Markenzie Jean-Baptiste

H & P

Long Term Care Rotation

11/03/2020

**Very complicated case and good job capturing information. Good job of sequencing the HPI (with one slight exception – see my comments). Good assessment of status of current active problems. One notable omission in this patient with dementia and schizophrenia is an assessment of cognitive status. Also would be important to have a sense of her functional status in the HPI.**

**Identifying Data:**

Full Name: J.B.

Address: Queens, NY

Age: 86

Date & Time: November 3, 2020 @ 9:00 am

Location: Far Rockaway Rehabilitation and Nursing Facility

Reliability: reliable

Source of Information: patient

Source of Referral: Flushing Hospital Medical Center

Mode of Transport: wheelchair

**Chief Complaint**: “I have a heart problem and difficulty breathing x 3 weeks”

**History of Present Illness**:

Ms. J.B. is a 86 y.o. female, **dependent in ADLs and IADLs,**  with PMHx of CHF, CAD, high degree AV heart block s/p permanent pacemaker in 2018, dementia, schizophrenia, constipation, DM, GERD, osteoporosis, osteoarthritis, hyperlipidemia, parkinsonism and HTN, **hypothyroidism,** was sent to Flushing Hospital Medical Center ER from her residing nursing home by EMS on 9/29/2020 presenting with SOB x 1 day. Patient was found in respiratory distress lying down in her nursing home bed with BP of 86/57 and was sent to ER. Patient was already receiving cefepime x 1 day in her nursing home for pneumonia diagnosed by chest x-ray. Chest x-ray in ER confirmed left basilar infiltrate, possible small effusion, and other bilateral opacities. Labs showed no leukocytosis, but a left shift was present with absolute neutrophil count of 6.6. Pt was admitted and completed antibiotic course of amikacin, vancomycin and Zosyn for treatment of PNA and UTI. Patient also had an echo performed which showed EF 30 %, bilateral ventricular enlargement, mild mitral regurgitation, tricuspid regurgitation and mild pulmonary hypertension. Patient was diagnosed with acute systolic CHF due to HCAP. Patients BP also tended to be on the low side so midodrine 5 mg 3 times daily was added to patient’s metoprolol 12.5 mg every 12 hours. Ace inhibitor/angiotensin receptor blocker and diuretics were continued to be held due to patients low BP. Lasix 20 mg Q 48 hrs was resumed, to be held if systolic BP was less than 90 mmhg. On 10/8, patient had a chest x-ray done which was mildly unchanged from previous x-ray and patient’s vitals remained stable. On 10/09/20, patient was discharged to Far Rockaway Rehabilitation and Nursing Facility.

On 11/3, patient was evaluated in nursing home and reported that she has been having difficulty breathing due to her heart condition. Pt described shortness of breath as constant, worsened with exertion or lying down. Patient sleeps elevated with two pillows. Patient appeared stable with oxygen therapy and saturating well at 96% on room air. Otherwise patient denies headache, dizziness, lightheadedness, LOC, nausea, vomiting, abdominal pain, diarrhea, chest pain, cough, leg pain/swelling.

**Past Medical History:**

CHF, CAD s/p PCI stent, high degree AV heart block s/p permanent pacemaker, dementia, schizophrenia, constipation, Diabetes Mellitus, GERD, osteoporosis, osteoarthritis, hyperlipidemia, hypothyroidism, parkinsonism, HTN, anemia. **Might want to re-order these in order of importance and group together the cardiovascular ones.**

Hospitalizations: 9/29/2010 for UTI and PNA- pt tx with abx and was discharged

 2018 for CHF exacerbation, started on dual antiplatelet and Lasix

 2018 high degree AV heart block s/p permanent pacemaker **Here you wouldn’t use S/P because it’s the date of the procedure – only S/P after that**

Immunizations: flu vaccine yearly, all other childhood immunizations are up to Date **What other vaccine should we ask about in this patient?**

Past Surgical History:

CAD s/p PCI stent-2018

Medications:

Acetaminophen 325 MG- 2 tabs by mouth q6h prn for osteoarthritic pain or fever

Alendronate 70 MG- take 1 tab every 7 days for osteoporosis

Alogliptin Benzoate 6.25 mg tab- t tab QD for DM

Amino Acids-Protein Hydrolys (PRO-STAT) LIQD protein supp 15 g/30 ml . Take 30 mls BID

Aspirin 81 MG, t tab QD for anticoagulation

Docusate sodium(COLACE) 100 MG capsule- Take 2 capsules by mouth QD for constipation

