APPENDIX B

Electronic Text Phrases Abstracted from

Dictated Physician Reports in Cases

of Adverse Drug Events

Type of Document	Phrase
Emergency Department Report	Given the patient's frail state of health, marginal hematocrit and continuing hemorrhage into the site, I elected to admit the patient to the hospital.
	He had an anaphylactic reaction requiring steroids, intravenous Benadryl and breathing treatments.
	She is anticoagulated on Coumadin after aortic valve replacement and presents with severe right periumbilical
	The CT scan was subsequently reported by radiologist DOCTORNAME to show an 8.3 x 7 cm, actively bleeding rectus muscle hematoma
	They also, because of an equivocal CPK and a nondiagnostic EKG, started heparin, though LifeFlight and I agreed to turn that off for the time being.
History/Physical Report	Additionally, he was given a dose of Lasix 40 mg as well as a dose of Benadryl.
	At that time he was given 125 mg of Solu-Medrol IV times one.
	He was treated with one dose of Azithromycin and one dose of Rocephin.
	The ER reported that after receiving the dose of Rocephin the patient developed hives.
	The patient is hypotensive. This is most likely secondary to volume depletion due to poor p.o. intake and Lasix dose given at the outside emergency room.
	We will provide secondary prevention, and the patient's Aggrastat will be stopped as she is currently having gross hematuria
General Surgery Report	Cardiac tamponade; status post cardiac arrest with resuscitation.
	He had been treated with anticoagulation and, subsequently, had developed hypotension.
	His platelet count was normal, though it was questionable whether platelet function was adequate.
	However, shortly after arriving on the floor, the patient had an asystolic cardiac arrest.

Type of Document	Phrase
General Surgery Report (continued)	I believe these episodes of asystole represent toxicity either to Amiodarone and/or Digoxin.
	I brought the patient back to the operating room early last morning because of persistent mediastinal bleeding. He was found to have a diffuse coagulopathy with no significant bleeding site encountered.
	Mediastinal bleeding
	Mediastinal bleeding secondary to diffuse coagulopathy
	Mediastinal bleeding with cardiac tamponade
	Mediastinal exploration for control of postoperative bleeding
	Probable toxicity to Amiodarone and/or Digoxin with episodes of asystole
	Resuscitative measures were undertaken and a normal sinus rhythm with a normal blood pressure was restored after his undergoing external cardiac massage and intubation.
	The patient was also given a platelet transfusion and fresh frozen plasma in hopes of correcting the coagulopathy.
	The patient's coagulopathy had previously been corrected with fresh frozen plasma and platelets.
	There was a diffuse coagulopathy with numerous small capillary-like bleeding sites throughout the mediastinum and on the undersurface of the sternum.
	Therefore, I placed temporary atrial and ventricular pacing electrodes and he was paced in an atrioventricular sequential manner.
	This 70/78-year-old male underwent mediastinal exploration on the evening of 09/05/2001, after he developed chronic cardiac tamponade secondary to a coagulopathy.
	While in the operating room, the patient had two further episodes of asystolic arrest.
Endoscopy Procedure	EGD was requested to localize the site of bleeding
	He is hemodynamically stable but still having coffee ground emesis via his NG tube which is not clearing
	He is now on pressors in cardiogenic shock with a nasogastric tube which was placed last night returning coffee ground emesis as well as emesis which he vomited around the tube starting this morning while he was still on Aggrestat and Heparin
	PATIENTNAME has had an upper gastrointestinal bleed from his nasogastric tube trauma and possibly from a small ulcer in his antrum which was exacerbated by anticoagulation and antiplatelet agents
General Consult Report	Acute renal failure, acute tubular necrosis which is likely ischemic and nephrotoxic (intravenous contrast).
	After Narcan he had a 4 for verbal, 4 for eye opening and 6 for motor or 14

