Rachel Freundlich
Professor Yuan

History

Identifying Data:
Full Name: A.S..
Address: Jamaica, NY
Date of Birth: 03/09/1963
Date & Time: Oct. 24, 2023 9:30am
Location: New York Presbyterian Hospital, Flushing, NY
Religion: Catholic
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Ambulance
Chief Complaint: "My chest is hurting" x40 minutes

History of Present Illness:
A.S. is a 60 y/o male with PMH of ESRD, HT, CAD and anxiety presenting with sudden onset chest pain. Pt reports the chest pain started during dialysis 40 minutes prior to arriving. He describes the pain as sharp and located in his lower R. chest and spreads centrally to the rest of his chest. He was given 3 sublingual nitroglycerin tablets before arriving and notes it did not alleviate his pain. He described the pain as 10/10. He admits walking around aggravates the pain and admits to mild dyspnea on exertion. The dyspnea began 40 minutes ago. Pt has found no relieving factors. He also mentions the chest pain is accompanied by nausea. Nausea began during dialysis x40 minutes concurrently with the chest pain.
Pt admits to switching to a new dialysis center one month ago. He notes he experienced similar symptoms 1 month ago following dialysis at the new center. Pt was unable to complete the dialysis treatment this morning due to intense chest pain. Pt denies history of MI, DVT, fever, vomiting or cough.

Past Medical History:
Present illnesses – ESRD (dialysis), HTN, CAD, anxiety
Past medical illnesses – None
Hospitalized – None
Childhood illnesses – Denies any illnesses
Immunizations – Up to date; received flu vaccine Oct '23; received COVID booster '22
Screening tests and results – Colonoscopy '21 - normal

Past Surgical History:
Denies previous past injuries or transfusions.

Medications:
Nifedipine, 90 mg, PO daily (HTN)
bASA, 81 mg, PO daily (CAD)
Valsartan, unknown dose, PO daily (HTN)
Carvedilol, unknown dose PO BID (HTN)
Lorazepam, 0.5mg, PO TID (Anxiety)
Other medications unknown

Allergies:
Denies any food, drug, or environmental allergies.

Family History:
Mother – deceased at age 89 from unknown causes, hx of HTN, CAD, MI, CVA
Father – deceased at unknown age from unknown causes, hx of HTN
Son –33 y/o, alive and well
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons

Social History:
A.S. is a married male living with his wife. He does not currently work due to the demands of dialysis. Previously, he worked as a handyman. He spends much of his time doing chores around the house and going on walks.
Habits - Pt admits to occasional alcohol consumption and marijuana smoking. He reports he engages in these behaviors about once a month. Pt drinks one cup of coffee each morning.
Travel - Pt denies recent travel.
Diet - Pt reports eating well-balanced diet including chicken, whole grains, and vegetables.
Exercise - Pt admits to minimal exercise such as mild power-walking.
Safety measures - Admits to wearing a seat belt.
Sleep – Pt reports regular sleep patterns.
Sexual Hx - Pt is currently sexually active with his wife.

Review of Systems:
General – Denies recent changes in weight, loss of appetite, generalized fatigue, fever or chills, or night sweats.

Skin, hair, nails – Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head – Denies headaches, vertigo or head trauma.

Eyes – Pt wears glasses for nearsightedness. Denies recent vision changes, photophobia, pruritis. Last eye exam unknown.

Ears – Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses – Pt admits to clear watery nasal discharge. Denies obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcer or voice changes. Last dental exam February ‘23.

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion.

Breast – Denies lumps, nipple discharge, or pain.

Pulmonary system – Admits to dyspnea. Denies cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Admits to chest pain. History of HTN, CAD. Denies irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system – Regular bowel movements daily. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – Pt does not make urine due to ESRD. Pt undergoes dialysis 3 times per week.

Nervous – Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status, weakness or recent onset memory loss.

Musculoskeletal system – Denies deformity or swelling, redness or arthritis.

Peripheral vascular system – Denies coldness or trophic changes, varicose veins, peripheral edema or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, or prior history of DVT/PE.

Endocrine system – Denies polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter.

Psychiatric – Admits anxiety. Does not see a psychiatrist regularly.

Physical

General: Well-nourished, short stature male in no apparent distress. Alert and Oriented x3, well groomed, looking about the stated age of 60. Ambulates without support with mild dyspnea noted.

Vital Signs: BP:

	R	L
Seated	156/80	155/80
Supine	158/82	154/84

R: 14/min unlabored P: 100, regular

T: 97.8 degrees F (oral) O2 Sat: 98% Room air

Height: 5'2 Weight: 125 lbs. BMI: 22.9

Skin: Warm and moist, with good turgor. Nonicteric, no erythema, pigmentation, lesions, scars, or tattoos.
Hair: Normal hair distribution and thickness on Pt's head. No lesions, lice, or seborrhea.
Nails: No clubbing, lesions of infection. Capillary refill <2 seconds in upper extremities.
Head: Normocephalic, atraumatic, non tender to palpation throughout. No swelling noted.
Eyes: Symmetrical OU. No strabismus, exopthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity -corrected vision 20/20 OD, OS, OU.
Visual fields full OU. PERRLA, EOMs OS intact with no nystagmus.
Fundoscopy- red reflex intact OU. Cup to disk ratio <.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.
Ears: Symmetrical and appropriate in size. No lesions, scars, scabs, erythema or tenderness present. Ear canal nonerythematous, no masses, foreign bodies present. Cone of light, tympanic membrane noted. Weber midline, Rinne reveals AC > BC. Auditory acuity intact assessed with whisper test.

