Rachel Freundlich
Rotation #9 - OBGYN

Chief Complaint: “My chest is hurting” x6 hours

History of Present Illness:
Pt is a 20 y/o F G1P0 currently 27w5d with no significant PMH presenting with complaints of chest pain, shortness of breath and headache x6 hours. Pt states that she began experiencing difficulty taking deep breaths around mid-day. She reports that she is experiencing mild chest discomfort. She explains that the discomfort comes on spontaneously and is not triggered by anything specific. She denies any relieving or exacerbating factors. Pt denies association with eating and states her last meal was at 2:30pm today. She has not changed any foods in her diet recently. Pt describes the discomfort as a feeling of pressure in the mid sternum. Pt also reports a headache which she rates 6/10. Pt states the headache began about 6 hours ago as well. She describes it as tension like. She has not taken medication for the pain. Pt admits recent close sick contact and mild sore throat. Pt recently moved from Kansas and established care at this hospital in her second trimester. Normal findings at most recent visit. Pt denies any history of these symptoms previously. She denies cardiac history, pulmonary history, psychiatric history, recent long travel or period of stasis, leg pain, leg swelling, vision changes, nausea, vomit, epigastric pain, lightheadedness, syncope, cough, fever, rhinorrhea.

Past Medical History:
Present – Pregnancy, 27w5d
Past medical illnesses – Denies past medical illnesses
Hospitalized – Denies previous hospitalizations
Childhood illnesses – Denies any illnesses
Immunizations – Up to date

Past Surgical History:
Denies

At home Medications:
No reported medications

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

Family History:
No significant family history

Social History:
K.C. is a G1P0 female currently living with her boyfriend.
Habits - Admits one cup of coffee with sugar and milk daily. Denies tobacco, alcohol, and drug use.
Travel - Denies recent travel.
Diet - Pt reports eating a well balanced diet.

Exercise - Pt denies exercise.
Safety measures - Admits to wearing a seat belt.
Sleep – Pt reports regular sleep patterns.
Sexual Hx - Pt is currently sexually active with her partner.

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

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

Head – Admits headache. Denies vertigo or head trauma.

Eyes – Pt does not wear glasses. Denies recent vision changes, photophobia, pruritus.

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

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

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

Cardiovascular system – Admits chest pain. Denies syncope, edema or known heart murmur.

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

Genitourinary system – Denies pelvic pain, cramping and vaginal bleeding, urinary frequency, hesitancy, nocturia, urinary urgency, flank pain, oliguria, polyuria, or dysuria.

Nervous – Denies seizures, 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 peripheral edema, discolorations, coldness or trophic changes.

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

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

Psychiatric – Denies history.

Physical

General: 20 y/o F appears A&Ox3 in mild pain. Pt is well groomed, dressed appropriately for the weather and in no acute distress.

Vital Signs:
BP: Seated: 118/64
HR: 92 BPM
R: 18 min unlabored
T: 98.9F (forehead)
O2 Sat: 100% room air
Weight: 166lb BMI: 27.66

Physical Exam:
Skin: Non diaphoretic. Warm and moist, with good turgor. Nonicteric, no erythema, pigmentation, lesions, unhealed scars, or tattoos.
Hair: Normal hair distribution. No lesions, lice, or seborrhea.
Nails: No clubbing, lesions or infection. Capillary refill <2 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: Nasal mucosa pink with no discharge or bleeding noted. No bony deformities or tenderness present. Septum midline.
Sinuses: Sinuses nontender to palpation.
Lips: Pink, moist, and well hydrated.
Mucosa: Pink, no masses, well hydrated, nontender, no leukoplakia.
Palate: Pink, intact with no lesions, scars, erosion.
Teeth: Good dentition.
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 unlabored.
Lungs: Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. Normal breath sounds throughout.
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: Abdomen round and slightly enlarged secondary to pregnancy. Abdomen is without striae or pulsations noted. Bowel sounds normoactive. No CVA tenderness appreciated. No aortic/renal/iliac or femoral bruits. No hepatosplenomegaly to palpation.
Pelvic Exam: Not performed secondary to presenting complaint.
Rectal: not performed
Neuro Exam: Patient is alert to person, place and time. No focal deficits present.
PVS: Extremities are warm and without edema. No varicosities or stasis changes. Calves are supple and nontender. Pulses are 2+ and symmetric.
MSK: No erythema, warmth or crepitus noted. FROM bilaterally in upper and lower extremities.