Type of Document	Phrase
General Consult Report (continued)	After one dose of an ampule of Narcan 0.4 mg he was more awake, speaking in short sentences but remained confused
	After the addition of 1 mg of atropine and Neo-Synephrine, the patient's blood pressure has improved to 110s/70s, and the heart rate has increased to the 60s.
	carvedilol recently discontinued
	Delirium
	Difficult to obtain secondary to sedation level of patient
	Digoxin level was somewhat elevated at 2.1
	Digoxin toxicity with level mildly elevated at 2.1
	Discontinue digoxin
	During the operation she became severely hypotensive requiring high dose inotropes including epinephrine and Levophed.
	Episode of shock and hypotension. This appears to be anesthetic related.
	Glasgow coma score prior to Narcan was 10 with a 2 for verbal, 3 for eye opening and 5 for motor
	He did respond to these measures but remained relatively obtunded.
	He was bagged and also given 3 liters of intravenous lactated Ringer's and given several doses of epinephrine in order to improve his pressure.
	He was reported to have an aspiration event yesterday afternoon
	however, after Narcan she denies chest pain, shortness of breath, palpitations, pleurisy, denies abdominal pain, denies knee pain
	However, in combination with beta blocker, calicum channel blocker, and amiodarone this likely resulted in heart blockade. Plan dc dig, diltiazem,amiodarone, and beta blocker.
	However, postop in the PACU, the patient became hypotensive, bradycardic to a rate of 40, unresponsive and apneic.
	Hypertension now with some moderate hypotension intermittently likely secondary to pain medications
	I agree with discontinuing carvedilol
	I was asked by DOCTORNAME to evaluate and manage hypoxemic respiratory failure in this 79-year-old gentleman who was transferred from West-7 to the CCU after a witnessed aspiration event yesterday afternoon on 06/04/2001
	Late last night he was observed to require increased supplemental oxygen up to 100% face mask in order to maintain an oxygen saturation of greater than or equal to 90%

Type of Document	Phrase
General Consult Report (continued)	Mental status is also significantly improved at that time.
	Ms. U has obstructive sleep apnea which is giving her difficulty in waking up from anesthesia
	My understanding is that she received 2 amps of epinephrine and atropine, 1 amp of calcium, and was subsequently paced
	Narcan 0.4 mg IV q.1h. p.r.n. for clinical over sedation
	Opiate sedation
	Postoperative shock with an open vascular bed manifested by a high cardiac output and narrow oxygen extraction.
	Regarding atrial fibrillation with slow ventricular response, this may be as a consequence of her most recent cardiac ischemic event and may be due to underlying AV conduction system disease with concurrent beta blocker therapy
	respirations 12 before Narcan, 20 after Narcan
	She also developed some confusion
	She does not know what she is in the hospital for
	She has been intubated and been unable to communicate with her to this at this point.
	She is in mild respiratory distress with use of accessory muscles, mild hyperventilation
	She said the month was December, but thought it was 2001
	She was felt to be hypovolemic from marked vasodilation
	She was transferred to the med/surg unit for continued ventilatory support.
	She, today, had general anesthesia by DOCTORNAME which went uneventfully but she was unable to wean from the ventilator and would not breathe spontaneously despite multiple attempts.
	Show decreased breath sounds at the bases with markedly decreased lung volumes
	Start Neo-Synephrine to keep the mean arterial pressure greater than 65.
	Surgery was stopped because of the patient's shock.
	The differential diagnosis seems largely to be some sort of anesthetic reaction, although this seems rather unlikely considering the number of surgeries she has had in the past without similar problems.
	The patient developed intra- and postoperative hypertension and the surgery was discontinued.
	The patient is a lethargic, somnolent, elderly gentleman who opens his eyes to voice and mumbles words

Type of Document	Phrase
General Consult Report (continued)	The patient presented with a blood pressure of 94/44 to the shock/trauma Intermountain respiratory intensive care unit and a heart rate of 102 which was sinus.
	The patient was also intubated during the code
	The patient was noted to develop a rash with prior administration of fresh frozen plasma
	The patient was relatively stable early during surgery, but then shortly after surgery began she dropped her blood pressure, requiring IV fluids, placement of Swan-Ganz catheter, epinephrine, Neo-Synephrine, and dopamine.
	The patient's level of consciousness improved significantly with Narcan, therefore, confirming that some of her mental status change is secondary to sedation
	The review of systems is otherwise not obtained today due to his decreased mental status secondary to narcotics
	There are no focal deficits to neurological examination besides orientation and memory
	This could all be explained by hypoventilation and atelectasis after surgery worsened by narcotics
	This is a very somnolent, diaphorectic female in moderate distress
	Watching her throughout the day and holding sedation has worked and she is now awake and able to be safely extubated
	We were asked to see PATIENTNAME in consultation with DOCTORNAME for postop hypotension, bradycardia and apnea.
	We will keep the patient on 100% oxygen by face mask in order to try and achieve an SPO2 of greater than 88%
	When I evaluated him in the CCU he was somnolent, would open his eyes to voice and would mumble incomprehensibly and would not follow commands
Radiology Report - Diagnostic	Large right retroperitoneal hematoma extending from the superior level of the right kidney inferiorly to the right obturator externis
	Decrease in hematocrit, evaluate for retroperitoneal hematoma
	Right rectus abdominous muscle hematoma appears to have ongoing active bleeding
	There is marked enlargement of the right rectus abdominous muscle, with fluid-fluid level consistent with hematoma
	These findings are most consistent with a large retroperitoneal hematoma

