Rachel Freundlich
Rotation #3 - Internal Medicine

History

Identifying Data:
Full Name: O.H.
Address: Flushing, NY
Date of Birth: 01/04/1939
Date & Time: April 2, 2024 10:15am
Location: NYPQ
Religion: Not stated
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Arrived with wife to ER
Chief Complaint: "I've been really out of breath" x1 week

History of Present Illness:
O.H. is an 85 y/o M with HFpEF, HTN, HLD, DM, gout, Afib controlled on Metoprolol and Eliquis and a history of prostate cancer who presents to the ED with exertional dyspnea x1 week. The patient reports that he typically is able to walk up a flight of stairs before becoming dyspneic but for the last week he has become dyspneic after walking up just a few stairs. He sleeps with one pillow at night. He reports that he stopped taking his Lasix 2 days ago because it was "causing him to urinate too much". The patient admits he noticed his legs are more swollen than usual and he reports a 15lb weight gain within the last week. The pt reports that he was hospitalized in July 2023 for CHF exacerbation with an uncomplicated hospital course. During his previous admission he received an echocardiogram which revealed EF 55-60%. He denies chest pain, palpitations, syncope, nausea, vomit, chills, fever, cough and abdominal pain.

Pt was seen for admission to medicine for further workup. Pt was interviewed one day after initial presentation to the ED. Pt was saturating 89% upon arrival to ED. He was started on 3L NC and is being maintained there currently saturating 95%. Pt is currently being worked up for acute CHF exacerbation vs pneumonia vs ACS. To date, patient has received CXR which revealed enlarged cardiac silhouette, pulmonary vascular congestion, interstitial edema and retrocardiac opacity which may reflect PNA vs atelectasis, although PNA is unlikely due to absence of focal consolidation. Pt also received EKG which showed Atrial fibrillation. EKG was negative for ST elevations and other abnormalities. Of note, initial hgb 11.2, hct 34.4, aleukocytosis, Cr 1.22, BNP 3,942.

As per cardiology consult, pt was started on IV Lasix 40mg q12h. Pt reports mild improvement in lower extremity edema and moderate dyspnea improvement although he notes he has remained in bed since admission so dyspnea on exertion has not been assessed.

Past Medical History:
Present illnesses – HFpEF, HTN, HLD, DM, gout, Afib
Past medical illnesses – Prostate cancer
Hospitalized – CHF exacerbation (July 2023)
Childhood illnesses – Denies any illnesses
Immunizations – received COVID vaccine 11/17/2021, 05/17/2021, 04/21/23
Screening tests and results – Unknown

Past Surgical History:
Denies past surgical history

At home Medications:
Amlodipine - 5mg tablet PO QD
Apixaban - 5mg tablet PO q12h
Furosemide - 40mg tablet PO QD
Losartan - 50mg tablet PO QD
Metoprolol succinate ER - 25mg tablet PO QD
Simvastatin - 20mg tablet PO QD
Metformin - 500mg tablet PO BID with meals

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

Family History:
Mother – deceased at unknown age, hx of Rheumatoid Arthritis
Father – deceased at unknown age, hx of Lung cancer
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons

Social History:
O.H. is a married male currently living with his wife. He does not report any concerns regarding access to food, medicine or housing.
Habits - Pt has a history of cigarette use which he reports he quit many years ago. Admits occasional alcohol consumption. Denies caffeine, tobacco and drug use
Travel - Pt denies recent travel.
Diet - Pt reports eating a well balanced, low sodium diet.

Exercise - Pt typically walks 1-2 blocks each day, however he is currently unable to do so.
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 – **Admits recent 15lb weight gain.** Denies loss of appetite, generalized fatigue, fever or chills, or night sweats.

Skin, hair, nails – **Admits excessive sweating, lower extremity bilateral hyperpigmentation due to chronic venous stasis.** Denies changes in texture, excessive dryness, 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, pruritus. Last eye exam unknown.

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

Nose/sinuses – Pt denies nasal discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcer or voice changes.

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

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

Cardiovascular system – **History of HFpEF, HTN, HLD, Afib**. **Admits worsened lower extremity edema**. Denies chest pain, syncope or known heart murmur.

Gastrointestinal system – Denies epigastric pain, nausea, diarrhea, change in appetite, rectal bleeding, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructations, jaundice, hemorrhoids, constipation, hematemesis.

Genitourinary system **– Admits urinary frequency, urgency, mild nocturia.** Denies flank pain, oliguria, polyuria, or dysuria.

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 back pain, deformity or swelling, redness or arthritis.

Peripheral vascular system – **Admits peripheral edema and color changes to the lower extremities due to chronic venous stasis.** Denies coldness or trophic changes.

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

Endocrine system – **Admits history of T2DM.** Denies polydipsia, polyphagia, heat or cold intolerance, excessive sweating prior to admission, hirsutism, or goiter.

Psychiatric – Denies history.

Physical

General: 85 year old male appears well groomed, dressed appropriately for the weather, A&O x3, looking about his stated age of 85. Pt in no acute distress. Ambulation is complicated by significant bilateral lower extremity edema.

