OAP #1 Gagandeep Munday 2/24/2021

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S: on 2/ actual date

HP is a 62 yo F with PMH of HTN, DM2, glaucoma p/w worsening LT middle finger pain. Pt is s/p abscess drainage by ortho to the same finger yesterday, was d/c'ed on Augmentin & Motrin. States that she is having worsening 'throbbing burning" pain with minimal relief with Motrin. Endorses increase in swelling. Initially presented yesterday in ED with L middle finger pain, swelling, erythema for the past 3 days s/p pulling out a hangnail. Patient has scheduled ortho hand follow up.

mention Rome glucose / check for elevation indicative of possible infection

Denies fever, chills, body aches, n/v, paresthesias, focal weakness, gross weakness, discharge, recent trauma, skin changes, CP or SOB.

would be better ~~should~~ to state this at the beginning of HPI

bedside vs OR suggesting severity

PMH: HTN, DM2, glaucoma
PSH: Denies any
Allergies: NKDA
Medications: Losartan, Timolol eye drops
FHx: Non-contributory
SHx: Non-smoker, Denies EtOH use, Denies illicit drug use

O:
T 37.2C orally | BP 144/89 mmHg | P 85 BPM, regular | RR 16 breaths/min, unlabored | SpO2 97% RA
H 69 in| W 189lb. | BMI 23.3

Gen: Neatly groomed, looks her stated age 62 of years. AxO x3. Appears to be in no acute distress.
Skin: Warm, dry, no rash, mild erythema to distal LT 3rd finger
Head: Normocephalic atraumatic
Eyes: PERRL, EOMI
Ear, nose, mouth, throat: Mucous membranes moist, no erythema, airway patent, no stridor
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion symmetrical. No wheezing, rhonchi, rales, dullness.
Abdomen: Soft, non-tender to palpation throughout, no guarding, no rebound tenderness, no CVA tenderness
MSK: ***tense swelling to distal LT 3rd digit, TTP, bruising to LT 3rd fingernail***, no flatulence, no induration, radial pulse 2+ to BILAT UE, FROM intact, negative kanavel sign, intact strength and sensation bilateral UE and LE

fluctuance

A: s/p (significant precipitating event)
62 yo female with throbbing pain, swelling, and tenderness to distal LT 3rd digit. Likely felon.
Differential Diagnosis:

- felon
- cellulitis
- paronychia

? erythema
? crepitation
? distant tenderness

P:
Labs: None CBC c diff maybe helpful
Imaging/Tests: LT Hand XR 3 views r/o fracture or FB, US of LT 3rd finger r/o deep space infection and abscess
Felon: Change abx to cephalexin and doxycycline for MRSA coverage; tylenol #3 for pain, f/u with hand clinic, RICE

Initial DDx Based on CC:	Adjusted DDx After H&P:
• flexor tenosynovitis • deep space infection • felon • cellulitis or paronychia • abscess	• felon • cellulitis • paronychia

SOAP # 2

S:
RC is 31 y/o F with no significant pmhx p/w LT shoulder pain with ROM since yesterday. Patient states that pain worsened when she woke up this morning. States that pain radiates from neck to fingertips of her LT hand. Endorses minimal relief w/ 800 mg of ibuprofen.

Denies any recent trauma, past injury to shoulder or neck, headache, dizziness, weakness, LOC, CP, SOB, unintended weight loss, ptosis, cough, fever, chills, body aches, recent illnesses or sick contacts

PMH: Denies any
PSH: Cholecystectomy (include year of surgery)
Allergies: NKDA
Medications: Denies any intake of prescription medications
FHx: Non-contributory
SHx: Non- Smoker, Denies past or present EtOH or illicit drug use

O:
T 36.8C | BP 124/71mmHg | P 68 BPM, regular | RR 16 breaths/min, unlabored | SpO2 97% RA
H 65in | W 123 lb. | BMI 20.5

Gen: Slender, neatly groomed, looks her stated age of 31 years. AxO x3. Appears in no acute distress.
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion symmetrical. No wheezing, rhonchi, rales, dullness.
Neck: supple, no LAD, no midline c-spine tenderness, ***flexion and extension limited by pain, +spurlings***
Musculoskeletal: ***LT sided paravertebral T-spine spasm, active abduction of LT shoulder limited by pain, passive range of motion limited by pain***, normal tone, strength 5/5 in UE and LE, sensation intact, cap refill <2, 2+ radial pulses bilaterally
Neuro: Cranial nerves II-XII intact, reflexes symmetric, sensation normal, cerebellar testing WNL, EOMI, PERRL

A: timing of onset (acute vs chronic)
31 yo female with LT shoulder pain radiating to LT hand appearing with positive spurlings and ROM of neck and shoulder limited by pain on exam. Likely cervical radiculopathy.

