

*Patient Name*

*DOB: MM/DD/YYYY*

**Narrative Summary - Patient Name**

On April 19, YYYY Mr. XXXX vital signs were weight: 141.6 pounds; BMI: 20.39; BSA: 1.80; Temp: 97.7 degrees; Pulse rate: 74 per minute; Pulse rhythm: Regular; Respiratory: 12 per minute; BP sitting: 140/ 85 (right arm); Cuff size: Regular; Weight (Lbs): 141.6.

From April 19, YYYY through December 7, YYYY, Mr. XXXX received treatment for his hypertension at Desert View Family Medicine. His medication included Amlodipine, Atenolol 50 mg, Lisinopril 20 mg, Aspirin, and Ativan 1 mg. His highest BP was 168/96.

On December 10, YYYY, at 11: 06am., Mr. XXXX presented to XXXX Care, where he was examined by XXXX M.D., for the complaints of chest pain. He stated that 4 days ago he had sternal pressure as if something was sitting on him. His pain radiated to both sides of jaw and left arm. He was noted to have shortness of breath with slight nausea and weakness no diaphoresis. On examination, he was noted to have decreased breath sounds bilaterally and regular rate and rhythm. His vital signs were Bp: 170/104, Temperature: 97.8 F, Heart Rate: 89, Respiration: 16, O2 Saturation: 99, Pain Scale: 10. On examination, he was noted to have decreased breath sounds bilaterally and regular rate and rhythm. The EKG was obtained that revealed normal sinus rhythm and poor T wave progression. Chewable Aspirin 81 mg x 4 tablets were given orally. At 11:22 am., He was transferred to XXXX Health for further management care.

**XXXX - XXXX, D.O. and XXXX, P.A.**

On the same day (December 10, YYYY), at 11:47 am., An electrocardiogram was obtained that revealed rate 83, QRS interval left ventricular hypertrophy, Normal PR, QRS, and QTC, No STEMI.

On the same day (December 10, YYYY), at 11:55 am., his triage results were obtained by XXXX, RN and the values were Temp C: 36.5°C, temperature Site : Oral, heart Rate : 83 bpm, pain Present : No actual or suspected pain, respiratory rate : 16 br/min, Systolic Blood Pressure : 197 mmHg, Diastolic Blood Pressure : 127 mmHg, AVPU : Alert and responsive, SpO2 : 96 %, Oxygen Therapy : Room air.

At 11:55 am., his initial vitals were temperature: 36.5°C, Oxygen saturation: 96 %, Spo2: 96%, Oxygen Therapy: 96 %.

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At 11:57 am., his initial vitals were Temperature: 36.5 Degree, Temp F - 97.7 Degree F, Systolic Blood Pressure - 197 mmHg , Diastolic Blood Pressure - 127 mmHg , Heart Rate - 83 bpm , Respiratory Rate - 16 breath/minute, SpO2 - 96 % , Oxygen Therapy - Room air. His laboratory test included Troponin-T, High Sensitivity <6 ng/L WBC 13.5, RBC 4.02, HGB 12.7 g/dLL Protime 13.5 second(s), INR 1.2, D-Dimer, Quant 717 ng/mL

On the same day (December 10, YYYY), at 1:13pm, his triage part 2 results were obtained by XXXX, RN and the observation stated that he had chest pain on Friday lasting 20 minutes with pressure and jaw pain. He continued to have twinges in his chest. His symptoms began at his home. His Glasgow coma scale was 15.

