ur. 24.5.

UO : ~ 20ml/h.

currently aiming for neutral FB

CNS GCS 3. On M:M 10:5

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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Abdo · lge open wound
· dressed ī opsite and has 2x collecting drains (1x on either side)

(R) · aiming for replacement of vol. lost from wound each 6/24 ī NSA over next 6/24

Coags PT 15·4 Hb 97
INR 1·2 WCC 20
APTT 64
Plt 194

Plan · continue CVVHD aiming for Neut. FB.

· continue ionotropic support but slowly wean Ad infusion aiming to keep MAP > 65

→ plan is to move over to NAd rather than DA/DBAm

· recheck ABG's this shift

· continue Abs

· Surg R/V manc – re return to OT

(O'Donnell)

24.01.00 NE ICU. 2215.
Ventilat^n – returned to 100% O_2 post desaturating after position change. Sa_2O now 89%. ↑ to 70/80% after turn. Scant → s/a secretions retrieved via E.T.T. Peep continues @ 15 cm. Rare occasional spontaneous breaths associated ℅ nursing interventions. ——
Weaning adrenalin as per above plan — tolerating. Urine output has ↑ over duration of shift. Haemofiltration continues. Sedation continues. Stable sinus rhythm. Wound drainage as charted. ——
V/B family. ——— K Lawrence

24/1/00 Evening
emo Problems

2359h ① ARDS ↑ v. poor gas exchange
- reduced to F_iO_2 of 95% early in shift based on SaO_2 ~95%
→ subsequently desaturated ↑ turn to high 70's & required ↑ to F_iO_2 100% - ~~PaO_2~~ SaO_2 on this (ABG) only 89%.
- recently ↑ SaO_2 to 97% → ↓ F_iO_2 to 95% (needs recheck ABGs).
- tentative plan for bronch tomorrow.

② Acute severe pancreatitis
?aetiology - lipids awaited
- remains critically unwell ↑ multi-organ failure

③ Oliguric renal failure
UOP actually improving
~30-60 ml/hr.
On CVVHD
Aiming at neutral balance
Replacing wound losses 9%/24 ↑ colloid

④ Inotrope dependence
- Adrenaline weaning well - BP robust
- Tolerating wean of 2mcg/min/hour
- now at 2x mcg/min.
- Dobutamine/dopamine continue unchanged.

~~OE~~/ T 35.3 PR 83 BP 130/70 RR 18.
Chest

↓AE L>R
PCSIMV RR 14 Insp pressure 25 PSuppt 20 F_iO_2 95% SaO_2 now 96%.

~~HS~~
Abdo - open as previous.
CNS - heavily sedated GCS 2+T
Imp - Marginally more stable
Oxygenation remains v. precarious

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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NURSING NOTES 24/01/00 06:45 hours.
Patient's G.C.S remains 3/15, PEARL, pupil size. 2 for both (L) and (R) eyes. C.V.S Patient continues to require inotropic support. ADRENALINE continues at 25ml/hr 50 mcg/Kg/min, Dobutamine and Dopamine both continue. Blood pressure has had a M.A.P 80↑ this shift. Systolic 113 - 150 mmHg, diastolic 65 - 80 mmHg. C.V.P 18-22. Temperature has been constant at 38.5°C. Urine output 7 - 34 mls/hr. I.V.T N. Saline running at 42 ml over 24 hours. N.S.A running 42ml/12hrs B.S.L between 8.4 - 11.2 mmols. Ventilation remains SIMV RR 14, T.V 700ml, PS 20, Peep 10 cm/H2O. Patient remains on 100% Fio2. Sao2 between 83-96%. C.V.V.H.D continues ~~to~~ running as per regime prescribed by medical staff. Pt blood pressure has remained stable. R.N. T. Hitchen. Clotting times have been between 20-30 minutes which are the parameters ordered by medical staff. R.N. Thomas Hitchen.

RMO - GOLIKOV
24/1/2000.
0810hrs.
Pt more stable this shift c.f. previously.

(1) Haemodynamically more stable
BP 145/80.
PR. 80/min.
Still on - Dopamine
- Adrenaline
- Dobutamine.

(2) Dialysis - neutral fluid balance

(3) Resp: - improvement.
Sats 90%. pCO2 40
(on 100% O2) pH 7.38 BE -1.3
PO2 56 HCO3 23

CLINICAL EXAMINATION

DATE:

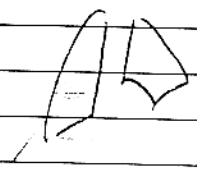
Ventilation parameters remain the same.

(4). oliguric still 34 – 14 mls/hr.
K 4.1, Cr 0.54, Urea 24.1

(5) BSL's stable 5-10
(last one 9.1).

(6) Amylase 389 (824 on admission)
Lipase 1183 (12337).

O/E :- T 38.5



AE

HS 1+2+0.

Plan:- Continue CVVHD
- continue inotrope support
- continue current ventilar orders.

McGowan.

24/1/00. SURGERY FOR CARMODY

42 yo ♂ NF from Logan : pancreatitis ? cause

admitted 20/1
transferred 22/1

problems : severe pancreatitis
iatrogenic gastrogastric aspiration
A.R.F.
hypotension

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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O/E BS [illegible]. Abdo wound intact, pink, [illegible] classic bags either side loss @ 12MD total 650mls — replaced over the next 6hrs with 4% Albumin @ 120mls/hr. Jejunostomy tube blocked off to be removed. NG tube F/U ~ 700 mls (2hrs), [illegible]. Pt now to be NG feed as per surgeons BNO. Abdo distend
Renal U/O ~ 40-70mls an → lasix infusion commenced @ 10mg/hr
U/O via IDC ~ 80-90 mls/hr continues. U/O & [illegible] BE
Noradrenaline for MAP 80 < mmHg. Metabolic T° 38.6 Maintenance 42mls/hr. BSL 8.6mmols. Note ( ) with fluids running for output no greater than -500mls in balence → notify RMO if goes above this aim. [illegible] Skin integrity satisfactory mouth/eye care. Wound - pad, [illegible] loss continues. Ooozing fluid
CVVHD → off @ present. Lumens - heparin locked.
Social seen by family today.

Christopher Arthur RN [illegible]

PHYSIOTHERAPY 25.1.00.
Remains ventilated
Chest - harsh breath sounds throughout
Sputum M/A thick dirty pus coloured
R/ bagging + ules N saline + suction
Evening physio to R/V
[signature]

25-1-00 1530hrs
- nasojejunal tube [illegible] on removal ∴ laryngoscopy + Maggill forceps & cut under direct vision → removed intact
- new NGT inserted under direct vision → difficult insertion
[signature]

25/01/00
RMO Claydon Day Shift Summary
1730hr.

Main issues:

(1) Resp:
(i) Bronchoscopy performed this am by Dr Leditschke.
(large amt of thick sputum suctioned)
[signature]

CLINICAL EXAMINATION

– gas exchange improved for most of shift –
ABG 1500h
FiO2 0.9
① pH 7.45
CO2 37
O2 70
HCO3 24
Sats 95.

– some decline in a'noon (after ETT manipulated):
② FiO2 90: 1554h
pH 7.37
O2 53
CO2 44
Sats 87%.

– will need rpt ABG in evening shift

– also sudden cuff leak ~1730h – now stable

(CXR – ETT: possibly moved higher up but okay psn. no PTX.)

– as per Dr Leditschke:
aiming to ↓ FiO2 as able.
(to avoid lung injury 2° to high inspired O2 [↑]s)
– if PO2 reasonable (eg ≥70) & measured sats ≥90 can ↓ FiO2 (suggestion for ~~overnight~~ next)
H'ever at ~1800h – sats in high 80s.
Dr Leditschke currently R/v ing.

② Renal Creat remains stable 0.42.

⇒ CVVHD ceased o/n.

→ commenced on 10mg/h Lasix infusion this am c good response in UO
(aim = 100 mL/h)
UO:

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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- chase lipids.

G.I.T
- Repeat lipase + amylase as feed last night
- consult with surgeon regarding feeding (Dr Carmody)
- Commence TPN 3:1, avoid lipids (CHO + AA only) and K+.

SEPTIC/NECROSIS Continue imipenem

(Hamer)

ICU WARD ROUND Tuesday, 25 January 2000 **DR A LEDITSCHKE**

Name: Terence Lindsay UR No. 778512

This man has multiple organ dysfunction, complicating severe pancreatitis and gastrografin aspiration. Currently he is sedated with a GCS of 3 on Morphine 10 mgs/hour and Midazolam of 5 mgs/hour. He has severe respiratory failure with a PO2 of 55 and oxygen saturations of 91 on 100% oxygen, with a 15 of PEEP. His compliance has improved however, with tidal volumes up to 7-800 mls this morning, compared with 550 mls yesterday with an inspiratory pressure of 25 on pressure control ventilation. His haematology is stable. He is making 40-70mls/hr of urine off the filter (clagged at 5.00am). His balance is currently approximately 800 mls negative. His cardiovascular failure appears to be improving with weaning off his Adrenalin. Now on approximately 7 or 8 mcgs/minute. He is still on 10 mgs/hr of Dobutamine and "renal dose" of Dopamine. His drain losses have continued to be copious and are being replaced with 4% albumin. His naso-jejunal tube is blocked. He did get some naso-gastric feeding for a brief period last night and seemed to tolerate this. Note that his bilirubin is now up to 123. His transaminases appear to be decreasing and his alkaline phosphatase is normal. His prothrombin time has remained normal and his skin integrity appears okay. His peripherally warm and well perfused. The plan is to lighten his sedation, to try and keep him comfortable, but capable of eye opening. However, before this, he has had a trial of Vecuronium to see whether this helps with his ventilation and gas exchange. He is to have a bronchoscopy, as there is small amounts of thick sputum. His chest x-rays this morning shows persistent left lower lobe collapse consolidation and also some new right mid-zone collapse consolidation. From the renal perspective, we are going to try to initiate an urine output with Frusemide and blood pressure support with noradrenaline, whilst maintaining a neutral or negative fluid balance because of his perilous gas exchange. I will discuss the issue of feeding with Dr Carmody and we will commence TPN in the interim. Chase the lipids that were done yesterday. He is to continue on Meropenem.

25/1/00
13:00 **NUTRITION & DIETETICS**

42yr old ♂ adm ?c aspiration pneumonitis & pancreatitis. Referred for feeding

Biochem No 138 K 3.6 Cr 0.42 Ur 24.2
Alb 26 Lipase 329 Amylase 160 Chol 2.2
TG 4.3 HDL 0.1 Bili 123 ALT 773 Hb 92

NJ tube inserted ~30ml/hr osmolite commenced & has been stopped due to tube blockage

To commence TPN 3:1, avoiding lipids, K+

Awaiting direction re commencement of enteral feeding

CUVHD has been ceased

CLINICAL EXAMINATION (Cont.)
DATE:

Dietitian cont.
Plan 1) TPN feeding 3:1 No lipids No K
To provide ptn at ~RDI (< theoretical
requ's for pancreatitis) whilst pt
off CVVHD
To ↑ energy if ↑ temp continue
2) To reassess ptn & glucose requ's Wed
3) To consider lipid inclusion in TPN Wed/
Thu?
J Anderson [signature] #684

25/1/2000 · BRONCHOSCOPY ·
LEDITSCHKE · Copious Sputum from RML Bronchus.
1300 R Apical lower bronchus.
Apical Bronchus LLL.
· very thick. – Blocked Bronchoscope lumen
· Specimen sent for m/c/s.
[signature]

Nursing Am Report. 1330hrs 25/1/00
CNS – PEARL size 2, Nil movement of limbs to stimulus, eye opening when hearing x [illegible] only. Morphine @ 7mg/hr midazolam 3.5mg/hr & Pt not lightened up yet. CVS BP 105/50 88/45, HR 90. Peripheral warm pedal pulses present. Art line ✓. CVC line ✓. Noradrenaline commenced & titrated up, now @ 0.17mcg/min/kg. Adrenaline weaned too 0.04mcg/kg/min continue to wean. Dobutamine @ 10mcg/kg/min Dopamine @ 2.5mcg/kg/min CVC ✓. CVP 18–20, TEDS ✓. As weaning adrenaline BP ↓ & to peripheral procedures → noradrenaline titrated up – If urine output maintained continue as is, if urine output drops, try to maintain MAP ≤ 80mmHg. If Noradrenaline up to 0.20mcg/min/kg → inform Consultant before further actions taken. Resp SIMV x 14, PEEP 15, PS 20, FiO2 100%, AER ↓ L crepes throughout & ↓ AE. TV 860–850, O2 sats 88–93%. Bronchoscopy – pus/mucous taken out of lungs → pt desats – down to ↓ 77–80% had to attempts till sats ↓ then given a break before starting again – Suctioned up dirty thick brown mucus – moderate amount → specimen sent. ABG – Pen. ——

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID---------- SEX--- UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

25/11/00 0830. SURGERY.

D3 post pancreatic necrosectomy

severe pancreatitis
aspiration pneumonia
ARF
open wound.

improving
- abdominal wound 2s → 4
- passing wind
- lungs being cleared physically

Lower
- nasojejunal tube now blocked

O/E. temp 38·8 GCS 3-4 sats 90% on 100% O_2

CVS. HR 90 BP 110/60 good perfusion

RESP SIMV. sats 90%

ABD. open wound. distended
brown but not cloudy ooze.

RENAL V.O. 30-70 mls/hr.

pH 7.47	HCO3 32	Na 138	Cr 0.42
O_2 55	WCC 23	K 3.6	Urea 24.2
iO_2 75			

plan - try flushing nj tube ± Coke
- if unsuccessful → ? n-g.
- wound charge wound swab - MC&S

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

25-1-00 1030hrs ICU WR Dr Lenitschke

(*) Acute pancreatitis (idiopathic)
- Adrenaline 7mcg/min
- UO > 40 mls/hr (Mean ≈ 65 mls/hr)
- Frusemide 10mg/hr
- Neg 300ml fluid balance + 500ml NGT loss = 800ml neg
- O_2 sats ok on 15cm PEEP, increasing compliance (TV 800ml) cf before
- Warm periphery now Dobutamine 10mg/hr Dopamine
- CXR - RML/Apical lower lobe worse
  - LLL improving but still has collapse/consolidation

- nasojejunal tube blocked/not in right place (NGT feeds last night
- ↑↑ bilirubin last 24 hours, otherwise LFT decreasing. Coag (N).

RENAL

Rx:- Start noradrenaline, wean adrenaline (+ then dopamine)
- Aim for MAP of 80mm Hg
  - if achievable, try for MAP of 90mm Hg.
- Titrate frusemide to achieve UO of 100mls/hr
- Neutral to slight negative fluid balance
- If UO not achievable

BRAIN

- ↓ midaz/morph to [illegible] to achieve "twilight state" (not distressed but able to interact)

CARDIAC

- Improving

RESP - Trial of vecuronium ? ARDS / Multiple organ dysfunction
- Poor function contours ⟸ ? Aspiration

- Bronchoscopy today
- May need trial of pure ventilation if not improving

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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25/11/00 POD 3. SURGERY.

D3 post pancreatic necrosectomy

SWCL pancreatitis
aspiration pneumonia
ARF
open wound.

improving
- convulsions weaned 25 → 4
- passing urine
- lungs being cleared physically

Lower
- nasojejunal tube now blocked

O/E. Temp 38·8 GCS 3-4 Sats 90% on 100% O_2

CVS. HR 90 BP 110/60 good perfusion

Resp 5 IMV. sats 90%.

ABD. open wound. distended
brown but not cloudy ooze.

RENAL V.O. 30-70 mls/hr.

pH 7.47	Hb 92	Na 138	Cr 0.42
O_2 55	WCC 23	K 3·6	Ur 24·2
CO_2 35			

Plan - try flushing nj tube ? Coke
- if unsuccessful → ? n-g.
- wound dressing wet/dry - with culture

SHAW

NAME —
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Plan (per late dlw Dr Leatherdale ~1730h)
- continue to wean adren 2mcg/kg/min/hour until unable to go further (MAP 65)
- then add NorAdr at 5mcg/min
- wean Adren further as tolerated until unable to proceed
→ escalate NorAdr & repeat process
- aiming for support ± NorAdren & dobutamine.
- wean O_2 as possible - happy ± SaO_2 of 90% on ABGs.
- s/b Dr Carmody - happy for feeding to begin. s/b.
→ start non-elemental feeds

25.1.00 Nursing
0640 Pt remains intubated + ventilated on PC, SIMV
FIO_2 95%-100% Rate 14 breathing up to 18 breaths total
TV 710-810 PEEP 15 PS 20
SaO_2 88% to 96%. pt ↓ SaO_2 when on ⓓside to 76%. bagged to ↑ SaO_2. plus bagged + sanctioned when SaO_2 88%. -
M/A thick creamy sputum returned chest - good air entry but has course crackles - ? sputum retention.
Monitored ± SR. Rate to 385
ABP stable CVP + 18 to 23 Map 69 to 84.
Neuro GCS 3-4/15 responds & opens eyes occasionally to nursing interventions
CVVHD - maintained until 0340hrs ? machine malfunction lines flushed easily no blockage. fluid removed 4ml/hr
fluids Noradrenaline weaned 1ml/hr now 12mcg
Dopamine at 15mg/hr Morphine 10mg/hr / Midazolam at 5mg/hr.
Dobutamine at 10 mcg/kg/min.
Maintenance - NSaline at 42mls/hr
Output 10K - 26 to 60mls of concentrated urine
Wound - 350mls + 300mls bags emptied 6/24 hrs
Limit replaced over next 6hrs ± 10SA.
NJ Feeder. 30mls/hr Jevity aseptic.

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CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

25/1/2000 RMO - Goc/Cov
0830 hrs Shift report.

Pt stable but still critically ill.

Summary

(1) • Pt being weaned off adrenalin
CVS now on 8 mcg/min.
- BP 120/60.
- MAP 75.
• Noradrenalin hasn't been started
∴ BP remains at desirable levels.

(2) ceased CVVHD due to machine problem
Renal Cr 0.42, U 24.2
UO b/n 30-70 mls/hr.

(3) Sats remain ↓ 88-92%.
Resp - required bag + suction o/n - thick secs removed
ABG pH 7.47
PO_2 55
PCO_2 35
HCO_3 25
back on 100% O_2

(4) GCS - 4

(5) Calcium corrected 2.13 (2.15-2.60)
∴ may need monitoring +/- replacement

(6) GIT - jejunostomy blocked
∴ feeding needs to be paused
- abdo wound remains covered c opsite.

Plan:- continue adrenalin wean + add Noradrenalin if required as per previous Shift orders.
- continue to monitor Ca.
- may need more neg bag + suction to clear secretions.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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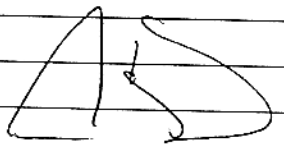
28/1/00.

(4) Inotrope dependence - Noradr
Dobutamine
Dopamine
Some weaning attempted but ↑ again (Noradr) as ↓ UOP.

OE/ T 38° PR 138 RR 14 BP 110/70.

