Urgent Clinical Summary for External Physician Review

Carol C. Poston | DOB 07/09/1960 | Hospitalization beginning 09/05/2026 | Records summarized through 09/11/2026

Purpose: Concise physician-facing summary assembled from the patient portal hospital record, laboratory/imaging reports, and a family clarification. It is intended to accelerate outside review and does not replace the certified medical record.

Immediate Clinical Picture

Primary acute problem	Cardiogenic shock in the setting of severe right-ventricular (RV) failure and severe/torrential tricuspid regurgitation, with acute-on-chronic right-sided HF/HFpEF and marked volume overload.
Hemodynamics/support	Hypotension requiring epinephrine infusion (documented at 5 mcg/min); aggressive IV furosemide infusion used for decongestion.
Rhythm	Long-standing/persistent atrial fibrillation; recurrent rapid ventricular response with HR ~130-140s. IV amiodarone used; digoxin also given. Apixaban continued.
Renal	AKI on CKD (notes variably call stage IV/V), felt to be cardiorenal. Creatinine 4.69 mg/dL/BUN 150 on admission, improving to Cr 2.36/BUN 62 by 09/11 while diuresing.
Anemia	Severe microcytic/iron-deficiency anemia with CKD contribution. Hgb reached 6.3 g/dL on 09/10; IV iron and 1 unit PRBC given, with Hgb 7.8 on 09/11.
Advanced therapies	Cardiology/advanced HF documented that she was not considered a candidate for temporary mechanical circulatory support/advanced HF therapies. Nephrology documented no current indication for dialysis and high risk/futility of outpatient extracorporeal dialysis in the setting of severe cardiac disease.
Code/goals	Full Code in available notes. Palliative care consulted; patient requested continued offered therapies and prioritized longevity.

Important Family Clarification Regarding Weight / Fluid Timeline

The family disputes the admission-history statement that approximately 18 lb was gained over only 3-4 days. Family reports that after the prior hospitalization she was visibly much thinner and that fluid progressively reaccumulated over the ensuing months. The exact prior discharge weight is not known to the family. A 09/11 cardiology note independently documents an approximate **dry weight of 190 lb based on the 06/22/2026 discharge**. This distinction may be clinically important when interpreting BMI/"morbid obesity," current weight, chronic congestion, and duration of volume accumulation.

Objective Weight / Volume Data

Date	Documented finding
09/05-09/06	Marked anasarca/peripheral edema and pulmonary edema; admission history recorded "18 lb in 3-4 days" (family disputes the timing).
09/06 TTE	Weight 108.7 kg (239.6 lb); BMI 43.8.
09/08	Weight ~101 kg (223 lb 8.7 oz).
09/09	Weight 99.5 kg (219 lb 6.4 oz); abdominal ascites and 2++ lower-extremity edema documented by nephrology.
09/10	Weight 98.7 kg (217 lb 9.6 oz).
09/11	Weight 98.1 kg (216 lb 3.2 oz); cardiology states approximate dry weight 190 lb from 06/22 discharge.

Cardiac / Pulmonary Findings

Transthoracic echocardiogram 09/06/2026: technically limited study; LVEF 53% (+/-5%), small LV cavity, severely dilated RV with moderately reduced RV systolic function, dilated left atrium, and **torrential tricuspid regurgitation**. Estimated RVSP 46 mmHg assuming RAP 15 mmHg, with report caution that RVSP may be underestimated because of severe TR. Mild mitral regurgitation. No significant change compared with 04/26/2026 TTE.

Historical cardiac/pulmonary context in notes: severe pulmonary hypertension; 09/2024 echo cited PASP 88 mmHg with RV enlargement/dysfunction and moderate-severe TR. Chronic respiratory failure/COPD with home oxygen (case-management note: 2 L O2 at night), obstructive sleep apnea on CPAP, and obesity hypoventilation syndrome are listed.

Chest imaging: pulmonary vascular congestion/interstitial edema and cardiomegaly. 09/07 chest radiograph after PICC placement showed stable pulmonary vascular congestion/interstitial edema, no pneumothorax, and PICC tip over mid-to-lower SVC.

ECG: atrial fibrillation, incomplete right bundle branch block, possible RV hypertrophy/minimal ST depression (admission record).