Famotidine (PEPCID) 20 MG tablet- take 1 tablet by mouth once daily for GERD

Fleet Enema 7-9 GM/118ML- insert rectally as needed for constipation

Furosemide (LASIX) 40 MG tablet- take 1 tab by mouth every 48 hrs., hold if BP less than 110/50 for CHF

Levothyroxine (Synthroid) 125 MCG tablet- take 1 tablet by mouth once daily for hypothyroid

metformin(GLUCOPHAGE-XR) 500 MG 24 hr tablet- take 500 mg by mouth daily with breakfast for DM

Metoprolol Tartrate(LOPRESSOR) 25 MG tablet- take 0.5 tablets by mouth every 12 hours for HTN

Midodrine (PROAMATINE) 5 mg tablet- take 1 tablet by mouth 3 times daily for orthostatic hypotension

Milk of Magnesia Suspension 400 MG/5ml- 30 cc by mouth as needed for no BO in 3 days c/o constipation

Multivitamin(TABAVITE)- Take 1 tablet by mouth once daily

risperidone(RISPERDAL)-0.5 MG tablet- take 3 tablets by mouth 2 times daily for schizophrenia

ropinirole(REQUIP)-1MG tablet. Take 1 tablet by mouth every night at bedtime for parkinsonism

Sennosides(SENNA) 8.6 MG TABS- take 2 tablets by mouth every night at bedtime for constipation

Simvastatin(ZOCOR) 20 MG tablet – take 20 mg by mouth every night at bedtime for HLD

Allergies:

Mushroom extract complex- hives and SOB

Sulfa antibiotics- SOB

Family History:

Mother- deceased, unknown medical hx

Father- deceased, unknown medical hx

Social History:

Ms. J.B. is a 86 y.o. female living in skilled nursing facility with elevator in residence. PT needs assistance with ADL’s, transfers and uses a wheelchair to transport. PT has a gait disorder due to shortness of breath. Patient transfers out of bed—to/from wheelchair with mechanical lift and assist of 2 nurses. Typical shorthand for this is “maximum assist and mechanical lift” PT reports that she is a non-smoker and denies ever smoking cigarettes and alcohol use.

Diet: Patient has a dysphagia level 1 consistent (consistency?) carb diet which is of puree texture

* Supplements—ensure pudding BID 4 oz
* Prostate sugar free- two times a day for supplement 30 cc bid **Pro-Stat sugar free? Protein supplement (I think auto-correct is getting in the way here)**

Exercise: Physical therapy in skilled nursing facility for functional/mobility training. **Would like to know how often**

**Review of Systems:**

General**:** DENIES fever, chills, fatigue, weakness, loss of appetite, recent weight gain or loss

Skin: DENIES any new rash or lesions

Head: DENIES Headache, vertigo, head trauma, loss of unconsciousness,

Eyes: DENIES visual disturbances, lacrimation, photophobia, pruritus,

Ears: DENIES Deafness, pain, discharge, tinnitus,

Nose/Sinuses**:** DENIES rhinorrhea, epistaxis, obstruction

Mouth and throat: DENIES bleeding gums, sore throat, mouth ulcers, voice changes,

Neck: DENIES localized swelling/lumps, stiffness/decreased range of motion

Pulmonary: **(+) Dyspnea, SOB**, **orthopnea**

 DENIES cough, wheezing, hemoptysis, cyanosis,

Cardiovascular: **(+) HTN**

DENIES chest pain, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope,

Gastrointestinal: **(+) hx of constipation**

DENIES changes in appetite, nausea and vomiting, abdominal pain, diarrhea

Genitourinary: Denies dysuria, flank pain, hematuria, urinary frequency, urinary urgency.

Musculoskeletal:

**(+) hx of osteoporosis**

**(+) hx of osteoarthritis (x-ray RT hip and femur on 9/30 showed chronic osteoarthritic changes, joint space narrowing and sclerotic changes, without fracture/dislocation) I would put this info about the X-ray in the PMH**

Denies swelling or redness.

Nervous System: DENIES seizures, dizziness, loss consciousness, headache, numbness/tingling, change in cognition/mental status/memory, weakness (asymmetric)

**Would be important to include Psychiatric in this patient**

**Physical Exam**

Vital Signs:

 Blood Pressure: 136/65 **(position – in this patient particularly important)**

 Heart Rate: 82

 Respiration Rate: 18

 Temperature: 98 F

 O2 Sat: 96 (On O2?)

 Height: 66 inches

 Weight: 184 lbs.

 BMI: 29.70

General: 86 y/o female, A/O x 3, with large build, appears comfortable in bed, receiving oxygen therapy, no acute distress.