Chest



Occas. resp.
LAE bibasal

HS I II
Abdo

open wound

CNS - GCS 7+T paralysed

Plan - continue inotropes
Continue Lasix
Bloods
CXR

B M Shepherd
SHO.

28-1-00 1645hrs ICU ward

- R/O pancreatic necrosis last night.
- No drainage bags on wound
  ∴ oozing all night into bed
- Tolerated ↓ PEEP to 12.5cm H2O p02 8kg on F1.0 50%.
- WCC 65,000 - Not opening bowels PR - empty rectum
  Hb + Plt stable ↑ Na.
  renal function stable creat 0.22
  UO good, 30 mg/hr Frusemide
- ↓ Bilirubin now.
- Sedated + paralysed, ++ Copious sputum (thick)

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

Px: Rpt ABG — Continue volume ventilation
- ? cholecystectomy Saturday
- T N/S to 10ml q4h down ETT
- Chase culture
- Aim to ↓ PEEP to 10 cm H_2O if ABG ok
- If tolerating PEEP at 10cm, trial off paralysis +/- ↑PEEP
- Cease frusemide (trial)
- T free water (as hyperNa)
- Continue antibiotics
  review Meropenem if not improving (Harman)
- Surgical review of wound.
- Vancomycin level — Neutral or positive fluid balance

[illegible]

WOUND MANAGEMENT 28/01/2000 1230hrs.
Attempted parcel dressings but failed! Oozing serous fluid at both ends of wound. Discussed with Dr. Carmody re: containment of exudate. Happy to picture frame the wound edges and apply Opsite over. at this stage, he is for theatre tomorrow. — [illegible] RN

28/1/00 1445hrs Nursing. SIMV 800 x 14 x FiO_2 60% PS 20 Sens 2 PEEP ↓10 T.V. now 680 – 890 mls. Cisatracurium infusion ceased GCS 3. pt is starting to breath up Resp - ↓ both bases, thick large sputum, O_2 sats 88 – 95% generally sitting around 93%, PEARL ✓, G.I.T - bowels not opened commenced on Sorbitol TDS, wound continues to ooze +++ pt skin integrity is good at present. Obs- BP 90 – 110 systolic. febrile 39.3° panadol given N.G. now 38.8° ST 130 – 140, N.G feeds 110 mls ultracal ½ 50mls/hr of H_2O. total 160 mls/hr. Urine output has dropped off from 200 mls/hr to 70 mls/hr since lasix ceased. Infusions Noradrenaline remains at 19mcg/min Dopamine at 15mg/hr, dobutamine 60mg/hr, actrapid to sliding scale BSL's 8.5 – 11.2 mmol Morphine 10mg/hr midazolam 5mg/hr maintenance 5% Dex at 80mls/hr. Family visited frequently for short periods throughout the day. — [illegible] (BINGER) RN

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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25/1/200 - 2230hrs Nursing.
Resp: Patient currently paralysed + ventilated on settings as charted. Although P+V patient is breathing up on his own although he exhibits nil response to stimuli from nerve stimulating machine. RMO aware awaiting consultants response. Sats around mid 80s - to 90s all shift. Desaturates very quickly on any movement or disturbance. Physio yielded nil secretions at 2130hrs
Cardiovascular - Adrenaline infusion turned off and Nor adrenaline to be weaned down as per RMO's ongoing instructions. ~~ABP~~ Dopamine and Dobutamine continue as charted. MAP to remain above 65 - currently on 83. Currently sinus tachycardia.
Output - Aiming to keep patient in negative balance and urine output of 7200mls/hr. This has been well exceeded in past two-three hours. Pt currently in negative balance. Lasix infusion has been turned down to 7mg/hr from 10mg/hr. Need to monitor output carefully.
BSL - Level at 2000hrs was 19.4. Pt now commenced on Actrapid infusion at 4units/hr. Needs 2/24 BSLs overnight please.
Nutrition - Patient commenced on TPN and N/G feeds this shift as charted. Developed hiccups approx 1hr following N/G feeding - to have Maxolon TDS. N/G to be turned off at midnight + aspiration
Social - Visited by family + friends this shift.
Brenda Goldie Gordie RN (OXLEY)

26/1 Continues to gradually improve.

Aim for full strength feeds.

I'll consider closing abdomen with Mesh on Friday
+ do cholecystectomy

[signature]

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

26/01/00
0100hrs
O'Donnell

Shift Summary Day 5 ICU

difficulty stabilising V this shift.

Resp · currently on SIMV FiO2 80%. Rate 14
PEEP 20
PS 20

· paralysed on Pancuronium 8mg/h but breathing up to 19/min
· ABG's 2300 show mod improvement
· pO2 62
· sO2 93

— Sats 89%.

CNS currently on Dopamine 7.5ml/h.

Dobutamine 12ml/h

NAd 16 µg/min.

pulse 103

BP 118/61 MAP 74 (ABP) 114/54 76 (NBP)

CVP 17.

Renal — UO ≈ 200ml/h.

on Frusemide 7mg/h.

last Cr 0.39
Ur 27.2
} improving slowly

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATIO

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CNS GCS 3
on M:M 7:3·5

nil obv. distress/pain.

Metabolic BSL's quite difficult to control this shift.
- as high as 24·0

Started Actrapid sliding scale @ ~2100hrs.

Other parameters stable.

Nutrition on TPN 84ml/h.

Plan · continue inf. as above Gas per Dr Leditschke
- rpt ABG's x 2 this shift
- attempt to slowly ↓ FiO_2 if tolerated
- aim for (−) FB ~ 1000c/24h.
(titrate Frusemide infusion to maintain this)

Note Despite pt not responding to low voltage stimulation of forearm muscles, he is still breathing up from rate 14 to 19 (5 volunt. breaths)

Dr Leditschke R/V pt @ 2300hrs and is happy that he is adequately paralysed

(O'Donnell)

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE: 26.1.00 Nursing

0600 Pt remains intubated ventilated & paralysed.
FiO_2 90% ↓80% TV 600-650, spontaneous TV 490-590 (despite being paralysed) R 14 breathing up to 19 SIMV PS20 PEEP 20
chest good air entry both sides SaO_2 89% - 92%.
GCS 3/15 PEARL ē Sedation
ABP (110-130) / 50-65 T 37.7 to 38.5 CVP +17 to +20
Input Morphine 7mg hr, Midazolam 3.5mg hr. pancuronium 8-14mg hr but now ceased since 0330 hrs - no change in condition or breathing.
Frusimide titrated to urine output ~~~~ 200mls ~~~~ ↓7mg to now 2mg hr urine 1DC 340 to now 180 mls hrly.
Actrapid 10u/s to 15u/s hrly sliding scale ē BSL's 17.0 to 25.3.
Noradrenaline, Dopamine Dobutamine + TPN unchanged + continues.
NGF Osmolyte now from 30mls to now 90mls Aspirates 24hrly bowls @ 0600hrs 100mls some returned. Feeds continued o/night due to late start yesterday.
Wound bags Ⓛ minimal drainage not emptied.
Ⓡ 500mls total tonight - area leaking ++ redressed + reinforced under drainage bag ē op-site.
Penile mouth + eye toilets given. pressure back + Ⓡ side turned 3/24 skin remains in good condition.
pt shaved. ———— [signature]

PRIVILEGE
CONFIDENTIAL
Under Section 91 and ... of the Health Rights Commission ...

RMO - GOLIKOV SHIFT REPORT
0825 HRS -

① Resp :- pt given pancuronium in an attempt to stop ~~them~~ him from "breathing up"
- Rate set at 14 (RR 18-20 ON)
- didn't respond to pancuronium. (given 165 mcg/kg) total 14mg/hr.
∴ D/C Dr Leditschke → to ↓ sensitivity.

ABG ~~prior to ↓ sensitivity~~

	(prior)	(post)
FiO_2	80%	80%
pH	7.34	7.36
PO_2	62	60
PCO_2	52	51
sats	90%	92%

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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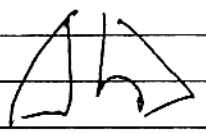
V parameters currently.
PC SIMV
80%.
Rate 14.
Peep 20
Sens, trig 2@
Flow by 5/1
Insp P 22.
1.5.



unchanged.

(2) CVS - Continues on NA, Dopamine, Dobutamine
- Aiming to wean NA.
- Aiming for neg balance. (-1616) in 24.

- BP 130/60
- PR 105
- MAP 80

(3) Renal - UO 6/h 170 - 340 mls / hr.
- frusemide infusion. 2mls/hr (10mg).

(4) · CNS - GCS 3
- morph 7 ! midaz 3.5.

(5) GIT - feeding on osmolyte continues
- amylase :- 73
- lypase. 103.

(6) BSL's - ↑ this shift,
· commencing at 25.3
∴ given actrapid bolus 6 units
then on 15 units/hr
+ now BSL's 18.

CLINICAL EXAMINATION

(7) WCC 36.6 ↑
Temp upto 38.1 O/N.

Plan:- continue to maximise V̇O.
- ?WCC ↑
- BSL's need stabilising further
- continue to wean NA.

Meadows

26/01/00
1045: DR Leditschke WR:

CXR - ↑ consolidation RML, RL zones, LLL
still heavily PEEP dependent improved.
however, overall gas XC improving.
at present on FiO2 0.70

neuro - PERL.