Type of Document	Phrase
Radiology Report – Diagnostic (continued)	This hematoma extends inferiorly along the right iliacus down the right groin, as will be discussed below under the CT pelvis findings
Radiology Report - Procedural Report	Patient with DVT and PE, on heparin, unfortunately developed a retroperitoneal hematoma. Now provide IVC filter placement.
	INFERIOR VENA CAVOGRAM AND IVC FILTER PLACEMENT
	He is currently on heparin anticoagulation with bleeding at the surgical site and through the penis
	Pulmonary embolus with patient on anticoagulation and significantly elevated INR, complicated by systemic bleeding
	We are asked for IVC filter placement so anticoagulation can be discontinued
Discharge Summary	A medicine consultation was arranged and she was transferred to the intensive care unit with the plan to pursue further neurologic evaluation
	A repeat Clostridium difficile toxin one day prior to discharge was negative.
	A spiral CT angiogram showed bilateral pulmonary embolism. Because of this, he was started on Coumadin and Lovenox.
	A subsequent Clostridium difficile toxin approximately four days after the first was positive and the patient was treated with a course of Flagyl.
	A subsequent event was witnessed by one of the physicians and it was felt that these were in fact not seizures but probably myoclonic events.
	After approximately 45 minutes of monitoring and giving respiratory support, the patient responded to verbal and painful stimuli and was able to ascertain that his spinal level was approximately T-3 to T-4 through dermatomes bilaterally.
	After discontinuation of these medications,she was feeling substantially better and ready to go home
	After his open appendectomy, he was admitted to the medical-surgical intensive care unit on a ventilator as he had lost a significant amount of blood during the surgery and was very difficult to intubate.
	After this event it was again discussed with the family the possibility of placing and IVC filter and the patient and her family felt that this might be a better way to go with her history of nose bleeds
	Allergic reaction to probably penicillin derivatives
	Anaphylactic reaction to cefuroxime
	Angioedema
	Angioedema secondary to ACE inhibitor
	Anticoagulation was discontinued at that time

Type of Document	Phrase
Discharge Summary (continued)	At that point, he received fresh frozen plasma and then gradually startedback down.
	At that time she had developed a very minor transfusion reaction that was responsive to diphenhydramine and albuterol.
	At the time of her arrival in the intensive care unit, it was noted that her IV was infiltrated, compromising the amount of Narcan she had received on the floor, and when more of this was provided to her through a more competent IV line,
	At the time of this exploration, his coagulopathy had been significantly corrected and there was no significant active bleeding following evacuation of this thrombus.
	Because of these reasons and because this was a stable situation, his Lovenox was discontinued and the bleeding discontinued as well
	Beta-blockers were discontinued, and his pulse remained stable throughout the rest of his hospitalization
	Clostridium difficile colitis
	Clostridium difficile positive diarrhea
	Consent was then obtained and inferior vena cava filter was placed on 08/01/2001
	Delirium
	Dilantin loading was stopped and central access was obtained through a left subclavian line.
	DOCTORNAME was consulted at the beginning of his apneic episode and was present during monitoring in the P-ICU.
	DOCTORNAME was consulted regarding her congestive heart failure and bradycardia
	During his time in the medical/surgical ICU, pain control was an issue and the patient had many hallucinations on morphine as well as on Demerol.
	Epistaxis
	FK506 toxicity
	Following initiation of Coreg 3.125 mg b.i.d., she developed bradycardia on 04/05/2001 and became hypotensive with that
	For this reason anticoagulation was reversed with fresh frozen plasma
	Gastrointestinal bleeding while on anticoagulation
	He also had some bleeding from his urinary tract which cleared
	He also required some fluid bolus to maintain an adequate blood pressure.