Skin: Skin is warm and moist, good turgor, non-icteric, no rashes,

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

Eyes: PERRLA, EOMI, scleral anicteric

Ears: Symmetrical and normal size. No evidence of lesions/ masses/ trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TM’s are pearly white/ intact with light reflex at AS/AD (AU)

Nose: Symmetrical no obvious masses/ lesions/deformities/ trauma/discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions/ deformities/injection/perforation. No evidence of foreign bodies.

Sinuses: nontender to palpation and percussion over bilateral frontal, ethanoic and maxillary sinuses.

Mouth and Pharynx:

Lips: pink, moist, no evidence of cyanosis or lesion. Nontender to palpation

Mucosa: pink; well hydrated. No masses. Lesions noted. Non-tender to palpation. No evidence of leukoplakia

Palate- pink, well hydrated. Palate intact with no lesions, masses, scars. Nontender to palpation.

Teeth: good dentition/ no obvious dental caries noted

Gingiva: pink, moist, no evidence of hyperplasia, masses, lesions, erythema or discharge, non-tender to palpation

Tongue: pink, well papillated. No masses, lesions or deviation noted. Non tender to palpation

Oropharynx: Well hydrated no evidence of injection; exudate, masses, lesions, foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema lesions.

Neck: Trachea midline. No masses, lesions, scars, pulsation noted. Supple, nontender to palpation. FROM no stridor noted. Thyroid non-tender, no palpable masses, no thyromegaly. No JVD/thyroid bruits noted.

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

Cardiovascular: 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. JVP is 2.5 cm above the sternal angle with the head of the bed at 30°.

Abdomen: (+) small non-tender reducible umbilical hernia present**.** Otherwise, abdomen is flat / symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits noted over aortic/renal/iliac/femoral arteries. Tympanic to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

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.

Musculoskeletal: hand grip strength equal b/l. Muscle strength of upper and lower extremities 3/5 Need to add the additional info from PT note – or just refer to it. As it stands, you’re contradicting it. No soft tissue swelling /erythema / ecchymosis. Non-tender to palpation / no crepitus noted throughout. No evidence of spinal deformities. Ambulation unable to assess.

Physical Therapy Notes

Therapy diagnosis—functional decline and gait disorder (due to difficulty breathing)

Therapy precaution- fall risk, aspiration

Strength—impaired

RUE 3/5

RLE 3/5

LUE shoulder 2/5, elbows finger 3/5

LLE 2/5

PROM-impaired

RUE/RLE/LUE/LLLE

AROM-impaired

RUE/RLE/LUE/LLE- minimal limitations

Tone- within functional limits

Bed mobility

Supine to sit-max assistance (75%)

Side to side- max assistance (25%)

Scooting/bridging max assistance (75%)

Transfers

Sit to stand unable to assess

Endurance

Sitting- poor

Standing- not tested

During activities- poor

Ambulation- unable to assess

Balance- poor

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. Unable to assess gait/ambulation. DTR’s 2+ and symmetric upper and lower extremities, cranial nerves I – XII intact; sensation intact to touch bilaterally

Labs: **Date – unless they were drawn that day**

**CBC:**

RBC 2.96 L

WBC 8.2

PLT 193

HgB 9.3 L

HCT 29.5 L

MCV 99.7 H – **As discussed, this is usually not considered high, though it’s at the high end of normal**

MCHC. 31.5 L

RDWCV 17.2 H

**CMP:**

Glucose 84

Albumin 3.2

Calcium 8.5

Sodium 135

Potassium 5.0

Chloride 100

Carbon dioxide 28

**BUN 35 (ref 9-23) H**

Calcium 8.5 (8.7-10.4) L

**BUN/Creatinine 32 (ref 10-20) H**

GFR 47( ref greater than 59) L

**BNP 534 H, last BNP on 10/9 was 3360**

**GFR 47(less than59)**

Differential Diagnosis I know you’re often asked to come up with 5 DDx’s, but in this case there is no evidence for 2-4 whereas CHF and Pneumonia are proven so what order should these go in and what else might you say about the remaining ones? Also there are other possible explanations for her hypotension – what are they?

