CASE PRESENTATION

DONE BY: SARA ALARFAJ

PATIENT INFORMATION:

- JM, is a 37 years old male, weighs 75 Kg.

CHIEF COMPLIANT:

- The patient was admitted for an Atrial Septal Defect Closure.

PROBLEM LIST:

- Large Atrial Septal Defect type II
- ASD closure in the 2nd of July.

PSICU

(2nd-3rd of July)

PHYSICAL EXAMINATION:

- **Vitals:** temp 36.8, HR 92 bpm, RR 12 BPM, SpO2 99%,ABP 116/66, NBP 117/67, CVP 8
- **GEN**: on RA, no distress
- **CHEST:** clear.
- **ECG:** normal sinus rhythm.
- **CVS:** well perfused, S1+S2
- **ABD:** soft.

CONT

- ECHO done in 04/28/2013 for an ASD II evaluation.
- **Results :**
  - Large ASD secundum with left to right shut.
  - Deficient rim towards IVC.
  - Prominent Eustachian valve.
  - Dilated RA/RV.
  - Normal ventricular function.
- Echo findings showed that the case is not suitable for device closure.

LABS:

Lab test	value	Lab test	value
Na	144	WBC	21.6
K	4.4	RBC	5.63
Mg	0.71	Hg	12.5
Ca	2.17	HCT	0.384
Urea	4.4	Plt	150
Cr	92	PT	9.9
Alb	42	PTT	33
ALT	26	INR	1.1
AST	25	Fibrinogen	2.3
BSL	11	Lactate	3.6

ASSESSMENT:

2 July

Pre-operative data:

- BP 111/63, Urea 4.4 mmol/L, Cr 101 Umol/L, WBC 7.5, Hg 15g/dl.

Post-operative data:

- Uneventful procedure.
- Orally intubated.
- Plan was weaning to extubate.

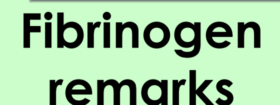
CONT. ASSESSMENT

3 July

- Hemodynamically stable with no support, on room air.
- Temp 36.8, HR 81 bmp, RR 24 bmp, SpO2 98%, ABP 135/71, CVP 8 .
- Urine output= 1.8 , Body Balance= -196
- Afebrile, with high WBC (21), will be off Cefazolin.
- Started on oral feeds.
- He was extubated, well tolerated.
- CXR showed congested lungs.

INTERVENTION:

Medication	Dose/frequency/route
Heparin	25 units IV q6hr for one day.
Acetaminophen	1000 mg PRN
Ranitidine	50 mg IV PRN
Cefazolin	2 gm IV q8hr
Metaclopramide	10 mg IV PRN
Magnesium Sulphate 50%	4 ml IV PRN
Tramadol 50-100 mg IV PRN	50-100 mg IV PRN
Cryoprecipitate	84 ml PRN
Dopamine	800 mg in 250 ml @ 5 mcg/kg/min



PLAN:

- Mobilize the patient.
- Transfer to ward 1/7.

WARD 1/7

(3rd of July – 9th of July)

LABS

	3rd	4th	5th	7th
Na	138	138	141	138
K	4.3	4.6	3.7	3.4
Mg	0.97	0.91	0.86	0.94
Ca	2.26	2.3	2.29	2.35
Urea	5.2	5	4.6	4.7
Cr	82	80	79	96
Alb	43	37	37	38
WBC	22.3	29	14.4	8.9
RBC	5.26	4.65	5.10	5.47
Plt	152	183	178	219

3 JULY

Assessment:

- Patient transferred to ward 1/7.
- BP 123/85, temp 36.8, HR 88, RR 22
- CRP= 110 (H)
- **Doctor's orders:**
  - Mobilize the patient.
  - encourage oral feeding.
  - keep K level high.
  - total fluids 1.8 L/D
  - start Tazocin, KCL tablets.

CONT.