Fetal Heart Rate monitoring
- 155bpm with moderate variability

Differentials:
PE
- The patient is at increased risk for a PE due to pregnancy status. In the setting of pregnancy and chest pain/shortness of pain it is important to rule out PE. Although PE is not likely due to the patient's vital signs and physical examination, it is a do not miss diagnosis and must be worked up.

Anxiety
- It is possible that the patient's symptoms of shortness of breath and chest pain are secondary to anxiety. This may be the result of pregnancy or other life stressors. This is a diagnosis of exclusion and can be evaluated during the interview.

GERD
- GERD is more common during pregnancy due to increased pressure on the abdomen which increases reflux. Mid sternal pain can be explained by acid reflux. This is also a diagnosis of exclusion and may be better explained during the interview.

Viral Illness
- The patient admits recent sick contact, headache, chest pain and sore throat. These may all be symptoms of a viral illness. Viral panel can rule out viral illness.

Labs:
- BMP: Unremarkable
- Troponin: <6
- CBC
  - Hgb: 9.4
  - Hct: 28.9
  - Otherwise unremarkable
- Coags: unremarkable
- LFT: unremarkable
- UA: negative
- T&S: O+

- COVID: negative
- Influenza A&B: negative
- RSV: negative

Imaging:

- **EKG:** Normal sinus rhythm
- **CXR:** There are no focal consolidations or effusions. There is no evidence of hilar or mediastinal lymphadenopathy. There is no evidence of cavitation lesions. The cardiomediastinal silhouette is borderline with mild central pulmonary vascular prominence. Rule out mild CHF.
- **CT:** There is no evidence to suggest PE on this study. This included in the right and left pulmonary arteries and it's major branches. The lungs are well aerated without evidence of consolidation. There is no evidence of effusion. No definite nodular densities. No significant adenopathy is identified in the mediastinum. There are scattered axillary small lymph nodes. Limited views of the upper abdomen is unremarkable.

Assessment:

K.C. is a 20 y/o G1P0 female presenting with shortness of breath and chest discomfort. Pt is in no acute distress and appears comfortable during interview. Physical exam is unremarkable. Labs and imaging do not indicate any acute process.

Plan:

- IV Bicitra 30mL
- Tylenol 650mg PO
- Reevaluate vital signs, if reassuring
    - Discharge with strict return precautions
    - Follow up in clinic for next appt in 1 week

Journal Article: Anticoagulant prophylaxis in pregnant women with a history of venous thromboembolism: A systematic review and meta-analysis

- Venous thromboembolisms (such as DVTs and PEs) are leading causes of mortality amongst both pregnant and postpartum women. Identifying the symptoms of VTE and managing it correctly are essential to avoid devastating outcomes. The risk of VTE is 5 times higher during pregnancy and increases significantly postpartum. This systematic review and meta analysis aimed to examine recurrence rates of embolisms amongst 5,075 pregnant patients with prior history of VTE. This article evaluated the efficacy of LMWH as thromboprophylaxis. For pregnant patients that were anticoagulated during pregnancy and throughout the postpartum period, recurrence rates were 2.5%. This is compared to the group that received prophylaxis only postpartum which had recurrence rates of 4.7%. A third group did not receive any thromboprophylaxis and experienced a staggering 13.6% recurrence rate. This research was undertaken due to the ambiguous guidelines for thromboprophylaxis for pregnant patients. Typically, LMWH is the preferred anticoagulant, however the dosing recommendations vary. Further research is necessary to further clarify recommended guidelines for thromboprophylaxis in pregnant and postpartum women with history of VTE.