Type of Document	Phrase
Discharge Summary (continued)	He became relatively hypotensive with blood pressures down into the 70s and 80s and felt quite lightheaded and dizzy with this.
	He developed a high temperature which was thought to be due to neuroleptic malignant syndrome arising from Haldol. It was discontinued.
	He did develop diarrhea after tube feeds were started and Clostridium difficile toxin was initially negative, however, his diarrhea did not cease and his perineal area was becoming quite irritated because of the skin contact with the feces.
	He did well and underwent some cardiac rehabilitation, but then on the second day of admission his groin popped open and he had some bleeding which required a femoral stop which controlled his bleeding
	He recommended holding the Coreg and continue off digoxin
	He underwent an abdominal CT scan which showed a large retroperitoneal hemorrhage
	He was also given 0.4 mg of Narcan IV, of which he had a dramatic response
	He was given Narcan and Atarax to reverse effects of Versed and Fentanyl given preoperatively.
	He was given packed red cells and an IVC filter was placed
	He was improving and discharge was planned until on 01/25/2001, the patient developed a marked drop in his hematocrit
	He was placed on beta-blockers and on 08/14/2001 was found to have sinus bradycardia with a heart rate in the 20s as well as a potassium of 6.7, resulting in a cardiac arrest
	He was started on thymoglobulin to try to rescue the graft, though he had a reaction to this, dropped his pressures and a had a respiratory distress. This had improved after finishing the infusion.
	Hemarthrosis secondary to over anticoagulation on prophylactic Coumadin
	Her Coumadin continued to rise until it reached a peak of 6.8 on postoperative day seven. At that time she was given some vitamin K in an effort to stem the tide.
	Her Coumadin was held and her INR was repeated
	Her digoxin load was stopped, and the patient was continued on amiodarone
	Her heart rate was in the 30s, blood pressure 80
	Her INR continued to rise. On postoperative day five it was 3.0 and around postoperative day six it was 4.
	Her INR however had again increased to 4.20 despite the FFP
	Her INR however had increased dramatically to 4.90
	Her INR was down to 2.90 and finally stable

Type of Document	Phrase
Discharge Summary (continued)	Her TSH was checked when the atrial fibrillation developed.
	His medications were adjusted with Captopril held and Imdur and Aldactone stopped.
	His platelets also were noted to be quite dramatically decreased from a value initially of 135 to 42; even got down lower than that to a value of 21
	His protime rose very quickly to an INR of 5.8,went higher even to 6.3, and then started back down.
	His white count dramatically responded to this Flagyl as it was quite elevated during the height of his diarrhea and we were initially unclear as to what was causing the white count elevation as he was being appropriately treated with antibiotics
	History of narcotic overdose on a postoperative patient-controlled morphine anesthesia pump
	Hospitalization was slightly prolonged because she had been given an ACE inhibitor and a beta blocker and developed hypotension.
	However, at approximately 2300 hours on the night of the 28th, it was noticed that the left side of her tongue had now swollen significantly
	However, he began having some significant bleeding at the site of puncture through the next day
	However, she continued to have some bleeding from her anterior Jackson-Pratt drain and her enoxaparin was discontinued.
	However, shortly after starting the transfusion he experienced decreased oxygen saturation, hypotension, and increased somnolence.
	However, upon transferring the patient from the surgical bed to the hospital gurney on transition from operating room to recovery room the patient became apneic in a very abrupt fashion.
	Hypertension, steroid induced
	HYPERTENSION: On day +25, he developed moderate hypertension which was clearly related to initiation of his steroids. He was started on Norvasc 5 mg a day and has had good control since.
	In addition, we had also asked the pulmonary service to see the patient in case she required emergent intubation for respiratory compromise
	It did drop somewhat to 26 after this episode and we continued to follow it throughout her hospital course and it remained stable
	It was felt it could have possibly been due to her rheumatological medications.