Intervention:

Medication	Dose/frequency
Ranitidine	50 mg IV q8hr
Furosemide	20 mg PO BID
Potassium Chloride	1 tab 8 mEq BID
Tazocin	3 gm IV q8hr
Paracetamol	1000 mg PO PRN
Morphine	7 mg IV PRN
Tramadol	50 mg PO PRN

4 JULY

Assessment:

- Vital signs: temp 37, BP 120/53
- CRP= 94
- **Chest:** clear, **CVS:** S1+ S2, **Abd:** soft.
- Urine output= 106/24, Body Balance= + 484
- **Doctor's orders:**

  - total fluids 1.8 L/Day.
  - start Vancomycin.
  - increase lasix dose to 40 mg BID.

CONT.

Intervention:

Medication	Dose/frequency
Ranitidine	5o mg IV q8hr
Furosemide	20 mg PO BID
KCL	1 tab 8 mEq BID
Tazocin	4.5 gm IV q8hr
Vancomycin	1 gm IV q12hr
Morphine	7 mg IV PRN

D/C

Dose increased to 40 mg BID

WBC=29,Tazo increased, Vanco added

5-6 JULY

Assessment:

- BP 120/60, Temp 37.
- Vancomycin pre level came 7.9 on the 6th.
- WBC are still high (14.4).
- **Doctor's orders:**
  - Mobilize.
  - Free fluids.
  - Start Heparin 40 mg OD on the 5th.

CONT.

Intervention:

Medication	Dose/frequency
Furosemide	40 mg PO BID
Tazocin	4.5 gm IV q8hr.
Vancomycin	1 gm IV q12hr
Heparin	40 mg (4000 units)SQ OD

7 JULY

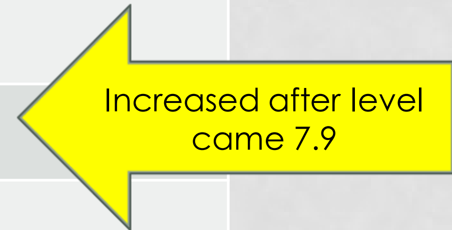
Assessment:

- Vitals are stable.
- WBC and CRP decreased, 8.9 and 98, respectively.
- INR= 1.3
- **ECHO results:**
  - No residual atrial shunt.
  - Dilated RA/RV.
  - No pericardial effusion.
  - Good LV systolic function.

CONT.

Intervention:

Medications	Dose/frequency
furosemide	40 mg PO BID
Tazocin	4.5 gm IV q8hr
Vancomycin	1250 mg q12hr
Heparin	40 mg SQ OD



8 JULY

Patient was stable with the same medications and no significant changes on his vital signs and lab results.

9 JULY
(DISCHARGE DAY)

Assessment:

- BP 119/63, Temp 37
- Vancomycin pre level 11.9
- **Doctor's orders:**
  - Home after completion of IV antibiotics.
  - to be switched to oral Augmentin.
  - reduce Lasix to 20 mg BID.

CONT.

Discharge Medications:

Medications	Dose/frequency
Paracetamol	500 mg 2TAB PRN
Diclofenac Emulgel	MA FAP Tpoical
Augmentin	1 gm 1TAB q12hr for 5 days
Furosemide	40 mg HTAB 2D

RECOMMENDATIONS:

- Infective Endocarditis prophylaxis with antibiotics is only indicated when patient is at high risk and going to a high risk procedure. (ESC)
- Endocarditis doesn't occur in patients with isolated ASD and usually associated with concomitant vascular lesions, so prophylaxis is not indicated. (ACC/AHA)

FOLLOW UP:

- Assessment of residual shunt, RV size and function.
- TR and PAP by ECHO, Pulmonary vein stenosis and pericardial effusion.
- Assessment of arrhythmias by history, ECG and, if indicated, Holter monitor.
- Patient should be informed about possible late occurrence of late Tachyarrythmias.
- Follow up should be on a regular basis after repair during first 2 years, then every 2-4 years.

THANK YOU

Questions?