On the same day (December 10, YYYY), at 1:13 pm., Mr. XXXX was examined by XXXX, D.O. and XXXX, P.A., at XXXX for the complaints of pain with pressure, and jaw pain, which were associated with shortness of breath and headache. He continued to twinges in his chest. He had one episode of chest pain. He stated that he went to urgent care on December 7, YYYY, where he was asked to visit to Emergency Department for his chest pain. He stated that he had immense pressure on his chest. He also had a headache and SOB (Shortness of breath) during the episode but he denied any diaphoresis. He stated that he did not come to Emergency Department on Friday because he believed it was just an episode of GERD (gastroesophageal reflux disease). He was given 324 mg of ASA (Aspirin) at UC today PTA. (prior to arrival). On examination, he was noted to have regular rate and rhythm, and normal peripheral perfusion. He had no edema, S1, S2, no S3, no S4. He had non-labored, breath sounds are equal and symmetrical chest wall expansion. He had breath sounds and he had no rales, no rhonchi, and no wheezes. His treatment plan included laboratory test, EKG, X-ray of his chest and CTA of chest.

At 1:15 pm, he was prescribed Lorazepam and Atenolol by XXXX PA.

At 1:45 pm., Mr. XXXX nursing assessment report taken by XXXX, Registered Nurse included the Neurological procedures such as Cognition-Normal; PERRLA-Yes; Pupil size(right and left) – 3mm; Characteristics of communication – appropriate; Characteristics of speech – clear; Aspiration risk-None; Facial symmetry- Symmetric. The report also included cardiovascular assessments such as Capillary Refill- Less than 2 seconds; Nail Bed Color-Pink; Pulses- Radial, Bilateral; Radial Pulses Bilateral-3+ Normal; Skin Temperature-Warm; Jugular Venous Distention- Unable to visualize; Heart Sounds ICU-S1S2 and Heart Rhythm-Regular.

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At 1:48 pm, Dr. XXXX Mr. XXXX treatment plan included cardiac Monitoring, RSP Oximeter Continuous: 48 ERP Completed, EKG: 12/10/18 13:48:00-Portable, insert Peripheral IV: Instructions: Apply saline cap for patient with SBP greater than 120, PT (Protime)/INR: ER Stat, ES, Nurse Collect, Troponin T, High Sensitivity: ER Stat, ES, Nurse Collect, CBC (With Differential): ER Stat, CBC- ER Stat, Chest PA + Lateral and comprehensive Metabolic Panel (Includes GFR).

At 2:17 pm., Mr. XXXX blood report given by XXXX included the results Type of Blood Draw: Venous; Blood Draw Site: Antecubital; Blood Draw Site: Laterality Left; Blood Draw Skin Preparation: Chlorhexidine; Pain Management Blood Draw: Positioned for comfort; Blood Draw Time: 12/10/18 14:15; Blood Draw Number of Attempts: 1 times; Blood Draw Response: Tolerated.

At 2:20 pm., CT of Chest and D-Dimer and Troponin T, High were planned to obtain. His laboratory test included WBC 13.5, RBC 4.05; HGB 12.7; HCT 38.3; Neutrophils 9.9, protime. 13.5 (high), INR 1.2 (high), D-Dimer, Quant (717 high).

At 2:29 pm., Glasgow Coma Score was 15/15.

On the same day (December 10, YYYY), at 2:46 pm, an X-ray of Mr. XXXX chest was obtained at XXXX. The study revealed no definite radiographic evidence of acute cardiopulmonary disease.

At 04:05 pm., Mr. XXXX troponin-T, was High Sensitivity <6 Ng/L.

On the same day (December 10, YYYY), at 4:25 pm., a CTA of Mr. XXXX chest was obtained at XXXX. The study revealed mild linear dependent atelectasis or scarring in the lung bases and left nephrolithiasis without hydronephrosis measured to be 3 mm nodule right apex. The findings indicated follow up CT in twelve months. In a low risk patient, single or multiple solid nodules <6 mm did not require routine follow-up. If he was a high risk patient (risks such as smoking, known neoplasm, suspicious nodule morphology, or upper lobe location) initial follow-up CT at 12 months might be warranted.

He was diagnosed with chest pain.

At 5:30 pm., XXXX, R.N., assesses Mr. XXXX neurological status, which was normal.

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At 5:34 pm., Glasgow Coma Score was 15. He was recommended to follow-up with his primary care physician for this nodule in his lung as this could be cancer. He was also recommended to follow up with a cardiologist Dr. XXXX in three to four days as an outpatient for continued workup including stress test. His troponin test was negative while in Emergency Department. He was stable for outpatient therapy. He was recommended to follow up if his symptoms worsened. The chart was designated for review and attestation by the supervising physician on duty, Supervising physician Dr. XXXX was in the ED and available if needed for consultation. Mr. XXXX was discharged from the facility. His mode of departure was Ambulatory and Departure Transportation was Private vehicle.

On December 11, YYYY, at 8:51 am., the paramedics of American Medical Response arrived at Mr. XXXX home and found him lying on his bathroom floor. He complained of left-side CP (Chest pain) that radiated to his left-arm and jaw. He was seen in the ER the previous day for the same symptoms and was diagnosed with GERD and released without follow up orders. Continuous EKG monitoring was done that revealed Suspected ST-Elevation Myocardial Infarction and Septal. Aspirin 81 mg chewable tablet was given orally. His vital signs were Bp: 108/62; pulse: 70; pulse regularity: regular; respiratory rate: 20; mean arterial pressure: 77. Pulse oximetry - 97% on room air. He stated that the pain returned this morning after waking up. Fire Medic report he was noted to have an elevation in leads v1 and v2 w/depression in the leads 2, 3 and AVF. He was rolled onto a lift sheet and carried to the gurney x4 and placed into a position of comfort with side rails x2 and safety belts x3. He was then transported to the Emergency Department of XXXX for further evaluation and care.

At 9:15 am., Mr. XXXX vital signs was taken by XXXX, RN., that included Temp C : 36.4; Temperature Site: Oral; Heart Rate: 78 bpm; HR Site: Monitor; Respiratory Rate: 14 br/minutes; Systolic Blood Pressure: 105 mmHg; Diastolic Blood Pressure: 58 mmHg; AVPU: Alert and responsive; SpO2 : 100 %; Oxygen Flow Rate : 15 L/min., via Nonrebreather mask. His breathing was unlabored. His numeric rating pain scale was 8/10.

On the same day (December 11, YYYY), at 9:15 am., Mr. XXXX was examined by XXXX M.D., and XXXX, M.D. at XXXX for chest pain. At 09:13 am., his EKG revealed rate 74, EP Interpretation, ST segment elevation in V1, V2, and AVR with ST depression in limb leads II, III, and AVF, suspect anterior wall infarct. He was diagnosed with Acute Myocardial Infarction (AMI), heart Failure, pneumonia, surgical Care improvement Project (SCIP).

At 9:20 am., Mr. XXXX vital signs revealed Temp C - 36.4; Temp F - 97.5°F; Systolic Blood Pressure - 105 mmHg; Diastolic Blood Pressure - 58 mmHg; Heart Rate - 78 bpm; Respiratory Rate -

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14 breath/minute; SpO<sub>2</sub> - 100 %; Oxygen Flow Rate - 15 L/min; Oxygen Therapy - Nonrebreather mask.

At 9:29 am., Mr. XXXX laboratory test included HGB13.7; HCT 41.9; Neutrophils 11.7, platelet 266, protime was 12.8, INR was 1.1, and Heparin was <0.04, Glucose Level – 146,, Troponin-T, High Sensitivity – 17 ^7.

At 9:43 am., Mr. XXXX was assessed his fall risk by XXXX, R.N.,

From 9:12 am until 10:19 am., Mr. XXXX treatment plan included laboratory test and he was in nil per oral status.

At 11:01 pm., Mr. XXXX was examined by XXXX, M.D. His condition was critical and he was unlikely to survive. A plan was to provide adequately pain relief.

At 11:05 am., his INR was 1.3 and Protime was 14.8.,

At 11:07 am, XXXX, D.O., performed intubation.

