1. Describe the patient's condition, including signs/symptoms that led to this admission.

*** LK is a 58 year old white female at a local clinic to have hardware removed from her tibia/fibula on 10/22/2012. Patient developed SOB and hypotension post-op. The symptoms did not resolve so the patient was transferred to an acute care facility ICU. Upon chest x-ray, bilateral infiltrates were seen in the lungs. Patient was intubated; a right radial arterial line was placed along with a right internal jugular triple lumen catheter. Patient also had a #20 PIV in right hand. Patient has a previous history of developing SOB and hypotension post op.

2. Briefly describe the pathophysiology related to the patient's diagnosis and current medical/surgical condition.

***COPD (chronic obstructive pulmonary disease) is a progressive disease of the lungs that makes it difficult to breathe. Most people with COPD are smokers or past smokers. The best way to stop the progression of the disease is to stop smoking. COPD causes coughing that produces mucus, wheezing, shortness of breath, and chest tightness. In normal lungs, the air that is breathed in goes into tubes in the lungs into the bronchial tubes. The bronchial tubes branch into smaller tubes called bronchioles. These tubes end in round air sacs called alveoli. Capillaries run through the walls of the air sacs and when the air reaches them, oxygen passes through into the blood in the capillaries and carbon dioxide moves into the air sacs. When you breathe in the air sacs blow up like a balloon and when you breathe out, the air sacs deflate. In patients with COPD, the air sacs can lose their elasticity, the walls between the air sacs are destroyed, the walls of the airway become thick and inflamed, and the air ways make more mucus than usually, clogging the airway which produces the chronic cough. When you have a COPD exacerbation makes it harder for a patient to breathe. An exacerbation can be caused by an infection (patient had possible pneumonia – cultures had not come back yet). An exacerbation could also be caused by the intensity of the procedure the patient had done. The patient was sedated during surgery which slows the breathing increasing the mucus in the lungs.

3. Describe the patient's head to toe assessment findings and explain how they related to the pathophysiology.

***During the patient's AM assessment, the patient was alert and oriented. Patient was cooperative and followed commands appropriately. Patient had an ETT size 7.5 and 23 at the lips. Upon suctioning, little thin secretions were extracted. Patient also had an OG tube to low intermittent suction with dark brown drainage. Also, intact was a right internal jugular triple lumen catheter. Patient's capillary refill was less than 3 seconds. Patient had a right arterial line, dressing dry and intact. Bilateral radial pulses present. Patient's lungs were CTA. Abdomen was soft, non-tender, present BSx4. Foley catheter intact with 8 hour output of 335, clear, yellow urine. ACE wrap to RLE below knee to foot. Strong pedal pulses present and feet were warm and dry. Patient had stead vital signs throughout the day. HR averaged in the high 50s to low 60s, except when stimulated HR increased to the low 80s. BP averaged 90-100/60-70 and MAP was above 70. Respiratory rate when calm was 12-13 but went as high as 17 when patient was stimulated. CVP was 12. Around 1230 patient's propofol was increased from 4 to 5. When this was done, LK's BP dropped to the high 80s/low 60s but MAP stayed above 70. Levophed was running through the night but patient was able to ween off. Patient's vent settings were Tidal Volume: 480, Rate: 12AC, Peep: 12, FiO2 @ 50% but was decreased to 40% at 1230. ***Patient was on ventilator due to the shortness of breath and low SaO2 when admitted to the ICU. Patient had RIJ TLC to help measure CVP because COPD can cause right sided heart failure. ACE wrap below the knee to foot was due to surgery that patient had performed. All pulses were strong indicating a good cardiac output.

4. Integrate the current laboratory, diagnostic test results, hemodynamic parameters, medications, medical and surgical interventions, and other treatments into the pathophysiology and explain how it is affecting this patients outcome/current condition.
***The patient's H&H is low d/t having surgery. The patient was in uncompensated respiratory alkalosis on admission and being intubated. Intubating the patient helps to correct the patient's blood gasses and correct the respiratory alkalosis along with stabilizing the patient's condition. The patient was on Vancomycin and Zosyn d/t the possible pneumonia. Hopefully, these steps will help correct the patient's condition and the patient will be able to ween off the vent and be discharged.