CVS - stable.
acceptable MAP on current inotropes
aim MAP > 65-70 if UO > aim 200 ml/h
→ if <150 ml/h consistently try & push MAP.

ie Plan if ↓s UO -
aim MAP up to 80.
(consider if "over-drying")
then can ↑ frusemide after this.

gastro - Plan - to ↑ to full NG feeds over next 24h (aim 110 ml/h)
then can stop TPN. (↓TPN to 40 ml/h if can get NG feeds to 110 ml/h today)
- start bowel care

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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26/1/00 - Visited by family.. Father now in Brisbane. Anne Leditski d/w family plan & prognosis to date. —— [signature] RN

Nurses notes 26.1.00. 2230hs.
CNS - GCS still 3/15 on sedation. Pupils equal & reacting
CVS - still requiring noradrenaline @ 0.17 μg/kg/min & dobutamine @ 10 μg/kg/min. MAP 70'S - has req^d x1 unit 4% NSA which has brought BP back up from 90'S to 110'S systolic & brought CVP back from +13 - +15.
Well perfused & warm. T° to 38.9 followed by Skin action
Resp - remains on PCV SIMV rate 14 FiO2 .6
Peep down to 17.5 cm. Auscultation - creps + 'out (R) lung, bibasally AE ↓. & bronchial breathing posteriorly (L) LL.
GIT - decreased BS but appears to be absorbing NG feeds. TPN ceased. Osmolite continues 110mls/hr. On bowel regime.
Renal - output 130 - 400 mls/hr. currently lasix @ 20mg/hr
Endocr - insulin requirements reducing now TPN ceased.
General - family all in to visit - aware of situation
—— (Houghton) [signature] RN

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MHPH 45-1 1/92 Chart B

26/01/00 Shift Summary
2345
O'Donnell Day 5 ICU.
(JHo)

Multi organ failure 2° to Acute Severe Pancreatitis

pt quite stable this shift.

Resp on PS/SIMV. Sats 93%

FiO$_2$ 0.6
Rate 14 - breathing up to 19
PS 20
PEEP 17.5 (adjusted by Dr Leditschke ~1800hrs)

ABG's @ 2340 : pH
pCO_2
HCO_3
pO_2
SO_2
BE.

CVS Currently on Dopamine 7.5 µg/kg/min
Dobutamine 12 µg/kg/min
NAd 17 µg/min.

BP 114/61 MAP 78 (ABP) 124/58 (NBP)

pulse 112

CVP 14.

pt ↓ BP ~ 2110hrs and had ↓ UO and ↓ CVP.
Responded well to stat 500ml NSA.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID---------------	SEX---	UR NO--
LINDSAY	M	778512
TERENCE		
27-29 CULGOA CRES		14-06-1957
LOGAN VILLAGE 4207		M
Ph(H) 0755 468256		
Ph(B) 0419655702		
NO RELIGION	SELF EMPLOYED	

Renal - creat. improving.
→ watch urea n'ever for ↑ rise.
(will probably plateau ~30)

WCC ↑ing. - chase sputum
ie (Bronch! aspirate culture)

BSLs - high
- should improve as TPN is reduced to 40 ml/h.

lines - Vascath to remain until Fri; then situation will be reviewed re CVVHD.

* As of yesterday - DO NOT disconnect from circuit (eg for bagging) due to Peep dependence!

→ physio - vibes & suction please.

Overall Plan Today -

① leave meds as same
② aim ~~[illegible]~~ (-) Fluid Balance
③ + ↓ FiO_2 as able. (aim FiO_2 0·60)

↓ whatever can achieve ∈ maintaining haemodynamic stability.

R Claydon

PRIVILEGED AND CONFIDENTIAL

Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

26/1/2000 **PHYSIOTHERAPY** 14:00

Orders noted - for vibes + s/o only.
No Bagging, No breaking the circuit.

Chest: Anxc: AE (R) = (L) = Fair.
few +/sounds only.
RIC: Vibes on the machine.
s/o = NaCl p/o scant, yellow.
Plan: Evening Physio. to R/U.

Lisa Coles.

26/1/00 - NURS - 1530
Remains critical/stable. Ventilation continued on PC/SIMV FIO2 60% PS 20 Peep 20 SaO2 85-92%. Minimal secretions suctioned.
CVS - Peripherally warm, haemodynamically stable on inotropic support. Noradrenaline + Dopamine + Dobutamine as charted.
Need to aim for MAP >65-70 & U/O >200mls/hr If u/o <150mls/hr try to improve by pushing MAP.
CNS - Remains sedated on morphine + midazolam + was not assessed from pancuronium d/t two stage. GCS - 3 PEARL
Input. (1) Noradrenaline 17mcg/min (2) Dobutamine (3) Dopamine (4) Actrapid as per sliding scale (5) frusemide titrate to U/O (6) M+M @ 7mg/3.5mg respectively
Output. U/O changeable need to monitor same generally >150mls/hr aim for 200mls. Wound loss >400mls two shift
Dressing to wound attended. Microxbx given + coloxol + senna.
Input cont'd - TPN @ 40mls + Osmolyte @ 110mls
Refer to previous page for feeding plan.
For OT two friday @ two stage S/B Dr Carmody

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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LINDSAY SEX--- UR NO--
TERENCE M 778512
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NO RELIGION
SELF EMPLOYED

1400

27/1/00 - cont'd Haemodynamically still inotrop dependant. All infusions continue ie Norad, Dobutamine & Dopamine ad per previous shift, except ~~forever~~ Noradrenaline which is now running @ 20 mcg/min. Required 1 x fluid bolus of 500 of Haemaccell this shift for hypotension. Aiming for MAP ≥70 if opening urine. ↑ Lasix infusion to max of 100mg/hr for u/o to be >100mls/hr. Lasix presently @ 50mg/hr. u/o still not @ optimum level

Monitoring ST. Febrile to 40·1. 1 x panadol given for same with marginal effect. Temp now 38·1

Input. ① Lasix ② Actrapid (BSL's 7·1 - 9·6) ③ Gsactrac (now paralysed) ④ Dobutamine ⑤ Dopamine ⑥ Noradrenaline ⑦ Morphine + midazolam as charted.

Plan - for OT this pm. U/Basound & Xray to be attended prior. New arterial line & CVC attended. For transport to OT on Bird ventilator.

Needs consent signed by wife. Wife aware. Visited by family.

1545h

27/01/00 Shift Summary

RMO

Claydon main issues:

PREVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

① ↑d WCC: 64·2, Neuts 53·19
T° up to 40°C

∴ → CVL art. lines re-sited
(TIPS sent - m/c/s)
→ FOR Return to OT at ~1800h

(X match 4u ✓
consent ✓)
+ given stat dose Vancomycin (1500mg)
→ needs level mane please

CLINICAL EXAMINATION

② Bronchoscopy this am
(given desaturations early am
& infiltrates RML)

→ thick sputum suctioned.
→ sent for m/c/s

→ leucs mod.
no organisms seen.

- gas XC reasonable at present on FiO_2 0.60 (PO_2 70, Sats 93%)

- Ventolin added.

→ started on cisatracurium to ↓ ventilator dyspnchrony & improve TVs, sats.

③ CVS - haemodynamically stable on current inotropes.

④ Renal - Creat 0.25
UO >100-150 ml until ~ 1300h
(34 ml/h)

∴ lasix ↑ to 50mg/h

→ Dr Leditschke trialling haemacell bolus

(Plan re. FB/UO/MAP - see WR notes)

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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Renal UO good, av 150 - 200ml/h.

currently (-) FB ✓

Cr

Ur

on Frusemide 20mg/h.

CNS GCS 3

Sedation M:M 7 : 3·5

pt is breathing up every once in a while

Nutrition pt tolerating NGF
(TPN ceased)

aim to stop NGF from M/n until 0400 hrs
→ NSaline 500ml 9th written up for this time.

Plan continue as per day plan.

- do not disconnect from circuit
- Aim (-) FB
- ↓ FiO2 as able
- continue Meds as written.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE: 27.1.00 Nursing

0615hrs. Remains critical & unstable at times.
Ventilated SIMV. PC. FIO_2 60-100%. TV 720-610 Spont TV 440-590
R 14 breathing up to ~~to~~ 31. PEEP 17.5 PS 20
SaO_2 89% to 95%. Osuctioned Pt ↓ SaO_2 to 74% on 60% O_2
poor air entry R+L, occasional resp rate ↑ 31-40
chest xray - no further changes. - had hiccups - IV
Maxalon given. IV Morph+Midaz bolus 2mg/1mg given
episode lasted 5-10 minutes O_2 ↑ 100%. Regained
SaO_2 very slowly, pt settled himself.
Suctioning - ETT sl thick purulent sputum - needs N/Saline to
loosen + suction up.
Wound - 500mls dem bags of clear brown fluid.
CVS Monitored in ST 105 to 125 ABP stable. Map 73-90
Febrile to 38.5 CVP +16 to +18
Neuro 3/15 Pearl. Sedation.
GI/Lines Lasix titrated to output ran at 20mg → 10mg now
off. IDC draining 200 to 360mls hrly.
Actrapid 2-6 units hrly for BSL's 7.5 to 8.8.
Morph/Midaz @ 7mg/3.5mg bolus x 2 given.
Dopamine/Dobutamine/Noradrenaline remain
unchanged.
NG N/Saline 500mls 4/24 given when ~~on~~ NG feed off.
NGT - minimal aspirate 5mls. recommenced at 40ml/hr @
110mls/hr of osmolyte
ABG progressively decreasing FIO_2 from 100% to
currently 70%. aim is for 60%
Skin integrity intact, facial shave, penile, mouth + eye
toilets given. family in to visit regularly
27/1/2000
RMO - GOLLOV
0715hrs. NIGHT SHIFT REPORT.

① Resp :- pt was tolerating FIO_2 60%.
- then at ~ 0500 hrs.
- episode of tachypnea
- ↓ sats 74%
- ↑ resp effort.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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Overall Plan - ① see WR notes
② return OT
③ chase sputum/
CVL/Art tip cults.