Vital Signs:
BP: Seated: 164/62
HR: 68 BPM
R: 18 min unlabored
T: 97.3F (forehead)
O2 Sat: 95% 3L NC
Weight: 255 BMI: 35.56

Physical Exam:
Skin: Non diaphoretic. Warm and moist, with good turgor. Nonicteric, no erythema, pigmentation, lesions, unhealed scars, or tattoos.
Hair: Normal balding pattern on Pt's head. No lesions, lice, or seborrhea.
Nails: No clubbing, lesions or infection. Capillary refill 3 seconds in upper extremities.
Head: Normocephalic, atraumatic, non tender to palpation throughout. No swelling noted.
Eyes: Symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pale pink.
Visual acuity - not assessed..
Visual fields - full OU. PERRLA, EOMs intact with no nystagmus.

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.
Nose: No 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, erosion.
Teeth: Mild erosion of teeth noted with few teeth missing.
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, no bruits noted bilaterally, no cervical adenopathy, JVD noted.
Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.
Chest: Symmetrical, no deformities, no trauma. Respirations mildly labored with audible occasional wheezing.
Lungs: Chest expansion and diaphragmatic excursion symmetrical. Bilateral crackles auscultated with decreased breath sounds.
Heart: No JVP present. Irregular rate, irregular rhythm. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Abdomen: Nontender, nondistended abdomen. No CVA tenderness appreciated. No striae or pulsations noted. Normoactive bowel sounds present with no aortic/renal/iliac or femoral bruits. Tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation.
Rectal: not performed
Neuro Exam: Mental status normal with no focal deficits. Gait was not assessed due to patient lying in bed.
PVS: Extremities are warm. 2+ pitting edema present on lower extremities bilaterally. Calves are nontender with discoloration due to chronic venous stasis. Pulses are 2+ and symmetric though slightly difficult to assess.
MSK: No erythema, warmth or crepitus noted. FROM bilaterally in upper and lower extremities.

Differentials: Acute CHF exacerbation vs pneumonia vs Acute coronary syndrome

Labs:
Sodium - 144
Potassium - 3.9
Chloride - 105
Calcium total level - 9.4
Magnesium - 2.3

Phosphorous - 2.8

BUN - 20.8
Creatinine - 1.21
BUN/Cr - 17
Glucose - 122
Anion gap - 13
GFR - 60

WBC - 8.04
RBC - 3.23
Hgb - 10.8 (11-17.3)
Hct - 32.7 (35.4-56.5)
MCV - 101.2 (90.4-128)
MCH - 33.4
MCHC - 33.0
RDW - 14.7
Plt - 172
Mean platelet volume - 10.6

Liver profile:
Protein - 6.7
Albumin - 3.8
Globulin - 2.9
Bilirubin Total - 1.5
Bilirubin Direct - 0.6
Bilirubin Indirect - 0.9
Ast - 0.9
Alt - 11
Alk Phos - 198

HA1c - 5.3
BNP - 3,942
Troponin - 43 (04/01: 44 -> 04/01: 43)
Urinalysis - unremarkable

Lipids
Cholesterol - 114
HDL - 65
LDL - 41

Cholesterol/HDL ratio - 1.8
Triglycerides - 37.0

TSH - 1.97
T4 - 6.06
Procalcitonin - 0.10
Ketones - negative
Lactate - 1.1

PT - 19.7
aPTT - 37.6
INR - 1.72

T&S - O+

All other labs within normal limits.

Problem list:

- Acute respiratory failure 2/2 CHF exacerbation
- HTN
- HLD
- DM
- Afib
- Gout

Assessment:
O.H. is an 85 y/o M with HTN, HLD, DM, gout, afib controlled on metoprolol and eliquis and with a history of prostate cancer presented to the ED with exertional dyspnea x1 week. Pt is being worked up for CHF exacerbation vs ACS.

Plan:

- **Admit to medicine for workup of CHF exacerbation**

#CHF exacerbation

- As per Cardiology
  - Increase IV Lasix 80mg BID
  - Strict Is & Os and daily dry weight
  - Continuous telemetry
  - Keep Mg >2 and K >4
  - Repeat TTE

#HTN/Afib

- Continue Losartan 100mg PO QD
- Continue Amlodipine 5mg PO QD
- Change to Coreg 6.5mg PO BID
- Continue Eliquis 5mg PO BID

#HLD

- Change to Atorvastatin 10mg PO nightly

#DM

- A1c 5.2
- Monitor fingerstick glucose levels QID
- Hold Home medication Metformin while in patient
- Initiate Insulin Sliding Scale
    - Insulin Lispro, 1-3U, SubQ nightly
    - Insulin Lispro, 1-4U, SubQ TID with meals

#Gout

- Continue Allopurinol 50mg PO QD

Updated Medication List:

IV Lasix - 80mg BID
Losartan - 100mg PO QD
Amlodipine - 5mg PO QD
Atorvastatin - 10mg PO nightly
Coreg - 6.5mg PO BiD
Eliquis - 5mg PO BID
Allopurinol - 50mg PO QD
Insulin Lispo - 1-3U SubQ nightly
Insulin Lispro - 1-4U SubQ TID with meals

Patient Education:

The patient was educated that his current symptoms are associated with his previous diagnosis of heart failure. We are going to treat him in a similar manner to the way in which he was treated when he was admitted for CHF exacerbation last year. The pt was reminded of the need for constant diuresis and that continuing to take the Lasix everyday will help avoid future exacerbations. The patient was also advised to elevate his legs at night to encourage venous return as well as to wear compression stockings. The pt was made aware that we will repeat an echocardiogram to determine if any changes to his heart function/wall motion abnormalities have occurred over the last year. The pt was educated in regards to maintaining a low sodium diet as

this will reduce salt and water retention which will cause more work for his heart due to increased volume.