Hospital Course - Key Events

Date	Course
09/05-09/06	Presented with severe leg swelling/anasarca, weakness/ambulatory dysfunction, mild dyspnea, fatigue/drowsiness and renal failure. BNP 1086, BUN 150, Cr 4.69, Na 123. Pulmonary edema on CXR. Developed hypotension on Lasix and transferred to CVICU. Cardiogenic shock attributed to severe RV failure/TR; lactate initially 5.7. Epinephrine and high-dose IV furosemide infusion initiated.
09/07	Net ~-2 L; lactate normalized to 1.6. Continued epinephrine 5 mcg/min and Lasix infusion, adjusted for hypotension. PICC placed.
09/08	Net ~-3.2 to -3.3 L. Hgb ~6.7; IV iron favored initially. Palliative consult: patient wanted all offered interventions and Full Code status.
09/09	Net ~-3 L; Cr improving (~3.36-3.7). Nephrology: >4.5 L urine output, no dialysis indication; dialysis considered high-risk/futile without bridge to cardiac therapy. AF with HR ~130s.
09/10	Net ~-1.9 L. Hgb fell to 6.3 with tachycardia; 1 unit PRBC transfused. Lasix increased/bolused. Persistent AF/RVR.
09/11	Net ~-3.5 L. Hgb improved to 7.8 post-transfusion. Cr 2.36/eGFR 22. Persistent AF with HR ~140s; IV amiodarone and repeat digoxin documented; aggressive diuresis continued.

Key Laboratory / Diagnostic Data

Test / Date	Result / Trend
BNP 09/05	1,086 pg/mL (high).
High-sensitivity troponin I 09/05	20 ng/L (above reference <12).
Renal / electrolytes 09/05	Na 123, K 4.8, Cl 81, CO2 19, anion gap 23, BUN 150, Cr 4.69, eGFR 10.
Renal / electrolytes 09/10	Na 139, K 4.1, CO2 27, BUN 87, Cr 3.27, eGFR 15.
Renal panel 09/11 07:48	Na 140, K 4.2, Cl 103, CO2 23, BUN 62, Cr 2.36, eGFR 22, albumin 3.6, phosphorus 2.3.
Lactate	Initial 5.7 mmol/L in cardiogenic shock; 1.6 by 09/07.
CBC / anemia	Hgb 7.3 on 09/06; 6.7 on 09/08-09/09; nadir 6.3 on 09/10; 1 unit PRBC; Hgb 7.8/Hct 25 on 09/11. 09/11 MCV 77, RDW 19.3. TSAT 5% cited in cardiology notes.
Liver panel 09/10	Albumin 3.7, total bilirubin 0.9, direct bilirubin 0.4, ALP 131, AST 29, ALT 16, total protein 5.9.
TSH 09/09	1.821 uIU/mL.
Digoxin 09/11	0.4 ng/mL (below lab reference 0.50-1.20).
Magnesium	2.6 mg/dL on 09/05; 2.1 mg/dL on 09/11.
MRSA/SA nares PCR 09/06	MRSA negative; S. aureus negative.

Transfusion / Blood Bank

Blood type **A positive**. Antibody screen positive with **warm autoantibody with E specificity**; DAT broad spectrum positive and DAT IgG positive, C3d negative; eluate positive with all cells tested. Blood bank specifically requested extra time for antigen-negative and/or compatible units. A leukoreduced PRBC unit was issued 09/10/2026 at 10:19 and documented compatible.

Medication Information

Home / Pre-admission Medication List in Hospital Record

Medication	Recorded regimen
Allopurinol	100 mg daily; record says patient taking differently: 200 mg at bedtime.
Amiodarone	200 mg by mouth daily.
Apixaban (Eliquis)	5 mg by mouth twice daily.
Ascorbic acid	500 mg daily.
Cholecalciferol (Vitamin D3)	1,000 units daily.
Coenzyme Q-10	100 mg daily.
Cyanocobalamin-cobamamide	5,000-100 mcg sublingual, 1 tablet daily.
Ferrous gluconate	324 mg tablet (38 mg iron); record states 37.5 mg iron daily.
Gabapentin	300 mg at bedtime as needed; record notes patient taking “continuous as needed.”
Krill/omega-3 supplement	1 daily.
Magnesium oxide	400 mg nightly.
Metformin	1,000 mg twice daily with meals.
Metoprolol tartrate	25 mg every 12 hours.
Potassium chloride ER	20 mEq twice daily.
Pramoxine topical	As needed for itching.
Torsemide	80 mg daily (4 x 20 mg tablets); record notes this dose started 08/29 after a 48-hour hold.
Vitamin K2	1 daily.