RClaydon

addit CXR - CVL good pos ✓.

PHYSIOTHERAPY 27/1/00
Remains ventilated
Chest harsh breath. sounds throughout
Sputum dirty cream
Rx mbs ō machine.
N saline + suction
For R/V post-op J Murphy (Murphy HH)

27/1/00 1400 **NUTRITION & DIETIETICS** R/V (as of 11^00 - chart not avail to write in)
Biochem: - Na 144 K 3·4 Cr 0·24 Ur 28
Lipase 103 Amylase 73 WCC 64·2
Chol 2·2 TG 4·3 HDL 0·1 Bili 189 Ast 262
ALT 303.
Pt was tolerating 110ml/hr Osmolite TPN ceased
Pt paralysed Temp 38°
Est Requ's ~ 15·5MJ
Rec to try Ultracal (Δ from Osmolite) - lower
cho & has DF which may help BSL's w/o
sig. ↑ in fat content.
In order to meet pts estimated requ's, pt
would require 3·5L of feed ie final regime of
175ml/hr over 20/24. This would provide
15·4MJ, 430g cho, 158g fat, 154g pro.
To ↑ pts intake ½ small increments. Aim
for target 175ml/hr. If pt doesn't tolerate
these levels just maintain highest rate tolerated.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

Dietitian cont. Don't rec a more concentrated feed - ↑ renal sol load + ↑ pro may not be tolerated by kidney. In addition a more concentrated feed will ↑ cho intake

Plan 1) In view of pt going to OT to
w/ feed in am - re evaluate
req's + ideal feed if any sig
changes post op.

J Anderson [illegible] #684

27/1/00 ① Bronchoscopy. (~ 11 Am).

LEDITSCHKE.

1600. Copious thick sputum R Main Bronchus, trachea occluding RML bronchus + several LL Bronchi.

Also thick inspissated sputum → [illegible] LLL Bronchi.

Suctioned; Specimen sent to culture.

② this pm has developed Temp to 40°c, more haemodyn. unstable (↑ NA to 20 μg/min). WOP. despite ↑frusemide.

. In view of this + [illegible], D/W Surgical team → for OT this pm

. lines changed, tips for culture.

. for Blood & Urine cultures please. then start Amikacin 1g.

③ In view of ↑ BR to 189 with Ⓝ ALP; AST + ALT in 200's but ↓ing.
- USS looking for dilated ducts.
- Conj vs unconj BR.
most likely [illegible] due to SIRS.
[illegible]
is on Ranitidine

[illegible]

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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• air entry poor R > L
• also ? hiccups simultaneously.
↳ Mx - O_2 ↑ to 100%.
- position change
- suction - PEEP maintained.
- CxR - (no new Δ's)
- ABG pH 7.36
PCO_2 57
PO_2 46
HCO_3 32
BE 5.6.
sats 85%.
- maxalon given; bolus morphine 3 given
- Then settled, hiccups stopped & has been weaned down to 70%. O_2 again - sats ~92-94%.

Last ABG's - 70%.		V orders
at 0720	pH 7.44.	70%.
	pCO_2 48.	PS 20.
	HCO_3 32.	Resps total 26
	BE 7.2.	Set resps 14.
	pO_2 62.	
	S 94%.	

(2) CVS: - Drugs noradrenalin 17 mcg/min
dobutamine 10 mcg/kg/min
dopamine 2.2 mcg/kg/min.
(No further NA wean O/N).
- BP 115/60, PR 120, CVP 15.

(3) Renal: - Cr 0.24
U 27.7.
UO > 200 mls/hr
Now v/l negative.
Lasix turned off at 0530 hrs ∴ good U/O + already v/l negative.

(4) GIT : osmolite feeds continue
(no TPN)

(5) BSL'S : improved ~ 8

(6) CNS : GCS 3.
needed boluses x2 through night
of morph: midaz — appeared to
be 'fighting' ✓.

(7) Febrile : 38², WCC 64·2 (prev 58·4)

∴ Pt is still unstable at times.

Plans: — Continue to wean FiO2 — aiming for 60%.
— continue NA wean
— regular suctioning

MGolker.

27/1/00 **SOCIAL WORK**
Have provided pt's family with accommodation information + will attempt to arrange accommodation at [illegible] House.
Have made appointment for Mrs Lindsay to see Centrelink today at 3:30 pm for income support. Centrelink Medical Certificate will be required.

[signature] SW
(M ORMEROD)

27-1-00 1015hrs ICU WR Dr Leditschke

(*) ↑ WCC 64,000, ↑ bilirubin but otherwise improving, ie
— UO good, creat 0·24 urea 27·7
— Gas exchange improved
— CVS improved — Noradrenaline [illegible]
(MAP ≈ 70) — Dopamine [illegible], Dobutamine [illegible]

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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(*) GCS 3/10 (*) Cultures (N) ; on meropenem
(*) Periodic desaturations including down to 60's this am x2 (one as patient turned (R) side)
→ probable mucus plugging +/- the cuff prolapsing down (R) bronchus / obstructing tube
~~CXR → upper lobe redistribution~~ +/- ↑ Spont resp + ↓TV
(*) CXR – Patchy changes consistent with ARDS
– Tube position good,
– LU clearing
– worsening RML
(*) Tolerating feeds (nasogastric) at 110mls/hr
(*) BSL's maintained at 4 units/hr Actrapid
(*) Thick sputum (⊗) cuff leak
Imp Still critically ill but improving

Px :– Rpt Sputum M/C/S. ✓ :– Add salbutamol inhalation
:– Bronchoscopy this am to remove plugging + assess major airways
:– Chase nature of gastrografin aspiration in literature
– Now paralysed with cisatracurium + ↑ sedation (after desaturation at 0900hrs) → CO_2 retention is not a priority
Cease TPN today
Can add lipids
Aim for glycaemic control via current Actrapid infusion
Continue high IV / ō fluid input + output
→ aim for at least 500ml negative fluid balance per day
:– Continue lasix infusion up to 100mg/hr
:– If worsens, consider theatre
: 1500mg vancomycin stat dose + measure trough level tomorrow
:– Aim for UO > 100 mls/hr [illegible]
:– Continue current inotroper (Haman)
(↑ if ↓BP). Aim MAP ≥ 70 if UO adequate

CLINICAL EXAMINATION (Cont.)
DATE:

1215 h
RMO.
Claydon.

sputum m/c/s
from Bronch. on. 25/01

leucs - numerous
micro - no org. seen
Fungi - not seen

cult. - ⓝ regional flora:
light growth.

RL.

ICU WARD ROUND **Thursday, 27 January 2000** **DR A LEDITSCHKE**

Name: Terence Lindsay UR No. 778512

This man continues to be very ill. Gas exchange probably is improved. He was on 60% overnight with 17.5 of PEEP, but desaturated this morning associated with positioning on his right side. There has also been a problem with a cuff leak and there is only small amount of thick sputum. Ventilator dissynchrony has been a problem, as his Pancuronium has worn off. Neurologically he has a GCS of 3 on 10 of Morphine and 5 of Midazolam. Cardiovascularly he is relatively stable, with maps of approximately 80 on 17 mcgs/minute of noradrenaline and 10 mgs/hr of Dobutamine and low dose Dopamine. He is maintaining a reasonable urine output without much Frusemide and his creatinine has come down from 0.28 to 0.24 and his urea has plateaued at approximately 28. His potassium is 3.4 and magnesium is 1. Of note, his white cell count is now 64,000, which has been steadily increasing. He now has an appropriate tachycardia for his degree of illness and his temperature is in the 38's, which is also appropriate for his degree of illness. He is still on Meropenem and cultures have been negative so far. With regard to his feeding, he is now tolerating naso-gastric feeding and his insulin requirements have come down significantly. The plan is for a bronchoscopy this morning and addition of Salbutamol. To enter the circuit via bodai. He is to continue on his inotropes as is. We are going to continue to try and obtain a negative balance of at least 500 mls/day with a urine output of at least 100 mls/hr using the Frusemide infusion up to 100 mgs/hr as necessary. Can wean the noradrenaline, provided the mean arterial pressure is greater than 70 and he is passing urine. Ad Vancomycin. He has been paralysed to reduce his ventilator dissynchrony..

27/1/00 - NURSING - 1400 - Pt remains critical — Multiple vent changes today to accommodate desaturations. Presently on SIMV FiO2 60% Rate 14 TV 750 PEEP 17.5 PS 20 Insp pres 22. Maintaining Sats 85-94%. Cases reasonable - AE ↓ bilaterally. Minimal secretions suctioned manually through bodai. Bronchoscopy attended with moderate amounts of thick tenacious yellow secretions/sputum. extracted. Specimen of same sent.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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MATER PUBLIC HOSPITALS

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- bloods not repeated this shift, for repeat bloods mane.

- BSL'S: stable
continues on S/C insulin.

- GIT - eating well although reports feeling "full all of the time".

Plan:- back on T piece tomorrow after rest O/N.

[signature]

28.1.00 Nursing Entry:- 0600.
Slept well overnight - easily disturbed. Normison given 0130.
Observations:- Stable. In sinus rhythm. Normotensive. T° - 37.3
Ventilation:- BiPAP 12 (↓ 0500 to 10) RR 22-29 TV 370-440. PEEP 5 FiO2 - 35%. Saturations 98-99%. On T-piece 0600.
Intake:- IVN/Saline for drugs. Taking some small amounts of oral fluids. Output:- Voiding well using urinal. Dressing remains dry & in tact. Cares attended. Chest:- small → moderate thick creamy sputum suctioned. Neuro:- co-operative, responsive, ~~[illegible]~~ moving all limbs equally. For shower later today.