Differential Diagnosis:
- Torticollis
- Cervical disc herniation
- Rotator cuff tear
- Adhesive capsulitis
- Biceps tendinitis
- Subacromial bursitis
- Cervical radiculopathy

better to include adduction, internal rotation, external rotation, flexion and extension

P:
Labs: None
Imaging/Tests: Shoulder XR
Cervical radiculopathy:
- NSAIDS, robaxin, ortho follow up possible neurology / neurosurgery consults if persists

Initial DDx Based on CC:	Adjusted DDx After H&P:
• Torticollis • Dystonic reaction	• Torticollis • Cervical disc herniation

- Cervical spondylosis
- Cervical stenosis
- Cancer
- Cervical spine fracture and/or dislocation
- Epidural abscess
- Vertebral osteomyelitis
- Transverse myelitis
- Temporal arteritis
- Epidural hematoma
- Cervical disk herniation
- Blunt neck trauma
- Anterior horn disease
- C1 and C2 fractures
- Cervical radiculopathy
- Shoulder Dislocation
- Anterior shoulder dislocation
- Posterior shoulder dislocation
- Inferior shoulder dislocation
- Clavicle fracture
- Humerus fracture
- Scapula fracture
- Acromioclavicular joint injury
- Glenohumeral instability
- Rotator cuff tear
- Biceps tendon rupture
- Triceps tendon rupture
- Septic joint
- Rotator cuff tear
- Impingement syndrome
- Calcific tendinitis
- Adhesive capsulitis
- Biceps tendinitis
- Subacromial bursitis
- Cervical radiculopathy
- Brachial plexus injury
- Rucksack paralysis
- Axillary artery thrombosis
- Thoracic outlet syndrome
- Subclavian steal syndrome
- Pancoast tumor
- Myocardial infarction
- Pneumonia
- Pulmonary embolism

- Epidural abscess
- Rotator cuff tear
- Adhesive capsulitis
- Biceps tendinitis
- Subacromial bursitis
- Cervical radiculopathy

OAP #3

S:
JC is a 22 y/o M endorsing no PMHx presenting with SOB and atraumatic acute CP that radiates from right to left. Patient states that he had a CXR done at CityMD 1 hour ago indicating a right ptx and was prompted to go to the ER.

Denies recent trauma, fever, chills, body aches, weight loss, palpitations, diaphoresis, orthopnea, edema, any recent procedures, sick contacts, h/o asthma, h/o HIV, h/o incarceration, or h/o smoking

PMH: Denies any
PSH: Denies any
Allergies: NKDA
Medications: Denies any intake of prescription medications
FHx: Non-contributory
SHx: Non Smoker, Denies past or present EtOH use or illicit drug use

O:
T 36.8C | BP 110/75mmHg | P 94 BPM, regular | RR 16 breaths/min, unlabored | SpO2 93% RA
H 70in | W 121 lb. | BMI 17.4

Gen: Slender, neatly groomed, looks stated age of years. AxO x3. Appears.
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: ***No breath sounds on RT***. LT Clear to auscultation and percussion bilaterally. Chest expansion symmetrical. No wheezing, rhonchi, rales, dullness.
Musculoskeletal: No signs of trauma, no focal tenderness

A:
JC is a 22 yo male with SOB and atraumatic CP appearing with no breath sounds on RT lung on exam. Likely spontaneous pneumothorax.