Nose: Mild watery discharge noted. Symmetrical, no bony deformities, tenderness. Nasal mucosa pink and well hydrated. Septum midline with no perforation or inflammation. No foreign bodies.
Sinuses: Nontender to palpation and percussion over bilateral frontal and maxillary sinuses.
Lips: Pink, moist, and well hydrated.
Mucosa: Pink, no masses, well hydrated, nontender, no leukoplakia.
Palate: Pink, intact with no lesions, scars.
Teeth: Good dentition, no caries noted.
Gingivae: Pink, moist, no hyperplasia, masses, lesions, discharge.
Tongue: Pink, well papillated, no masses, lesions, deviations. Frenulum intact.
Oropharynx: No exudates, masses, lesions, foreign bodies. Tonsils present with no exudate. Uvula pink, no edema.
Neck: Trachea midline. No masses, lesions, scars. FROM, no stridor, 2+ carotid pulse, no thrills, bruits noted bilaterally, no cervical adenopathy noted.
Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.
Chest: Symmetrical, no deformities, no trauma. Respirations unlabored/ no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout.
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.
Heart: JVP is 2.5 cm above the sternal angle with head of bed at 30 degrees. Carotid pulses are 2+ bilaterally without bruits. PMI in 5th ICS in mid-clavicular line. Regular rate and rhythm. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Abdomen: Abdomen round and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all 4 quadrants with no aortic/renal/iliac or femoral bruits. Tender to palpation in right middle quadrant. Tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation. No CVA tenderness appreciated.
Male Genitalia and Hernia: Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias noted.
Anus, Rectum and Prostate: No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate enlarged, smooth and non-tender with palpable median sulcus.
Neuro Exam:
Cranial Nerves: CN I- XII are intact
II, III, IV, VI: visual acuity 20/20 bilaterally. Visual fields normal in all quadrants. PERRLA. EOMS intact without ptosis.
V: Facial sensation intact bilaterally to dull and sharp stimuli.
VII: Facial muscle strength is equal and normal bilaterally.
VIII: Hearing is normal bilaterally.
IX, X: Palate and uvula elevate symmetrically, with intact gag reflex. Voice is normal
XI: Shoulder shrug strong and equal bilaterally.
XII: Tongue protrudes midline and moves symmetrically.

Mental status exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to name, date, time and location. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.

Problem list:

- Chest pain
- ESRD
- Anxiety
- Dyspnea
- Nausea
- HTN
- CAD

Assessment:

60 year old male with past medical history of HTN, CAD, and anxiety presents with chest pain and nausea x40 minutes post dialysis. Pt presents with mild dyspnea on exertion. No notable abnormalities on physical exam. The chief complaint is most consistent with chest pain induced by volume overload secondary to rapid dialysis. No labs are available at this time.

Differential Diagnosis:

1. Volume overload secondary to rapid dialysis
    a. Based upon the pt's history and physical presentation, volume overload is a likely diagnosis for this pt. Pt reports the chest pain started during the dialysis treatment. He also notes that the technician at the clinic does not follow accepted scales to determine flow rate and has had this happen before. He has only had chest pain of this nature associated with dialysis.
        i. This is a diagnosis of exclusion
2. MI
    a. The pt presents with chest pain rated 10/10 that was not relieved with nitro. Pt has a history of CAD. This may also explain dyspnea the patient is experiencing. HTN is also a risk factor for MI.
        i. EKG, cardiac monitor, pulse ox, troponin, CBC, pre-op labs
3. Pulmonary edema
    a. The pt presents with chest pain and dyspnea. ESRD can cause fluid retention which results in swelling and fluid buildup in areas of the body. This can result in pulmonary edema.

        i. Chest x-ray
4. Anxiety
    a. The pt has a history of anxiety. He has experienced these symptoms before following a dialysis treatment and it is possible that the chest pain is a result of anxiety.
        i. This is a diagnosis of exclusion
5. Hyperkalemia
    a. The pt was unable to complete his dialysis treatment due to severe chest pain. Due to this, the pt is likely to have electrolyte imbalances which were not corrected during the treatment. This can be associated with chest pain.
        i. CMP blood test, EKG

Work up:

- EKG
- Chest xray
- Cardiac monitor
- Continuous Pulse ox
- Troponin, CBC, CMP, T&S, PT/PTT, INR

Plan:

Chest pain

- Workup for MI
- bAspirin 81mg / sublingual Nitro pending EKG results
- Treat hyperkalemia if present (calcium gluconate, albuterol, bicarbonate, insulin, beta agonist)
- Complete dialysis treatment

Dyspnea

- If pulmonary edema present, fluid restriction, Lasix 20mg PO
- Educate the patient on limiting salt intake

Nausea

- Zofran 4 mg PO

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History and Physical Verification Form

Class: Physical Diagnosis II (HPPA 522)

Student Expectation:

- Obtain medical history and perform physical exam up to the point covered in class.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

Student: Rachel Freundlich

Clinical Site: _____

Date of Visit: 10/24/23

Activity performed: H+P, assessment + plan

Supervisor:

Name and Credentials: Timothy Wong, MD

Supervisor Signature: [signature]

Supervisor Comments:
great job