[signature] S.H. Forbes RN (NUM)

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

28/2/00 Night Shift Summary
0740 am
O'Donnell (JHO) Day 37 ICU.

pt stable this shift.

. re-started on T piece @ 0600 hrs this am. (after PSV o/night)

. tolerating (N) diet

- BSL's stable

MHPH 45-1 1/92 Chart B

- Haemodyn stable
- ABG's – unsuccessful despite 2 × attempts (sorry!)
  35%
  Sats 100% on ~~40~~% via T piece

Good UO.

Plan: continue on T piece ✓
- await bloods, CXR

28/2/00. SVEG
0830.
severe pancreatitis – improved ✓✓✓
afebrile GCS 11/11
spontaneously ventilating
(N) Sm eating drinking
P.U. – no BOC.
U/o, ✓✓.

D17 post insertion of mesh

p/w Dr. Cerruty

for tightening of mesh under g.a. Wednesday

SL
SHO

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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CLINICAL EXAMINATION

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NO RELIGION	SELF EMPLOYED	

28/1/00
1530hrs **PHYSIOTHERAPY** Rx x 3
O/E - SIMV (0.6%) 14/20 x 830/740 PEEP 12.5 SpO_2 95%
- chest/ harsh BS throughout
Tx - vibs & machine
- S/O & NaCl // P/O thick plugs yellow sputum
- desaturates following S/O
Plan - R/V by W/C physio
Stokes (ULCERS) PT

28/1/00 **NUTRITION & DIETETICS** R/V
1645
Biochem: Hb 98 WCC 64.6 Na 147 K 3.6 Cr 22
Ur 30.4 Alb 24 Bili 130 AST 99 ALT 164
Alk P 82 liver function tests improving
Renal function stable. Temp 38° BNO
PT tolerating Ultraval 110ml/hr.
Wd Rd directed to continue @ 110ml/hr 20/24
of Ultraval & the addition of free fluids
@ 50ml/hr. Feed meets ~ 65% of pts energy
requirements (↑ reqt's due to sepsis & burn
wound loses)
Plan 1) Continue ½ Ultraval 110ml/hr 20/24
+ 50ml/hr free fluids
2) To weigh pt when pt more stable
3) To r/v Mon
S ANDERSON #684

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

28/01/00
1500 R/V by Dr Leditschke & Clayden
RMO. - main issues - abdo. loss.
→ if no ↓ may need.
colloid boluses.
- tolerating cisat. & drawal @
peep ~ 10. RCC -.
28/1/00 22:30 O_2 ↑ 70 desats when turned or
disturbed - Bolus 5mg Morphine + Midazolam + 2.5mg Push
Midazolam - Urine output improved from 60 - 125 - O_2
reduced to 60% peep ↑ 12.5 N Parker RN.
Abdominal girth has increased this shift

CLINICAL EXAMINATION

Fluid draining freely via abdo dressings - Terence becomes very distressed when turned - if a lateral position is required support abdo mass ~ pillow

A Parker RN.

28/01/00
2315 hr
Stockaydon

Evening Shift Summary

overall, quite stable.

Resp - SIMV: rate 14
spont up to ~ 25 ~ TVs 600-800.
TV 0.8
PS 20.
- Peep was ↓d today to 12.5 &
cis atracurium ceased
→ sats stable most of shift ~ 96 on FiO2 0.60.
H'ever, ↓d to high 80's ~ turning.
- req'd ~ 20-30 mins on FiO2 0.70.
- currently: PO2 - 69, on FiO2 0.60.

also, ~ turn - ↑ RR, & interfering ~ V.
∴ given m.m bolus, ~ good effect.
(likely 2° pain)

CVS - inotropes unchanged:
NAd 19 mcg/min
Dobutamine 6 mg/hr
DA 15 mg/hr

BP ↑ing - 130/60

? try & wean NAdr again mane.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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Resp. continues on SIMV 0.6 F_iO_2
PS 20
PEEP 15 Paralysed on
Rate 14 Cisatracuronium
Sats 94%. 8mg/h.
ABG's as prev.

Renal UO variable b/t 100 - 300ml/h.
Still running on (+) Fluid Bal.
Frusemide infusion was @ 20mg/h and currently @ 30mg/h (was I @ 2300hrs)
Cr 0.23 Ur 29.4

Nutrition currently on Osmolyte (NGF)

CNS GCS 3
on M : M 10 : 5

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

Plan

ICU WARD ROUND **Friday, 28 January 2000** **DR A LEDITSCHKE**

Name: Terence Lindsay UR No. 778512

This man is Day 7 with multiple organ dysfunction complicating severe necrosis and pancreatitis and gastrografin aspiration. He went back to theatre last night and had more necrotic pancreas debrided. Neurologically he is sedated and paralysed and his pupils are equal and react to light. Cardiovascularly he is still on the same level of inotropes and Noradrenaline was increased to 20 yesterday because of some haemodynamic instability associated with a temperature of 40.1 precipitating his return to theatre. Gas exchange has improved this morning, with a PO2 of 89 on 60% and 15 of PEEP. He still has copious thick brown sputum. White cell count is still 65,000. Other haematology is stable. His renal function is stable with a Creatinine of 0.22 and urea of 30 and he is passing adequate amounts of urine on 30 mgs/hr of Frusemide. His bilirubin, which was 189 yesterday, is down to 130 and his AST is now 99. ALT is 164. This is down from nearly 1000 over the weekend. He is tolerating his naso-gastric feed at 110 mls/hr. The plan is to increase the Saline down his endotracheal tube to 10 mls/4th hourly to try and loosen his thick sputum and to reduce his PEEP to 10 if tolerated, and then consider ceasing his paralysis. He is to continue on Vancomycin and Meropenem. His large abdomen losses are related to his open abdomen, so his fluid balance is to be liberalised to a neutral or somewhat positive balance and we will try stopping the Frusemide to see whether he can self-regulate. This may need to be restarted again. He has sodium of 147 and so will add free water to his feeds at 40-50 mls/hr, which will give him a little over 200 mls/hr of maintenance and he can have Colloid as required in addition to this, to support his blood pressure and urine output.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE: 28.1.00 Nursing

0530 Condition remains critical but stable o/night.
Ventilated + paralysed on SIMV. FIO_2 60%. TV 740-800 R 14 PS 20 PEEP 15. Suctioned x1 - nil. Air entry R+L ↓ in both bases.
CVS ABP 105-130/60-73 NIBP 128-122/72-52.
Arterial Map 70-90. T 35.8. CVP +11 to +12 T to 38.8 Bld cultures collected.
Neuro - GCS 3/15 Sedated + paralysed. PEARL.
INPUT Noradrenaline - attempted to reduce from 20mls = 1.2mg/hr to 18mls 1.1mg/hr BP ↓ 98/58 ↓ CVP 10 now running at 19mls hrly = 1.1mg/hrly.
Cisatricurium at 6mg/hrly. x1 episode of breathing up at 0600h when washed & turned otherwise maintained rate 14.
Lasix @ 20-30mg hrly to maintain urine output 150 to 390mls at 0600h showing positive balance of 4.24mls
Actrapid 4 to 8u/s hrly titrated to BSL's 5.5 to 13.0mmol/l.
Dopamine @ 15mg/hr + Dobutamine @ 60mg/hr maintained + unchanged.
Morph + midaz @ 10mg/5mg hrly. maintaining sedation.
NGT Ultracal 110mls hrly - Dull bowel sounds present
Bowels not opened this shift.
Pt sponged, shaved, ETT retaped, eye, nose, mouth + penile toilets given.
Output IDC draining 150 - 390mls hrly
Wound - draining in excess of 200mls - approximately dressings leaking ↓ dressings reinforced.
Skin remains in excellent condition.
Note - small sore on tongue, swelling ↓ noticiably since yesterday

[signature] nurse

28/1/00 Night
RMO Problems
0745 (1) Acute severe pancreatitis
- necrosectomy repeated yesterday
- idiopathic.
(2) ARDS - gas exchange improving slowly
- satisfactory - 93-96% o/night on FIO_2 60%.
- resimv TV 800 RR 14 support 20
- PAP ~ 20 PEEP 15.
(3) Non-oliguric ARF (on lasix infusion 30 mg/hr).
- F. bal remains +ve but progressively less

SO-

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

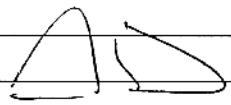
Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bilirubin	Blood	Urobilinogen	Remarks

--ID----------SEX---UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

29/1/00.

(3) ARF - polyuric
UOP remains good off lasix
(4) Inotrope dependence
- remains haemodynamically stable
on current inotropes - Norad
Dopamine
Dobutamine
} unchanged last 24/24
(5) Hypo K+ on replacement 5mmol/hr currently
(6) Nutrition - tolerating feeds.

OE/- T 37.5 PR 125 BP 110/55 RR 20
VCSIMV 500 × 14 support 20 PEEP 10.

Chest  ↓ AF L + R

H3 "
Abdo  large open wound

Plan (1) ↑ sedation as needed to settle
(2) ? attempt to wean NOS ADS today
(3) ↓ F_iO_2 to 55%.
(4) c/v f balance - ~3L Give today.
(5) CVR + bloods
(6) Hb 87 ? for top-up

B McAlpine
SHO

28/01/00. (RMO)
micro. so far -

- no growth on peritoneal swabs (OT spec.)
- sputum - Bronch (27/01) (N) regional flora } light growth
Bronch (28/01) (N) reg. flora

CVL - no organisms, no growth
+ Art line - mixed growth on culture
Blood Cultures ((-)ve)

RClayden.