Type of Document	Phrase
Discharge Summary (continued)	It was felt that his spinal most likely migrated proximally and affected his respiratory center.
	it was felt that it was most likely due to vasodilation due to general anesthesia at the time of surgery and an inability to compensate for this.
	It was restarted, however, once urine cleared of blood
	It was, therefore, thought that the patient might have been overly sedated with his pain medications
	Laboratory tests showed her hematocrit to be 30.5 from 34.8 above
	Lasix was given
	Mediastinal bleeding secondary to diffuse coagulopathy
	Newly diagnosed ACE inhibitor allergy
	On 10/29/2000 in the early a.m., the cross cover medical team was called to see the patient due to increasing acute respiratory distress.
	On postoperative day number one in the evening her hematocrit returned at 23.8.
	On the morning of the 28th, the patient was noted to have significant edema of the right side of her tongue.
	Postoperatively, he had an increase in his confusion with frank delirium
	Pt. taken to or 6/1. During the decompression procedure, the pt. developed significant hypotension requiring pressor support. Because of this the surgical procedure was abandoned.
	Retroperitoneal bleed
	Several days after the patient became therapeutic on Coumadin she experienced a severe nose bleed which required an ENT consult and packing of the nose to stop bleeding
	She became bradycardic in the low 50s
	She did develop gross hematuria and Agristat was stopped for approximately a 24 hour period
	She had been using CPAP at night and there was a prolonged recovery from her anesthetic.
	She had persistent bradycardia, and her amiodarone IV load was decreased to 0.25 mg per minute, and then on 05/02/2001 the patient was transferred to the floor and started on her p.o. load of amiodarone 400 mg b.i.d.
	She maintained her oxygen saturation, however; but as she failed to respond to three doses of Narcan given at the bedside, concern was raised for a possible neurologic event to explain her decreased mental status
	She then was reported to have guaiac positive stools and this was just felt to be due to a swallowing of the blood from her epistaxis

Type of Document	Phrase
Discharge Summary (continued)	She tolerated this well with no intraoperative difficulties, but in the immediate postoperative period within hours after her procedure, she was noted to be poorly responsive while receiving morphine analgesia through a patient-controlled pump
	She was also treated with scheduled steroids and Benadryl with gradual improvement throughout the day of her edema
	She was evaluated by DOCTORNAME, her cardiothoracic surgeon, who felt that the hemothorax, hemomediastinum, and hemopericardium were all due to her being on Lovenox. Her Lovenox was obviously discontinued
	She was given 2 units of packed red blood cells and her hematocrit and vital signs again were followed closely.
	She was monitored in the intensive care unit, off of her patient-controlled anesthesia pump, over the ensuing 24 hours
	She was temporarily in the medical/surgical ICU.
	She was therefore transfused and additional two units of fresh frozen plasma and given an injection of vitamin K
	She was therefore transfused two units of fresh frozen plasma
	She was treated for C. Diff positive stool with Vancomycin. She is allergic to Flagyl. Her diarrhea resolved.
	She went into an atrial fibrillation and got started on digoxin as well as amiodarone, then blocked down to an arrest situation and ended up re-intubated and back in intensive care in the shock trauma unit for 3 days.
	Stool for Clostridium difficile toxin which was initially negative and then positive approximately 7 to 10 days prior to discharge.
	The diarrhea did slow down somewhat during the rest of his hospitalization; however, after the last Clostridium difficile toxin was negative on the day prior to discharge, we did give him several doses of Imodium to help with the diarrhea.
	The emergency room physician administered 2 units of fresh frozen plasma, 5 mg of vitamin K and transferred the patient to LDS Hospital for further evaluation and treatment
	The etiology of his upper airway problem was unclear but thought possibly due to an allergic reaction to cefuroxime.
	The pain service was consulted to assist in pain control and the patient was placed on Dilaudid PCA which tended to provide adequate analgesia, however, the patient continued with some hallucinations.
	The patient also reports he has been having melena over the last week and knows he is "bleeding in my gut."

