**DAP NOTE**

**DATA**

Subjective Patient complains of SOB, fever, and cough with green sputum. BP 168/88; P 88; T 103F/39.4C; R 20 and labored. Diminished breath sounds, e-to-a changes and increased tactile fremitus over the left lower and middle lung fields, 2+ pedal edema. Sputum Gram stain shows gram-positive cocci in pairs. WBC 16.0 × 103 /mm3 with 12% bands, INR 3.5. Blood glucose and HbA1c elevated. Chest x-ray indicates cardiomegaly and left lobe infiltrate.

**ASSESSMENT**

* Community-acquired pneumonia: probably pneumococcal in origin. Azithromycin appears to be unnecessary without indication for atypical pneumonia.
* Hypertension: currently untreated. BP of 168/88 would usually be classified as isolated systolic HTN, but present measurements may reflect infection and fever. The heart rate of 88 while on metoprolol and digoxin is a relative tachycardia, assuming that in the baseline environment the drugs would achieve a HR of 60 to 80 bpm.
* CHF: Pedal edema and cardiomegaly on chest x-ray. Receiving no ACE inhibitor.
* Anticoagulation: INR above target range of 2.0 to 3.0. Identify and remove causes or reduce warfarin dose.
* Type 2 diabetes mellitus: HbA1c c above goal of 7%. Not receiving ACE inhibitor for renal protective effects.
* Lipid panel: no recent results available; goal LDL is 100 mg/dL in patient with existing CAD.
* Adverse effects: although metoprolol is a 1-selective b-blocker, consider that its 2-blocking properties (usually at higher doses) may contribute to SOB due to bronchoconstriction, negative inotropic effects, or both.
* Medication without indication: There appears to be no need for famotidine in this situation.

**PLAN**

* Continue acetaminophen 325 mg po q 6 h PRN temp 101F/38.3C
* Change gatifloxacin to 400 mg po QD, the dose indicated for community-acquired pneumonia (does not come in 500-mg strength); discontinue azithromycin.
* D/C metformin during hospital stay, in light of potential hypoxia/hypoperfusion during acute respiratory distress.
* Change glyburide 10 mg to glipizide XL 10 mg po QD.
* Continue digoxin 0.125 mg po q AM.
* Give warfarin 2.5 today and then resume 5 mg po QD; dose to be adjusted as needed based on INR.
* Continue aspirin 80 mg po q AM.
* Increase furosemide to 100 mg po BID because of persistent pedal edema.
* Hold metoprolol until cause of SOB is identified.
* D/C famotidine because of lack of indication in this patient.
* Start enalapril 10 mg po QD to reduce mortality from CHF, provide protection from diabetic-associated nephropathy, and help control HTN. 12. Obtain fasting lipid panel and start medical nutrition therapy and pravastatin 10 mg po q AM if LDL is above 100 mg/dL.
* Provide nasal O if appropriate for SOB.
* Obtain admission weight, and then measure daily weight. Obtain prior outpatient weight to serve as baseline if available.
* Diet: 3 meals with bedtime snack, with no concentrated carbohydrate (CHO) choices. Limit CHO intake per meal to 60 g; snacks 15–20 g CHO. No added salt.
* Check blood glucose AC and HS.
* Assess adherence with therapy.
* Supplement glyburide with insulin lispro for excessive premeal BG, based on an estimated insulin sensitivity of 1 unit per 30 to 40 mg/dL: If blood glucose: Give insulin lispro: >180 mg/dL 2 units >220 3 units >260 4 units >300 5 units >340 6 units, and test for urinary ketones. Call MD if ketones moderate or large.
* Anticipate reinstitution of metformin upon resolution of respiratory distress, peripheral edema, clearing of lung fields, and verification of SCr.