CLINICAL EXAMINATION

PHYSIOTHERAPY 29/1/00

Remains ventilated
SIMV R 14 x 800 mls 50% O_2
Chest ↓↓ BS both bases
Harsh breath sounds throughout
↑ tagging + wiles Nasline + suction
yielding m/A thick blood stained pus
coloured secretions
Evening physio to R/V

Anesthesiology (Anesthetist)

29/01/00 DR Leditschke IVR
RMO

stable during OT: cholecystectomy + debridement necrotic pancreas

- currently good gas XC
sats 96% on FiO_2 0.50.
- BP robust o/n (120/130 to 50) — watch post-op, if still robust consider weaning inotropes → start c Dobutamine then may be able to wean NAdr concurrently.
- needs regular vanco. dose.
cease amikacin.

otherwise continue

RClaydon.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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UO - > 100 ml/h since 1500h following fluid bolus.

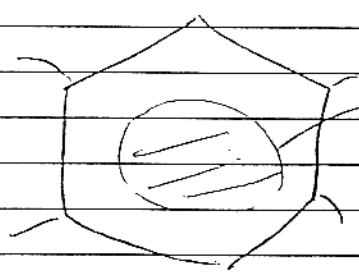
-> ~~Xxxxxx~~ est^d ~ 3000ml + FB today, but this not accounting for large abdo. loss. (unmeasured)

neuro - GCS 3 M:M 10:5.
- more awake at times - attempting to open eyes

OE -> BP - 126/61
HR 126
CVP ~ 16 *.
Sats 96%.

HS 1—11 —

Chest ↓AE both bases
↓AE Rm zones



- large open wound.

Plan - continue current Mx
- consider m:m bolus pre-/with turns for adequate analgesia
- discuss manē re ? inotrope wean
- Review ABGal. manē
- K+ 3.1 - currently having iv rplct

R Clayden

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE:

29/1/00 Nursing 0615hrs: Resp Ventilation stable on FiO2 .60 SIMV 14x800 c̄ PEEP +10 + PS 20. O2 Sat 94-98% with 1-2 hourly suction of thick, creamy sputum, N/saline instilled to assist sputum removal. AE ↓ bases, crackles R>L. CVS: Monitored ST, BP stable with MAP approx 80 mmHg, CVP +8 - +10. Febrile 39.5, given Panadol and tepid sponge and now 37.3. CNS: PEARL size 3. Hiccups a problem, miscoordination with ventilator, breathing up + peak airway pressure ≥45cmH2O when distressed with cares, turns + hiccups. Bolus of Morphine + Midazolam x2 and now such increased as ordered, much more settled. Input: Inotropic support unchanged from Dopamine, Dobutamine, Noradrenaline as charted. K+ result low and now infusion KCl @ 5mmol/hr. BSL stable on 2units/hour as per sliding scale actrapid. Output: Urine output 110-150mls/hr. NGT aspiration minimal + such returned. GIT: Tolerating NGT feeding, no audible bowel sounds. Wound: Open wound covered, appears to have increased in protrusion this shift. Continued ooze +++, dressing reinforced with more opsite. General: All cares attended, remains oedematous c̄ scleral oedema +++.

A Porter RN (PORTER)

29/1/00 Night
Rmo Problems
0745h (1) Acute severe pancreatitis
- post necrosectomy x2
- idiopathic
- associated multi-organ failure
- ? for cholecystectomy today + further necrosectomy - await surgical r/v

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

(2) ARDS 2° to the above ± gastrograffin aspiration
- no helpful micro thus far incl. bronchoscopy 25/1
- slowly improving gas exchange
- ventilation dyssynchrony last night + hiccoughs - settled c̄ ↑ sedⁿ (12/6 morph/midaz) and 2.5mg IV droperidol.
- oxygenation fairly stable.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION
SELF EMPLOYED

U.R. NO.
SEX---UR NO--
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M

29/01/00 NESNb: Remains relatively stable today - episode at 1500 hypotensive SBP ↓80 post O.T - treated with Haemaccel. SBP ≈ 110-120, HR 120-130, febrile to 39.4 today. U/O >100 mls /hr. Abdo. wound continues to drain large amounts of fluid today. A/E R=L ↓ to both bases. Dirty sputum on suction. Tolerating feeds - bowels not open today. Visited by family today. [illegible] RN

PRIVILEGED AND CONFIDENTIAL Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

29/01/00
RMO
Claydon
1645h.

Shift Summary

main issues:

- post-OT: ↓ BP — to 80 systolic (this a'noon) & ↓ UO
→ given 500 ml haemaccel bolus (~1500h)
→ UO ⇒ 260 ml/h.

BP still labile HR >140.
CVP 7-8

→ may require further boluses to catch up c̄ abdo. loss.
? recommence "chase" c̄ colloid
→ will d/w Dr Leditschke.

- also required ↑d m:m boluses post OT (mainly c̄ proning & physio) ⇒ desaturated c̄ ↓ TVs.

∴ background currently ↑d 10:75

→ as d/w Dr Leditschke earlier - would prefer pt. more awake but comfortable → ∴ should

MHPH 45-1 1/92
F0627

Chart B

aim to ↓ infusion again as able.
- otherwise stable.

R Claydon

2230 hrs 29.1.00. Nurses rang.
Reasonable shift up until ~2200 when HR ↑160
BP ↓ 70 systolic O2 sat ↓ 73 laying on (R)
side. Check Hb 65. RN & called Reg -
Surgeon notified - for review.
For top up transfusion.
Family aware of deterioration and called in.
Currently @ 2230 hrs: BP up to 82 systolic
USA fill while awaiting blood.
Abdomen: transverse colon still pink but
more small bowel now obviously extruded.
Unable to attach drainage bags to the wound
~~re-~~ re-inforced with Comfeel.
Dark ↑ & clots obvious beneath apparatus.
Dr Shirley in attendance.

Rudgley Hall

30/1/00 RMO - Golikov
0045 hrs.

Evening Shift Summary

- Pt v unstable this shift.
- went to OT 29/1 for cholecystectomy
  & debridement of necrotic
  pancreas. Stable in OT.

(1) CVS: unstable this shift.
- tachycardia 170/min
- ↓ BP ↓ 70 systolic.

simultaneously - tachypnea 40/min,
- hiccups
- sats 73%.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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↑ losses from wound
· serous fluid
+ · dark clotted blood.

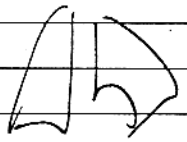
Given - Maxalon for hiccups
- ~~2~~ midaz bolus
- 500mls colloid.

ABG - 100%.
pH 7.48
pCO_2 39
HCO_3 29
BE 5.5
pO_2 60
S 96%.

Ix - ABG taken
inc Hb - 65.
∴ given 2 units PRC (6 units x matched in total).

- Dr Leditschke reviewed
- Reviewed also by Dr Chris Shirley (Surg reg on call) → not for any more surgical intervention tonight.
- remains on NA/Dopamine/Dobutamine. Unchanged doses.

(2) Reop
- Was on 50% FiO_2 prior to this episode ō sats in low 90%.
- on 100% during instability, now back on 50%.
- rate set 14/37.



↓ AE L+R.

Sats remain 96%.

- for repeat ABG.
- CXR now new changes.

(3) ACS: 3
now on morphine 15mg/hr
midazolam 3.5mg/hr.

CLINICAL EXAMINATION

DATE:

④ Temp :
T 39·8 tonight
WCC —

⑤ GIT :- Loops of bowel visible through opsite - viable, peristalsis evident.
- ~~abd~~ abdomen is more distended.
- on ultrasound ? H_2O.

⑥ U/O :- 60 - 110 /hr
U 23·9
Cr 0·16

Plan :- recheck FBC after 2 units PRC
→ ? need for more.
- needs repeat ABG on 50% FiO_2
- needs KT repeated ? on ICU infus-

M Goldner.

30·1·00 Nursing 0645 hrs: Critically ill overnight. Continued problems with wound loss up to 500mls estimated but remains haemoserrous, increase in protrusion from abdomen this shift. Surgical reviewr as suggested edges reinforced. Episode for > 2 hours of tachypnoea up to 49/min, tachycardic to 160, O_2 Sat 92%, BP ↓ 88/40, temp up to 39⁸ despite bolus sedation twice as ordered did not settle until placed into supine position from left side lying. PAC attended this morning, again unsettled, frowning +++, kept supine at this time. Ventilation unchanged, O_2 sat improved to >96%, minimal blood stained secreation. AE = crackles, Sinus tachycardia @ 135-145/min, BP somewhat better to now have MAP > 80 mm Hg for the first time this shift. Given P. Cells x 3 in total and ap—

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

NAME / U.R. NO.

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NO RELIGION SELF EMPLOYED

O/E Pulse 140 bpm Temp 39.0°c BP 110/60
O2 sats 96%. FiO2 0.5 TV 0.9L RR 21 (14 + 7 spont) Psup 20
Good lash reflex, GCS 3, PEARL
2×HS
Chest → reasonable BS, L=R, no crackles
Bowel peristalsis
(R) wound haematoma but controlled.
Pulses intact
CXR → ↑ air bronchogram
Physio → blood-stained, mucoid sputum
Px: Metoclopramide ceased
:- Watch sodium
:- Review of NGT feeds tomorrow (? ↓ salt content)
:- Watch Hb
:- Continue inotropes
:- 1/2 colloid 1/2 5% Dextrose to match wound losses
:-
(Hamm..)

