Markenzie Jean-baptiste

H & P: Family Medicine Rotation

01/19/2020

**Identifying Data:**

Full Name: Mr. FS

Address: Queens, NY

Age: 35

Date & Time: Jan 13, 2020 @ 7:00pm

Location: South Shore Medical Practice

Religion: None

Reliability: Reliable

Source of Information: Self

Source of Referral: Self

Mode of Transport: Ambulatory

**Chief Complaint**: “ I have LT sided chest pain x 2 days”

**History of Present Illness**:

35 y/o M, PMH hyperlipidemia c/o LT sided chest pain x 2 days, described as dull, constant and “stressing my heart.”. Reports that on the way to the clinic he was jogging and felt the pain. He describes chest pain as 2 out of 10 in pain while jogginh but now is 1 out of 10. States that he felt like he wanted to the ER last night with 3 out of 10 chest pain but he did not. Also reports having LT sided upper back pain which he awoke with 2 days ago. Back pain was worst with arm movement but has since resolved. PT has not taken any medication for his symptoms. Denies syncope, palpitations, leg pain/ swelling, SOB, headache, dizziness, nausea, vomiting, recent cough/cold, recent trauma. Denies illicit drug use.

**Past Medical History:**

Present illness: Hyperlipidemia, Vit D Deficiency

Past illness:  none

Hospitalizations: none

Immunizations: flu vaccine yearly, all others Up to Date

**Past Surgical History:**

Denies injuries, past surgeries and transfusions.

**Medications:**

Ergocalciferol 5000 Unit Capsule, 1 orally weekly

Denies taking any other medications or herbal supplements.

**Allergies:**

Dairy and peanuts- reaction is hives/rash

**Family History:**

Mother 69, alive, hx of type 2 diabetes, **Mother has hx of MI in her late 40’s**

Father 72, alive, hx Hyperlipidemia

**Social History:**

Habits: Mr. AR denies ever smoking cigarettes. Reports that he is a social drinker and drinks 1-2 beers on the weekend.

Travel: no recent travel

Marital History: single

Sexual History: pt is sexually active with women. Denies any history of STD.

Occupation: currently not working

Home: Pt lives an apartment building on the 3rd  floor. Denies any problems at home.

Diet: Reports that he consumes a balanced diet, lots of meats,  rice and vegetables.

Sleep: Reports that he usually gets 5-6 hours of sleep at night

Exercise:  Reports that he does not exercise often.

Safety: Pt admits to wearing a seat belt and uses all appropriate safety measures

**Review of Systems:**

*General*- Denies fever, chills, night sweats, fatigue, weakness, loss of appetite, recent weight gain or loss

*Head-* Denies headache, vertigo, unconsciousness,

*Eyes-* Denies vision changes

*Pulmonary*- Denies dyspnea, SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, PND

*Cardiovascular*- **(+) Chest pain,** Denies HTN, palpitations, irregular heartbeat, edema/swelling of

ankles or feet, syncope, known heart murmur

*Gastrointestinal:* Denies change in appetite, nausea, vomiting, dysphagia, abdominal pain,

diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, blood in stool,

*Genitourinary*: Denies urinary frequency, incontinence, dysuria, nocturia, urgency, oliguria, ‘

polyuria,

*Peripheral Vascular-* Denies intermittent claudication, coldness, trophic changes, varicose veins,

peripheral edema, color changes

*Nervous System*: DENIES  seizures, dizziness,  loss consciousness, sensory disturbances, ataxia,

loss of strength, change in cognition/mental status/memory, weakness

**Physical**

*Vital Signs*:

*Blood Pressure*: 110/70 mmhg

*Heart Rate*: 86 bpm

*Respiration Rate*: 16 breaths/min

*Temperature*: 98.3 F

*O2 Sat*: 98% room air

*Height*: 71 inches

*Weight*: 124 lbs

*BMI*: 17.29

*General Appearance*: 35 y.o. male A/O x 3. Pt has small build and good posture, well dressed and groomed. Pt does not appear to be distressed.

Skin: Warm and moist/dry, good turgor, noncitric, no thickness/opacity, no lesions, no rashes, no scars, no tattoos.

*Nails*: No clubbing, no infection, capillary refill <2 sec throughout.

*Hair*: Average quantity and distribution, no signs of alopecia, seborrhea, or lice.

*Eyes*: symmetrical OU, no evidence of strabismus or ptosis noted, sclera (white/ red), conjunctiva and cornea clear. Visual fields intact, OU, PERRLA, EOMI full with no nystagmus.

*Head*: normocephalic, atraumatic, nontender to palpation throughout, no signs of alopecia, seborrhea, or lice. Nontender to palpation throughout

*Chest*: Symmetrical, no deformities, no signs of trauma. Respiration unlabored/ no parodoxic respiration or use of accessory muscles noted. Lat AP diameter 2:1. Non-tender to palpation.

*Lungs*: Clear to auscultation bilaterally, no rales/rhonchi/wheezes, no egophony, no tactile fremitus, normal percussion.

*Cardiovascular*: Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

**Pt reported that chest pain improves minimally when leaning forward**

*Peripheral Vascular*: Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally (no C/C/E  B/L) No stasis changes or ulcerations noted.

*Neurological*: *Mental Status*: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted.

**Labs/procedures:**

**EKG: Widespread ST elevations, Normal Sinus Rhythm noted at 73 bpm**

(Link to EKG)---->[Ekg](https://markenziej.commons.gc.cuny.edu/wp-content/blogs.dir/5363/files/2020/02/Ekg.pdf)

Differential based off Chief Complaint:

1. Myocardial Infarction/ACS
2. Aortic dissection
3. Pulmonary Embolism
4. Pneumothorax
5. Pericarditis

Adjusted Differential Diagnosis

1. Pericarditis:
2. Myocardial infarction/ACS
3. Aortic dissection
4. Pulmonary Embolism
5. Pneumothorax

**Assessment**

35 y/o M, PMH hyperlipidemia c/o LT sided chest pain x 2 days, described as dull, constant and “stressing my heart.”. Also reports having LT sided upper back x 2 days, worst with arm movement but resolved 2 days ago. On physical exam; pt reports mild improvement of chest pain with leaning forward. EKG showed widespread ST elevations noted in multiple leads.

Problem List:

1. Chest pain

**Plan:**

PT was sent to the Emergency Room to r/o definitively any other causes

* Consider chest x-ray and/or echocardiogram to assess pericardial effusion/stiff heart
* Consider labs CBC,CMP,ESR,CRP, Troponin, CK-MB to assess for leukocytosis, inflammation and myocardial damage
* Evaluate for pulses parodoxus

if negative and no signs of hemodynamic compromise

Outpatient tx:

Rx NSAIDS( ibuprofen, aspirin, indomethacin) +  Colchicine 0.5 mg BID x 3 months

Patient will be advised to restrict strenuous physical activity until symptoms have resolved and biomarkers have normalized

If patient is responding- NSAIDS will be tapered and colchicine will be continued for 3 months with follow up after.

If patient does not respond to therapy or worsened, pt will be admitted to hospital for further evaluation.