Key Active Inpatient Therapies Documented

Therapy	Documented use
Epinephrine infusion	RV/hemodynamic support; notes repeatedly document 5 mcg/min.
Furosemide infusion	Aggressive IV diuresis; commonly 10-20 mg/hr, with IV boluses including 120 mg; adjusted for hypotension.
Amiodarone	IV infusion for AF rate/rhythm management; portal list shows 0.5 mg/min.
Digoxin	Doses given for persistent AF/RVR; level 0.4 ng/mL on 09/11.
Apixaban	5 mg twice daily continued for anticoagulation.
IV iron / oral iron	Treatment of iron-deficiency anemia; ferrous sulfate 325 mg daily also listed.
PRBC	1 unit on 09/10 for Hgb 6.3 with tachycardia.
Insulin	High-dose lispro correction scale plus NPH 10 units BID during steroid/epinephrine-associated hyperglycemia.
Other portal-listed scheduled meds	Allopurinol 100 mg qHS, vitamin C 500 mg daily, vitamin D3 1,000 U daily, famotidine 20 mg daily, polyethylene glycol 17 g daily, senna 8.6 mg qHS, potassium replacement as ordered.

Allergies / Adverse Reactions

Agent	Recorded reaction / reason
Flecainide	Vision changes, weakness.
Iodinated contrast media	Rash/itching ~24 hours after exposure; “heaviness on chest.”
Latex	Rash.
NSAIDs	Avoided because patient reports kidneys cannot tolerate them.
Spironolactone	Generalized weakness.

Known Chronic / Background Conditions in Record

Severe pulmonary hypertension; chronic RV failure; chronic HFpEF; severe/torrential tricuspid regurgitation; long-standing persistent atrial fibrillation (prior DCCV 2022, not durable); chronic kidney disease; type 2 diabetes mellitus; obstructive sleep apnea on CPAP; obesity hypoventilation syndrome; COPD/chronic respiratory failure with home oxygen; chronic iron-deficiency anemia; hypertension; former tobacco use. The record repeatedly labels “morbid obesity,” but current body weight is substantially confounded by documented anasarca/ascites and volume overload; see family clarification above.

Functional / Social / Decision-Making Information

Lives with spouse. Before this hospitalization she was described as functionally independent, using a cane/walker as needed. Case management records home oxygen at 2 L at night. Palliative care documented intact decision-making capacity and identified spouse Kenneth as surrogate decision maker. Patient remained Full Code in the available notes and expressed a desire to pursue offered interventions.

Questions an Outside Specialist May Wish to Address

• Whether any tertiary-center structural, pulmonary-hypertension, advanced-heart-failure, electrophysiology, or other intervention is feasible for torrential TR with severe RV dilation/dysfunction and cardiogenic shock.

• Best strategy for persistent AF/RVR when beta-blocker/calcium-channel blocker therapy is considered poorly tolerated because of RV failure/hypotension.

• Whether the apparent renal recovery during aggressive decongestion changes renal-replacement or cardiorenal management options.

• How much of current body weight represents residual congestion relative to the charted ~190-lb dry weight, and what decongestion target is appropriate.

• Transfusion planning given warm autoantibody/E specificity and need for additional compatibility work.

Source Record Inventory / Notes for Receiving Physician

This summary was compiled from the complete set of 40 hospital notes supplied by the family (09/05-09/11/2026) plus patient-portal laboratory, ECG, echocardiogram, chest radiograph, blood-bank/transfusion, urinalysis, and medication-list exports. The most clinically important source documents include the admission H&P;, serial CVICU/cardiology notes, nephrology consultation, palliative-care consultation, 09/06 TTE, 09/05 admission CMP/BNP/troponin, serial renal panels/CBCs, and 09/08-09/10 blood-bank/transfusion records.

Record limitations: The family did not provide the full records from the earlier June hospitalization. The ~190-lb dry weight is therefore taken from the 09/11 cardiology note referencing the 06/22 discharge, not independently verified from that discharge record. The family specifically asks that the “18 lb in 3-4 days” history not be treated as reliable.

Prepared 09/11/2026 from records supplied in this conversation. Medication orders and clinical status can change rapidly in the ICU; receiving clinicians should confirm current drips, doses, vitals, laboratory values, and code status directly with the treating hospital.