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

PHYSIOTHERAPY 30/1/00.
Remains ventilated
SIMV 14 x 800 FiO2 .5 PEEP 10.
Chest - ↓↓ BS both bases
- widespread harsh breath sounds
c̄ bagging + w/as N saline + suction
yielding 5-m/A dirty cream, blood stained secretions
For R/V in AM
by Evening Physio
(Meredith)

30/01/00 RMO Claydon 1730
Shift Summary:
main issues →
① ongoing loss from wound

PTO —

CLINICAL EXAMINATION

DATE:

30/1/00 NURSING ENTRY 1430h,
CVS/ BP NOW ⓢ 96 ⓓ 51 ST 147 B.P.M N.B.P 120/62 MAP 80
T° 39.4 UP TO 39.7 OVP 13 INOTROPES REMAIN UNCHANGED.
PERIPHERALLY WARM. GOOD CAPILLARY RETURN. RESP/ VENTILATION UNCHANGED
A/E BASES - NOISY THROUGHOUT. EQUAL EXPANSION SMALL
AMTS OF THICK SPUTUM REMOVED ON SUCTION WITH Physio - RAISED
RESPIRATORY. INTAKE/ MAINTENANCE 60ml/h 5% Dex + UMPHCHL ±
50ml/h H2O. 2x Pc GIVEN AT 1415h ALSO AMPICILLIN 500mg.
+5693 — 29/1/00. U.O/ GOOD URINE OUTPUT >60ml/h GNO
SINCE ADMISSION. NO LOSS/ BLOOD/ STEROIDS LOSE ++ FROM OPEN
ABDOMEN WOUND - NOT RE-INFORCED TODAY. UNCHANGED PADS ++
MOBILITY/ PAIN 2/24 - 3/24. - FAMILY/ WIFE, DAD - MUM .N
TODAY - UPSET BY EVENTS ADDIT./ SURGEONS NOTIFIED OF
STEROIDS LOSE TO SEE PT THIS P.M.

→ CTD:
~1330 h ± turn - moderate loss from wound (blood on R, haemoschesis on L)
→ associated ± ↓ BP 70-80 systolic
↑ HR ↑ to 150.
→ given 500 ml Albumex
BP ↑ to 80-90's
=> Hb 83 (96 this am) ∴ also given 2U packed cells
BP since has been stable MAP ~ 70.
- UO back to ~ 100 ml/h.

→ Dr Shirley (Surg. Reg) →
R/v'd pt. ~ 1700 h -

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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30.1.00

Nursing 0645 cont... NSA 500mls infusing. Peripherally warm/hot but capillary refill >3seconds. Temp @ 37°. Continues inotropic support and unchanged from previous Noradrenaline, Dobutamine, Dopamine. BSL's stable with sliding scale Actrapid. RCC infusion this sonce. Sedation Morphine + Midazolam @ 16mg/4mg /hr, pt will flutter eyes and as previous frown with turns. NGT feeds restarted @ 160ml/hr, aspirate acceptable + returned, note NGT feed present in oropharyngeal aspirates. U/o 60 to only 125 ml/hr. No audible bowel sounds. Noted to have 'thrush' appearance under both axilla, RMO aware. Skin intact but remains in mainly moist environment on back due to wound ooze. Visited by wife + brother this morning. (Reporter RN (PORTER))

30/1/00 Night
RMO Problems
0635h

(1) Acute pancreatitis
- post necrosectomy x3
- >1 post cholecystectomy.

(2) ARDS ? poor gas exchange
- stay fairly static
- CXR appearances worsening
- 2° to (1) ± gastrograffin
- ? for broncho toilet
- desaturates ? focus

(3) Non-oliguric renal failure
- vol 50-115 ml
- Cr stable 0.17.

(4) Haemodynamic instability ? inotrope req°
NAdr - 19 ucg/min
Dopamine - 15 ug/hr
Dobutamine - 60 mg/hr.
BP fairly stable 100-120 s/m e/night

(5) Episodic hyperventilation - seems to be associated ? lateral positioning (up to 40/m. ↑)
CXR - ° pneumothorax
Resolved ? repositioning.

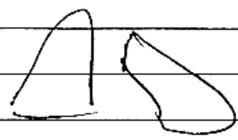
(6) Nutrition - remains on NG feeds + appears to be tolerating.

CLINICAL EXAMINATION (Cont.)
DATE:

(7) Post-op bleeding on evening shift
 - appears to have settled.
(8) Anaemia post-op - post 3U transfusion Hb 96.

OE/ T 38° (up to 39° o/night) - Blood c/s this am ✓
PR 135 RR 28 BP 115/55 SaO_2 96% on 50% O_2

Chest ↓ AE bilat (L) > (R) (worse)



scattered coarse creps

HS I II nil added.

Abdo

Distended ++
Ooze ++
Loop of bowel visible. pink.

CNS GCS 2+T

Imp More stable this am.

Plan. Aim to replace wound losses ē colloid.
?Branch today.
Bloods ✓
CXR ✓
Continue KCl at 5 mmol/hr

B. M. Shepherd
SHO

30-1-00 1015hrs ICU WR Dr Leditschke

- On 16mg Morphine + 4mg Midazolam per hour
- Clot evacuated last night
- UO >100 mls/hr last 2 hours
- 80 mls/hr Dextrose + 50mls/hr Free water
- Vancomycin daily
- Fluid balance + 3500 ml

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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CLINICAL EXAMINATION

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SEX | UR NO
M | 778512

14-06-1957
M

SELF EMPLOYED

AFFIX PATIENT IDENTIFICATION

Plan - return to OT tomorrow ~10 am
-d/N Dr Carmody
~> given that stable now -> observe
notify if ↑↑ loss or unable keep
stable.

Resp - gas XC remains good (even though CXR worse)
PO_2 83 on FiO2 50%.

Chest - ↓AE bibasally
↓AE Rm2 ant.

- Inotropes unchanged (as per WR plan)

Plan - recheck Hb & K^+ (5.0 after infusion)
after RBC's through

- ↑ maint. dextrose to 100 ml/h
to account for abdo. loss
& given high Na^{2+}
- watch abdo loss.

RClayden

30/1/00 - Relatively stable
2030 - Responds well to fluid boluses
Ledisthene Cl ↓ But Na still 146
- Gas exchange stable SaO_2 95% FiO_2 50% 10 l/min
Breathing up to 35 14 x 800
some breath stacking
- Now has fluid in oropharynx
- maxillon cleared this am
- No evidence of endotracheal aspiration
- Poor fluid balance but large unmeasured
loses from abdomen

CLINICAL EXAMINATION

- creat + urea still improving.

Plan - Continue with NG feeding / NG water + colloid / 5% D 50:50. for fluid loading.
- watch Na+: aim to keep ~/140.
- Change to PCSIMV 14 x IP 25 IT 1-5
↑PS to 25 also.
- leave inotropes "as is" at present.

30/1/2000 NURSING NOTE 2225

CNS Remains sedated on morphine and midazolam w/ response to painful stimuli, PEARL 2+, rest remains right, ↑ H.R and B.P. on stimuli.
CVS Monitored in Sinus tachycardia rate 150bpm, CVP 10-15 requiring fluid bolus 500mls Haemaccell + 500mls 5% Dextrose. Inotropes remain unchanged, Dobutamine, Nor-Adrenaline + Dopamine.
Respiratory. Ventilation changed to SIMV/PCV insp. press 25 insp. time 1.5, P.S. ↑ 25, resp remains at 10 FiO2 .5. Spo2 94-97%. moderate amounts thick E.T. secretions. Tachypnoeic to 35bpm on SIMV with some breath stacking much more settled on P.C.V.
Renal - Output 80-120ml/hr via I.D.C.
Integument, ✂ Abdo. dressing re-inforced, large clot evacuated, seaws drainage +++ ~ 200-300 mls 4/24. Skin otherwise intact.
G.I.T. Enteral feeds continue at 160ml/hr, minimal aspirate, continues small amounts gastric contents in oro-pharynx metoclopramide re-commenced. B.N.O.
Metabolic - Remains Hyperthermic to 39.3°C BSL 13 mmols, actrapid infusion continues, titrated to sliding scale.
Social - Visited by family members.
Other - For theatre in AM, approx 1000hrs, withheld feeds 2400 hrs. — (Brodie) Oxley

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31/1/00 RMO-GOLIKOV
0045hrs

pt a little more stable this shift.

Issues:-

(1) Resp.
much improved on new V orders
now on pressure ~~support~~ controlled as in
→ PCSIMV
→ ↑PS 25.
→ Rate 14
→ IP 25.

ABG's on 50% FiO_2.
PH 7.47
PCO_2 39
PO_2 105 !
HCO_3 28.
BE 4.2
Sats 99%. !

∴ much improved on this regime -

(2). CVS. more stables this shift.

· Hb 77 (if remains relatively haemodynamically stable no need for transfusion unless fall in Hb).
· BP 100/50.
· PR ~~88~~ 146
· MAP 70.
· CVP 13.

On noradrenalin 19 mcg/min
Dopamine (5 mg/hr
Dobutamine 15 mg/hr

CLINICAL EXAMINATION

DATE:

Since his Na remains high, fluid boluses should be given 50/50 & 5% Dextrose + colloid (to keeps Na ↓).

(3) Wound looks contamie + some clot
∴ due for OT at 10:00 am 31/1 (family aware).
∴ stop ng feeding at 0600 hrs as per Dr Leditschke's & give IV maintenance during this time.

(4) U/O — good
70 - 120
Renal fx) stable.

(5) GCS 3
on morphine : midaz 15 : 7.5 mg /hr.

(6) - Temp continue to 40°C
- also wound swab taken around CV line ∴ needs to be kept a close eye on.
- Vancomycin started 30/1.

Plan:- continue inotrope support.
- chase wound mcs
- continue current IV plan

MGahlot.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks