

# [Medical transcription case study](https://assignbuster.com/medical-transcription-case-study/)

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Patient is known to have COOP with emphysema and has multiple admissions for problems concerning this. At the time of initial evaluation, a small caliber chest tube was inserted in the anterior auxiliary line, which improved the patient’s respiratory distress but did not completely resolve the pneumonia. I was called to the ICC to place a second small caliber chest tube In the posterior auxiliary line below this. This further Improved the patient’s pulmonary status with his saturation Improving from 76& to 89%. Since admission he has felt better but complained of pain at the chest tube insertion site.

He has continued to leak out through the pleura-evacuee under water seal, and beginning yesterday he developed subcutaneous emphysema, which has gotten progressively worse.

Earlier today he began having increased respiratory difficulty again, with his saturation dropping to approximately 80 % despite oxygen per nasal canella. Chest x-ray today showed a worsening of the right lower lobe located pneumonia, and n examination today he is not only leaking air through the pleura-evacuee system but also around the two chest tubes.

Patient has had previous right pneumonia but never any on the left side. He has undergone some type of attempted pleural ablation therapy. Sputum cultures from this admission have grown Pseudonymous and Streptococcus, and he has been treated with Ciprofloxacin. , R 30, and appears moderately uncomfortable and cyanic.

WENT: otherwise unremarkable. CHEST: Breath sounds decreased bilaterally and cannot be heard in the right chest wall because of the crackling sounds from subcutaneous emphysema.

Heart tones distant, (Continue) patient ID: 115037 Date of Consult: 12/15/—- Page 2 no murmurs or gallops, rate seems regular. ABDOMEN: Unremarkable. Extremities: pedal edema is present.

There was bubbling from both pleura-evacuee systems and both chest tubes. When I removed the dressing from the upper chest tube, which was the initial one placed, fell out with the dressing. Patient suddenly became markedly more uncomfortable. There was an escape of air from the chest tube site period. The saturation decreased to 59%.

Chest x-ray revealed increased in the pneumonia from what was seen earlier today, measuring approximately 10%.

IMPRESSION: Pronounceable fistula with recurrent right pneumonia. PLAN: Small caliber chest tubes are not adequate to contain the leakage, and therefore a larger chest tube needs to be placed. If the pleural fistula does not close spontaneously with controlled infection, I would recommend CT scan of the chest ND/or bronchus’s to rule out associated malignancy and consideration of chemical pleurisy’s.