Type of Document	Phrase
Discharge Summary (continued)	The patient came to LDS Hospital and, on admission to the hospital, had a hematocrit of 28 and an INR that was followed closely
	The patient developed rash to Levaquin, which was switched to Zosyn and clindamycin to cover for anaerobic organisms in view of nausea and vomiting and question of aspiration pneumonia, but unfortunately, the patient developed recurrent rash
	The patient did developed, five minutes after an infusion of platelets on the early morning of 10/29/2000, rigors, sudden onset of pulmonary edema, became acutely hypertensive, and increased respiratory distress.
	The patient did developed, five minutes after an infusion of platelets on the early morning of 10/29/2000, rigors, sudden onset of pulmonary edema, became acutely hypertensive, and increased respiratory distress.
	The patient eventually had an episode of melena while in the hospital and GI was consulted.
	The patient had approximately 30 to 40 minute episode of heavy epistaxis while she was in the hospital as noted above.
	The patient had persistent nausea and vomiting throughout her hospital course until approximately one week prior to discharge. This correlated with elevated FK506 levels, particularly with the levels were greater than 12 to 15.
	The patient had swelling in her knee and presented to the emergency room in Ogden with an INR of 6.0
	The patient needed ventilatory support with bagging.
	The patient presents with an INR equal to 17.2. The patient received vitamin K 10 mg p.o. in the emergency room. We will recheck the coagulations in the a.m. with a goal INR of 2 to 3. We will also decrease Coumadin prior to discharge
	The patient received Solu-Medrol, Benadryl, and Pepcid.
	The patient reports occasional nose bleeds over the last two weeks that stopped readily.
	The patient was given atropine, calcium, bicarbonate, and was subsequently intubated
	The patient was started on levaquin to which she developed a rash and was changed to Bactrim
	The patient was still not having a terrible lot of p.o. intake and she was complaining of nausea and distention. She was also being treated for her presumed narcotic ileus with enemas and Milk of Magnesia.
	The patient was then loaded with Dilantin and, while receiving his loading dose, began to become hypotensive.
	The patient was transferred to Med-Surgical Intensive Care Unit and was followed by DOCTORNAME and his

Type of Document	Phrase
Discharge Summary (continued)	The patient was transferred to the floor on 12/15/2000, where he continued to improve and the hallucinations began to resolve and the patient became much more alert and aware of his surroundings, not having the same hallucinations.
	The patient's hospitalization was complicated by some confusion which was multifactorial, secondary to pain medications and a perioperative non-Q wave myocardial infarction
	The patient's INR started coming down and, because of the difficulty managing her INR because of it going so high with so little Coumadin, it was decided that the patient could be, from this point on, treated with no further anticoagulation
	The patient's postoperative course found him with an ileus. We eventually realized this was related to his narcotic pain medicines, but also led to have significant abdominal distension, and led to serous drainage from his abdominal wound.
	The patient's Synthroid was discontinued at this time.
	The transfusion was stopped
	The transfusion was, therefore, stopped and the patient was urgently transferred to the MedSurg ICU for closer observation
	The TSH was less than 0.06, the free T4 was 1.87.
	There was a protime that went as high as 39 with anINR of 10.7.
	This 55-year-old female with multiple medical problems... presents with a large left pleural effusion,for which she underwent a thoracentesis earlier today,as well as what appears to be an allergic drug reaction.
	This continued with critical hypotension through the night following surgery requiring a large volume resuscitation, steroids, and multiple pressors
	This gradually resolved after 24 hours with the presumed diagnosis being anaphylactic reaction to cefuroxime which had been given prophylactically intraoperatively
	this resp. distress and pulmonary edema was thought likely secondary to transfusion reaction. the pt received solu-medrol, benadryl and pecid. lasis also was given
	This thrombocytopenia was felt most likely to be secondary to Aggrastat induction
	This was not associated with any respiratory compromise, however, the patient was transferred back to the ICU for observation
	Today, he had a dose of bleomycin at 10 a.m. This was his second to last dose of this agent. Approximately two hours later, he began to have fevers, chills, rigors, shortness of breath, substernal chest pain, and bilateral hand numbness.

Type of Document	Phrase
Discharge Summary (continued)	Transferred to STICU with significan hypotension.
	Unfortunately, she then developed significant angioedema felt due to the ACE inhibitor and this medication had to be stopped.
	Unfortunately, the patient became hypotensive during the surgery
	Upon further evaluation with head CT and head MRI and consult with neurology it was the consensus that this was likely due to Prograf toxicity. He was therefore taken off his of his Prograf and changed to neoral at that time.
	While it was not felt that the patient had any evidence of active bleeding, there was concern of the possibility of bleeding secondary to her being anticoagulated on heparin.
	With that his blood pressure came up well.
Death Summary Report	DOCTORNAME was called, the NG tube was secured; GI was asked consult
	He underwent EGD on 03/08/2001 and was found to have the bleed from an NG trauma, questionable ulcer, which was problematic because the anticoagulation.
	Probable toxicity to amiodarone and/or digoxin with episodes of asystole
	The night of 03/07/2001, the patient developed coffee-grounds emesis with a possible self extubation.