Rachel Freundlich
Professor Yuan

History

Identifying Data:
Full Name: F.M.
Address: Jamaica, NY
Date of Birth: 04/02/1960
Date & Time: Sep. 14, 2023 10:30am
Location: New York Presbyterian Hospital, Flushing, NY
Religion: Catholic
Source of Information: Self
Reliability: Reliable
Source of Referral: Doctor
Mode of Transport: Self
Chief Complaint: "I gained a lot of weight and now I feel like something is sticking out of my stomach" x7 months

History of Present Illness:
F.M. is a 63 y/o male with PMH of HTN, T2DM, obesity, HLD, hypercholesterolemia, OSA, osteoporosis, Anxiety, Depression, COPD, asthma and BPH presents with recent weight gain. Pt reports 10% weight gain began 2 years ago. He reports mild discomfort due to excess adipose tissue and experiences no pain at the moment. Weight gain is primarily distributed around his abdomen as excessive adipose tissue. Pt has not initiated any attempt to lose weight and reports that his poor diet aggravates his weight gain. Pt also presents with a painful protruding bulge in his right middle abdomen. He notes that the pain began 7 months ago and radiates to his right upper back. He notes that the pain comes and goes and when he leans forward "it feels like something is sticking out of [his] stomach". The pain is aggravated by straining and coughing. The pain is sharp and stabbing and rates it 4/10. He reports that pushing the mass back into place relieves the pain. He notes he experiences similar symptoms 2 years ago and was treated for a ventral hernia.
Pt denies history of MI, CAD, DVT, dizziness, and changes in vision. Pt has not made any diet changes recently.

Past Medical History:
Present illnesses – obesity, T2DM, HTN, ventral hernia, HLD, hypercholesterolemia, OSA, depression, anxiety, COPD, asthma, BPH
Past medical illnesses – ventral hernia, compression fracture

Hospitalized – ventral hernia
Childhood illnesses – Denies any illnesses
Immunizations – Up to date; received flu vaccine Sep ‘23; received 5th COVID booster shot Oct. ‘22
Screening tests and results – Colonoscopy completed Jan ‘21 (no sign of disease)

Past Surgical History:
Ventral hernia repair – age 62, Flushing, NY (hospital not noted). No complications noted.
Compression fracture – age 27, Flushing, NY (hospital not noted). No complications.

Denies other past injuries or transfusions.

Medications:
Insulin glargine, 40 units, subQ nightly (T2DM)
Tirzepatide, 5mg/0.5mL, subQ once a week (T2DM)
Bupropion, 200mg, PO daily (Depression)
Lorazepam, 0.5mg, PO TID (Anxiety)
Carvedilol, 25mg, PO BID (HTN)
Olmesartan, 40mg, PO QD (HTN)
Atorvastatin, 80mg, PO QD (Cholesterol)
Albuterol inhaler (when needed)
Finasteride, 5mg, PO QD (BPH)
Silodosin, 8mg, PO QD (BPH)
Alendronate Sodium, 70mg, PO once a week (Osteoporosis)
CPAP, 10cm H2O, nightly (OSA)
Allergies:
Zofran, anaphylactic rxn
No other food, drug, or environmental allergies noted

Family History:
Mother – Deceased from Organic Brain Syndrome at unknown age
Father – hx of prostate cancer; Deceased at 94, natural causes
Son –28 y/o, alive and well
Son– 29 y/o, alive and well
Sister - died from leukemia at unknown age
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons

Social History:

F.M. is a married male living with his wife. He does not currently work due to his medical conditions. Previously, he worked as an EMT. He spends much of his time relaxing with his wife and watching TV.
Habits - Pt reports 30 year history of alcohol consumption. He denies consuming alcohol currently. Pt denies smoking cigarettes, hookah, and illicit drug use. Pt drinks one cup of coffee each morning.
Travel - Pt denies recent travel.
Diet - Pt reports eating mostly junk foods such as chips, candy, and fast-food.
Exercise - Pt admits to minimal exercise.
Safety measures - Admits to wearing a seat belt.
Sleep – Pt reports regular sleep patterns with CPAP.
Sexual Hx - Pt is currently sexually active with his wife.

Review of Systems:
General – Admits to recent weight gain (30lbs over 2 years). Denies 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 June ‘23 - age related macular degeneration reported.

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

Nose/sinuses – Denies nasal discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcer or voice changes. Last dental exam August ‘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 – History of HTN, hypercholesterolemia, HLD. Denies chest pain, 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 – Admits incontinence. Denies urinary frequency or urgency, oliguria, polyuria, nocturia, dysuria or flank pain.

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, blood transfusions, or prior history of DVT/PE.

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

Psychiatric – Admits depression and anxiety. Sees a psychiatrist regularly.

Physical

General: Obese male Alert and Oriented x3 looking about the stated age of 63.

Vital Signs: BP:

	R	L
Seated	120/79	122/80
Supine	120/78	120/77

R: 15/min unlabored P: 76, regular

T: 98.6 degrees F O2 Sat: 95% Room air

Height: 5’9 Weight: 321 lbs. BMI: 47.4

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: Symmetrical, no bony deformities, tenderness, discharge. 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.