1. Congestive Heart Failure (CHF) exacerbation
2. Myocardial Infarction
3. Abdominal Aortic Aneurysm
4. Pulmonary embolism
5. Pneumonia

**Assessment**

Ms. J.B. is a 86 y.o. female with PMH of CHF, CAD, high degree AV heart block s/p permanent pacemaker, dementia, schizophrenia, constipation, DM, GERD, osteoporosis, osteoarthritis, hyperlipidemia, parkinsonism, admitted to Flushing Hospital Medical Center ER from nursing home on 9/29/2020 presenting with SOB after she was found in respiratory distress lying down in her nursing home bed with BP of 86/57. PT was diagnosed with b/l pneumonia and UTI and treated with course of amikacin, vancomycin and Zosyn for treatment of PNA and UTI. Patient also had an echo performed which showed EF 30 %, bilateral ventricular enlargement, mild mitral regurgitation, tricuspid regurgitation, mild pulmonary hypertension and diagnosed with acute systolic CHF due to HCAP. Patient was started on midodrine 5 mg 3 times daily added to patient’s metoprolol 12.5 mg every 12 hours due to patients low BP. PT was discharged on 10/9 to Far Rockaway Rehabilitation and Nursing Facility. On 11/3, patient reported having improving shortness of breath related to CHF, maintained on diuretics, antihypertensive and oxygen therapy. PT appeared stable with oxygen therapy and saturating at 96% on room air.

As discussed, you don’t need quite all of this in assessment.

Here’s a possible alternative:

Ms. J.B. is an 86 y/o female with multiple morbidities including HTN, CHF, AV heart block with pacemaker, dementia, schizophrenia, DM, Parkinson’s disease, dependent in ADLs and IADLs and with very poor mobility. Admitted from Flushing Medical Center after resolution of CHF exacerbation due to LLL pneumonia, treated with IV antibiotics, diuresis, and oxygen therapy. Current status stable on O2 (mode of transmission and flow level).

**Plan:**

Chronic diastolic CHF

* Well controlled on current meds
* Continue aspirin 81 mg daily
* Continue Lasix 40 MG tablet- take 1 tab by mouth every 48 hrs. Hold if BP less than 110/50
* Continue Metoprolol Tartrate(LOPRESSOR) 25 MG tablet- take 0.5 tablets by mouth every 12 hours
* Continue Midodrine (PROAMATINE) 5 mg tablet- take 1 tablet by mouth 3 times daily
* Continue oxygen therapy as needed. Monitor patients breathing. Pt to use Incentive spirometer 6 times a day for 10 breaths(rest in between breaths)
* Evaluate for orthopnea while lying flat every shift for respiratory monitoring
* Run COVID 19 test- negative
* Monitor BNP 534 H, last BNP on 10/9 was 3360 **When will it be repeated**
* Complete Vital signs with SPO2, lung sounds and reassess symptoms daily
* Monitor weight weekly x 4

Stage 3 CKD/Elevated BUN/CR, Low GFR 47

* administer IV fluids 0.9% NS- daily requirement- 2769 ml per day. Hold if pt has signs/symptoms of CHF exacerbation.

Osteoporosis

* well controlled on current meds
* Alendronate 70 MG- take 1 tab every 7 days for osteoporosis
* Physical therapy—5-6 times a week for functional mobility/training, muscle strengthening, therapeutic exercises, balance training, ambulation/gait training

Osteoarthritis

* well controlled on current meds
* Acetaminophen 325 MG- 2 tabs by mouth q6h prn for pain

Constipation

* well controlled on current meds
* Docusate sodium(COLACE) 100 MG capsule- Take 2 capsules by mouth QD for constipation
* Sennosides (SENNA) 8.6 MG TABS- take 2 tablets by mouth every night at bedtime.
* Fleet Enema 7-9 GM/118ML- insert rectally as needed for constipation

Diabetes Mellitus

* well controlled on current meds
* metformin(GLUCOPHAGE-XR) 500 MG 24 hr tablet- take 500 mg by mouth daily with breakfast for DM
* Alogliptin Benzoate 6.25 mg tab- 1 tab QD for DM
* Monitor blood glucose

Hyperlipidemia

* well controlled on current meds
* Simvastatin(ZOCOR) 20 MG tablet – take 20 mg by mouth every night at bedtime.

Hypothyroidism

* well controlled on current meds
* Levothyroxine (Synthroid) 125 MCG tablet- take 1 tablet by mouth once daily
* **I don’t remember if this was checked, but thyroid up or down can cause exacerbation of SOB**

Schizophrenia, Parkinson, Dementia

* well controlled on current meds
* risperidone(RISPERDAL)-0.5 MG tablet- take 3 tablets by mouth 2 times daily
* ropinirole(REQUIP)-1MG tablet. Take 1 tablet by mouth every night at bedtime

GERD

* well controlled on current meds
* Famotidine (PEPCID) 20 MG tablet- take 1 tablet by mouth once daily for GERD

Goals of Care

Patient agreed to continue care in skilled nursing facility. MOLST form signed for DNR/DNI/DNH, comfort measures only. Determine use or limitation of antibiotics when infection occurs.