At 12:00 noon: An EKG was obtained that revealed sinus rhythm, abnormal right progression, consider ASMI or lead placement, abnormal suggests ischemia, and diffuse leads

At 12:52 pm., an X-ray of his chest was obtained that revealed an interval development of moderate perihilar ground glass alveolar infiltrates. These findings might reflect an infectious or inflammatory process. Noncardiogenic pulmonary edema could have this appearance. The endotracheal tube was about 5.7 cm above the carina at the level of the mid trachea. Consider advancement by 1 to 2 cm. There was a lucent appearance of the left upper quadrant which might reflect gaseous distention of the stomach. Findings could be further assessed by an acute abdominal series or by CT if clinical symptoms warranted.

At 2:28 pm., Mr. XXXX was examined by XXXX, D.O. who plan to perform left heart catheterization as his EKG showed ST elevation in V1-V3 with reciprocal changes

At 3:50 pm, XXXX M.D., performed primary repair of ascending aortic dissection with resuspension of the aortic valve with a 28 hemashield graft cabgx2 with saphenous vein grafts to the

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lad and OM. Cannulation of left femoral artery and left femoral vein for cardiopulmonary bypass. Placement of Impella3.5 device via right common femoral artery.

Mr. XXXX was examined by XXXX, D.O. His cardiac catheterization revealed LM occlusion. LM was engaged and 1 wire placed in the LAD and one in the LCx without difficulty. Balloon angioplasty was performed in the LM and TIMI 3 flow was established. ST segments was normalized and he was stabilized while on the table. Dr. XXXX, a cardiothoracic surgeon was on call, was paged and he immediately came to evaluate the Mr. XXXX while he was still on the cath lab table for urgent CABG.

Plan was to take him to the OR he was intubated on the table for airway protection. Left ventriculogram was performed showing a possible dissection flap in the ascending aorta and concern was for aortic dissection, with dissection propagating into the LM coronary artery, which was why the he presented with new EKG changes this morning consistent with anterior STEMI. Impella was placed in the right femoral artery for support and easily advanced across the aortic valve and into the LV. He was taken urgently to the OR. TEE was performed intraoperatively and recognized acute ascending dissection. He was hypoxic and with severe LV dysfunction at the outset. The heart was arrested with retrograde cardioplegia, and opened the aorta. There was a lead point of dissection. It was in mid ascending aorta - area of inflammation and thickening.

Continuity with the procedure, along aortic wall, aorta tore retrograde and antegrade, valve appeared to be intact, root not dilated, was able to resuspend the valve and opted to proceed with greater repair of aorta, Bio glued and felt repaired proximally and distally, proceeded with repair with DHCA, rewarmed and LV was still very dysfunctional, proceeded with CABG to lad and cx OM, attempted to fill heart and still very dysfunctional, replaced Impella and separated from bypass, LV not functional, had severe coagulopathy that was not able to be corrected in spite of heroic efforts.

On December 12, YYYY at 0129 am., Mr. XXXX was pronounced dead His aortic clamp time 108 minutes, circulatory arrest 23 minutes, CPB total 279 minutes. Family was allowed at bedside.

The Autopsy report Mr. XXXX dated December 13, YYYY, revealed that, it was discovered that he had a laceration of the proximal ascending aorta. There was hemorrhage outside the dissecting laceration with clot formation around the proximal left coronary artery. Emergency surgery included resection of the ascending aortic dissection and placement of a branching coronary artery bypass graft obtained from veins in his left leg. Care was taken to minimize grafting to the synthetic aortic graft

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and the native left coronary artery was left in place. Despite surgical efforts, he expired. Notification of the death was appropriately made to the medical examiner's office, but they declined jurisdiction.

The death certificate of Mr. XXXX was provided by State of Arizona on February 8, YYYY, revealed that his immediate cause of death included myocardial Ischemia, left ventricular ischemia. Due to or as a consequence of Type 1 aortic dissection of ascending aorta and retrograde tear into root, and hypertension Other significant conditions contributing to the death but resulting in the underlying cause given was tobacco use.

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