Problem list:

- Obesity
- Bulge in stomach consistent with ventral hernia

Assessment:

63 yo male with PMH of HTN, hypercholesterolemia, HLD, OSA, BPH, depression and anxiety presents with obesity and ventral hernia. Pt reports weight gain began about 2 years ago and he has gained 10% body weight over this time period. He also notes that he developed a ventral hernia two years ago which was surgically repaired. No other notable abnormalities noted on exam. The chief complaint suggests central weight gain consistent with central obesity. Pt should be worked up for any hormone abnormalities and diet should be assessed. No labs available at this time.

Differential Diagnosis:

1. Obesity due to poor diet
    a. Based upon the pt's history and physical presentation, obesity is a likely diagnosis for this pt. Pt has a history of T2DM along with HTN, hypercholesterolemia, HLD, and OSA. Pt reports eating larger portions of food and admits to poor diet over the last two years. He also lacks physical activity in his daily routine. Therefore, it seems likely that pt's recent weight gain is diet associated.
        i. Obesity can be diagnosed based upon a pt's BMI. I would be sure to measure the pt's height and weight in office to ensure an accurate result.
2. Ventral Hernia
    a. The pt presents with a bulge in his stomach which protrudes when the patient leans forward. The pt also notes that it is reducible. The physical exam confirms the pt's reports and is consistent with a right middle ventral hernia.

        i. Ventral hernias are often diagnosed clinically with a thorough physical examination. To confirm the diagnosis, an ultrasound of the abdomen or CT with IV contrast of the abdomen and pelvis can be performed.

3. Lipoma
    a. The pt presents with a mobile lump just under his skin. Lipomas develop due to excess fatty tissue in the area. These are commonly found in the abdomen, thighs, neck, arms, and legs. They are typically found just under the skin and easily move with pressure. The pt presents with obesity which can result in a lipoma.
        i. Lipomas can often be diagnosed through a physical exam. If the diagnosis is unclear, a core needle biopsy of the suspected lipoma would be necessary. An MRI of the abdomen is the gold standard to identify a lipoma. Imaging and biopsy are important to differentiate between benign and cancerous lipomas.
4. Pituitary adenoma
    a. It is possible that this pt developed a pituitary adenoma that is suppressing certain hormones that are contributing to his weight gain. A pituitary adenoma can cause excess ACTH to be released, therefore elevating normal cortisol levels. This can result in Cushing disease which most classically causes weight gain around the midsection and back, which is consistent with the pt's presentation. A pituitary adenoma can also alter thyroid levels which would cause changes in the pt's metabolism. Lastly, a growth hormone deficiency can also cause obesity in adults.
        i. I would order urine and blood tests to identify abnormal pituitary hormones such as prolactin, growth hormone, insulin-like growth factor1, testosterone, thyroxine and cortisol. I would also perform an MRI of the brain as this is the gold standard to diagnose pituitary adenomas.
5. Cushing's syndrome
    a. The pt presents with increased weight gain around his abdomen. This is a classic presentation of Cushing's syndrome. The pt also notes that he has osteoporosis which is another manifestation of Cushing's syndrome. While Cushing's is most commonly diagnosed in adults between the ages of 25-55, it is possible that this pt developed it at 63. He also notes that he feels pain radiating to his back which may be a result of discomfort from extra adipose tissue in the area.
        i. To diagnose Cushing's syndrome, a 24 hour free cortisol urine test is necessary. Two of these measurements must be completed. A nighttime salivary test is also often completed. Lastly, a low dose Dexamethasone suppression test can be completed to identify elevated levels of cortisol. After the diagnosis is confirmed, I would order imaging tests to identify the cause of Cushing's syndrome. I would order an MRI of the brain to rule out pituitary cause, CT of the abdomen to rule out adrenal tumor, and

if these are both negative I would perform a CT of the chest to identify an ectopic adrenal tumor.

Work up:

- BMI
- If physical exam can not confirm ventral hernia or lipoma
    - US abdomen (hernia)
    - Core needle biopsy (lipoma)
- Saliva and Blood test (to assess pituitary hormones)
- 24 hour urine cortisol test

Plan:

Weight gain

- BMI, urine, saliva and blood tests to identify cause of weight gain
- Educate the patient regarding healthy diet and exercise, refer to dietician
- Gastric sleeve surgery
- Transsphenoidal resection if pituitary tumor present
- Adrenal tumor excision if present
- Ectopic tumor resection if present

Painful bulge in stomach

- Physical exam to confirm lipoma or ventral hernia
- If hernia: hernioplasty
- If lipoma: liposuction (because it is painful and bothering the patient)
- Extra strength Tylenol as needed for pain

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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: NYPQ

Date of Visit: 9/12/23

Activity performed: History and physical

Supervisor:

Name and Credentials: Naeem Sadat, PA-C PRAC

Supervisor Signature:

Supervisor Comments: