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DATE OF EMERGENCY ROOM EXAMINATION: 3-27-85 (1353 hours)

HISTORY OF PRESENT ILLNESS: The patient is a 44-year-old male, educational physiology professor, from New Zealand who is a student at Stanford. He has had chronic asthma, and while on the road this morning, he had extreme respiratory distress and was brought in by his wife to the Emergency Room by automobile. All last week, he had to sit up to breath and could not sleep until last Saturday. He complained of no chest pain.

MEDICATIONS: Prednisone; a bromide by inhalation called Berotec; inhalation by the generic name of Hexoprenaline; Bcolide inhaler; Sudomyl which is similar to Sudofed; unknown type of theophylline.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure, 210 by palpation; respirations, 40; pulse, 120.

HEENT: PERRL. Ears, nose, and throat are grossly clear.

NECK: No jugular venous distension.

CHEST: Marked inspiratory and expiratory wheezes throughout with very little air movement.

HEART: Regular rhythm with no murmurs.

ABDOMEN: Soft.

EXTREMITIES: Pulses were equal and ++ bilaterally with no pulsus paradoxus present by palpation. There was definite cyanosis to all nailbeds.

NEUROLOGIC: The patient was unable to speak and could not answer questions appropriately.

EMERGENCY ROOM COURSE:

The patient walked in with great effort to the Emergency Room. He appeared to be extremely pale and diaphoretic. He was immediately taken to the gurney. He was using all extracostal muscles of respiration. You could hear wheezing without the stethoscope. He was in marked respiratory distress.

The patient had initial blood gases drawn and an O<sub>2</sub> at six liters was started. By facial mask, he was given Alupent but was unable to successfully complete the course because his mental status continued to deteriorate to the point where he was unresponsive to verbal stimuli. He was initially intubated with a #7 nasotracheal tube after the right nostril was prepped with a cocaine inhalation. The tube was not able to be passed easily into the trachea. It was passed several times into the esophagus. The patient was continuously given oxygen through the mouth through a nasal cannula while he was prepared with suction succinyl choline. He was given 20 mg and then immediately

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intubated through the mouth with an 8.5 ET tube with ease. After this, the patient was placed on a volume ventilator at initially 900 cc tidal volume at a rate of 18 and 100% FIO<sub>2</sub>.

I next ordered a 0.25 cc of Isorpril per ventilator and a 400 mg theophylline drip started over one half hour. Also a stat theophylline level was obtained prior to this. Dr. Steele was consulted and is presently with the patient.

Initial blood gases revealed a marked respiratory metabolic acidosis. He was treated with 30 mEq of bicarb, and approximately 10 minutes he was placed on the volume respirator, another blood gas revealed an improvement in his pH, no evidence of any hypoxia, and a reduction from approximately 87 pCO<sub>2</sub> to 57 pCO<sub>2</sub> on the second blood gas. The patient also began to look better and his monitor rhythm which initially was a sinus tachycardia remained the same throughout his Emergency Room Course. His chest sounds never improved; however, the patient's cyanosis improved and his diaphoresis improved but was still present. I initially also ordered Solu-medrol, but Dr. Steele arrived and instead ordered 20 mg of Decadron IV push. Because the patient's heart rate was so fast, the patient only received half of the total Isorpril dose (approximately one-eighth cc).

The patient's theophylline level came back 6.7. A CBC was drawn and he had an elevated white count with a shift to the left and normal hematocrit.

IMPRESSION:

Acute respiratory failure secondary to asthma; history of chronic asthma.

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D&T 3-27-85

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