Differential Diagnosis:
- Tension pneumothorax
- Spontaneous Pneumothorax

P:
Labs: Type and screen, aPTT, BMP, CBC w/ diff, PT/INR, COVID, TSH, Troponin
Imaging/Tests: CXR, CT-Lung w/o contrast
Spontaneous Pneumothorax:
- Needle decompression and chest tube insertion followed by CXR to confirm placement
- Supplemental O2
- Monitor over 1-5 days

Initial DDx Based on CC:	Adjusted DDx After H&P:
• Tension pneumothorax • Iatrogenic pneumothorax • Spontaneous Pneumothorax	• Tension pneumothorax • Spontaneous Pneumothorax

SOAP #4

S:
MS is a 41 y/o F with pmh of DM2 p/w LT sided facial drooping, numbness, and weakness for the past 2 hours. Patient states that sxs started upon waking up. She endorses difficulty drinking fluids without spilling.

Denies any recent trauma, head injury, LOC, headache, dizziness, nausea, vomiting, hearing/vision changes, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory, CP, SOB ? prior episode

PMH: DM2 and HTN
PSH: 2 c-sections year?
Allergies: NKDA
Medications: Metformin and Hydrochlorothiazide
FHx: Non-contributory
SHx: Non-Smoker, Social EtOH use, Denies illicit drug use

O:
T 37.2C | BP 112/71mmHg | P 68 BPM, regular | RR 16 breaths/min, unlabored | SpO2 98% RA
H 62in | W 146 lb. | BMI 26.7

Gen: Overweight, neatly groomed, looks her stated age of 41 years. AxO x3. Appears in no acute distress.
Skin: warm, dry, ***no rashes***
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion symmetrical. No wheezing, rhonchi, rales, dullness.
Musculoskeletal: Strength 5/5 in UE and LE. Full active/passive ROM of all extremities without rigidity or spasticity. No deformity or edema throughout. Warm to touch. Negative straight leg raise B/L. Sensations intact throughout. Pulses 2+ throughout.
Neurological: ***LT sided facial drooping, inability to wrinkle the forehead, inability to voluntarily contract LT facial muscles, drooping at the LT corner of mouth, incomplete closure of LT eye, inability to puff out cheeks.*** Otherwise cranial nerves intact, reflexes symmetric, sensation normal, cerebellar testing WNL, EOMI, PERRL, no nystagmus

A:
41 yo female with LT sided facial drooping, numbness, and weakness appearing with LT sided facial drooping with sparing of forehead, drooping at the LT corner of mouth, incomplete closure of LT eye, and inability to puff out cheeks on exam. Likely Bell's Palsy.

Differential Diagnosis:
- Bell's Palsy
- CNS tumor

P:
Labs: None
Imaging/Tests: None
Bell's palsy:
- Prednisone 60mg qd x 1 wk
- Valacyclovir 1000mg TID x1 week
- Artificial tears as needed for dryness, wear protective glasses or goggles for safety, tape LT eye close at night
- Follow up with optho

Initial DDx Based on CC:	Adjusted DDx After H&P:
• Bell's Palsy	• Bell's Palsy

• CVA • Trigeminal neuralgia • Tick paralysis • Lyme Disease • Ramsay Hunt syndrome • CNS tumor • Acoustic neuroma or other cerebellopontine angle lesions • Meningioma • Facial nerve schwannoma • Cerebral Aneurysm	• CNS tumor

SOAP #5

S:
SR is a 13 y/o M with glaucoma, asthma, and a murmur who is BIB mother is presenting with intermittent postprandial palpitations that occur every 2-3 days for the past two weeks. Patient endorses that during the episodes his lips and hands turn pale. He states that these episodes are usually relieved with rest however today they were not relieved by rest prompting his mom bring him to the ER. Mother endorses FHx of thyroid disease.

Denies n/v/d/c, diaphoresis, CP, SOB, fever, chills, sick contacts, weight loss, syncope, recent trauma, headache, dizziness, visual/hearing changes

prior cardiac workup? last echo?

PMH: Glaucoma, Asthma, Heart murmur
PSH: Denies any
Allergies: NKDA
Medications: Prednisolone drops, timolol drops, albuterol
FHx: Thyroid disease
SHx: Current Smoker, Occasional EtOH use, Denies illicit drug use

O:
T 36.8C | BP 124/75mmHg | P 90BPM, regular | RR 20 breaths/min, unlabored | SpO2 96% RA
H 60in | W 45.7 kg. | BMI 18.5

Gen: Slender, well groomed, well nourished, looks of stated age of 13 years. AxO x3. Appears in no acute distress.
Skin: Warm, dry, non-icteric, intact, no rashes no lesions, no erythema
HEENT: NC/AT, PEERL, EOMI, nares patent, mucous membranes moist
Neck: Supple, no lymphadenopathy, normal ROM, no JVD, no bruits, no palpable mass
CV: RRR. ***Holosystolic murmur***, friction rubs, no gallops
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion symmetrical. No wheezing, rhonchi, rales, dullness.
Abdomen: Soft, non distended, non tender, normoactive bowel sounds, negative murphy's, no mcburney's point tenderness
Extremities: Normal tone and ROM, cap refill <2s, no edema
Neurological: Cranial nerves II to XII intact, sensation intact throughout, no gait abnormalities, cerebellar testing normal
Psych: Patient states that they feel safe at home. Denies depression/sadness (feelings of helplessness, lack of interest in usual activities, suicidal/homicidal ideation), anxiety, or ever seeing a mental health professional. Denies past or present usage of psychiatric medications

A:
13 yo male with palpitations appearing with holosystolic murmur on exam. Likely dysrhythmia.

Differential Diagnosis:
- MI
- Mitral valve prolapse
- Dysrhythmia
- Electrolyte abnormality
- Hyperthyroidism
- Anemia
- Dehydration
- Anxiety

P:
Labs: BMP, CBC, D-dimer, LFP, Magnesium, Phosphorus, TSH, T3, T4, Troponin

Imaging/Tests: ECG, CXR

Palpitations:

- Consult cardio

Initial DDx Based on CC:

- Narrow-complex tachycardias
- Wide-complex tachycardias
- AV blocks
- Second Degree AV Block Type I
- Second Degree AV Block Type II
- Third Degree AV Block
- Premature atrial contraction
- Premature junctional contraction
- Premature ventricular contraction
- Sick sinus syndrome
- Non-arrhythmic cardiac causes:
- Acute coronary syndrome
- Cardiomyopathy
- Congenital heart disease
- Congestive heart failure
- Mitral valve prolapse
- Pacemaker complication
- Pericarditis
- Myocarditis
- MI
- Valvular disease
- Panic attack
- Anxiety
- Somatic Symptom Disorder
- Alcohol
- Caffeine
- Drugs of abuse
- Tobacco
- Anemia
- Hyperthyroidism
- Pulmonary embolism
- Dehydration
- Sepsis
- Pheochromocytoma

Adjusted DDx After H&P:

- MI
- Mitral valve prolapse
- Dysrhythmia
- Electrolyte abnormality
- Hyperthyroidism
- Anemia
- Dehydration
- Anxiety

SOAP #6

S:

MR is a 52 y/o M w/ PMHx of kidney stones who is presenting w/ right flank pain that radiates down to his lower abdomen. He endorses nausea, 3 episodes of vomiting, polyuria with urinary frequency. He states that pain was initially intermittent, but is now constant, 9/10, sharp pain.

Denies any intake of OTC pain medications, fever, chills, body aches, hematuria, foul smelling urine, nocturia, oliguria, incontinence, diarrhea, constipation, rectal bleeding, blood in stool, dizziness, radiation of pain, change in appetite, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructations, jaundice, hemorrhoids, inguinal pain, penile pain, penile discharge, testicular pain, testicular swelling, concern for STDs, or trauma

PMH: Kidney Stones, ~~denies any other pmh~~
PSH: Cholecystectomy
Allergies: NKDA
Medications: Denies intake of any prescription medications
FHx: Non-contributory
SHx: 20 pack year h/o smoking, social EtOH use, denies illicit drug use

O:

T 36.6C orally | BP 143/85cmmHg | P 64 BPM, regular | RR 17 breaths/min, unlabored | SpO2 99% RA
H 67in | W 143 lb. | BMI 22.4

Gen: Overweight male dressed appropriately in hospital gown, looks stated age of 52 years. AxO x3. Appears uncomfortable and in no acute distress.
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion symmetrical. No wheezing, rhonchi, rales, dullness.
GI: **+CVA Tenderness**, abdomen soft, non-tender to palpation throughout, no guarding, no rebound tenderness, no pulsatile masses, no McBurney's sign, no psoas sign, no obturator sign
Musculoskeletal: FROM in all extremities and C/T/L-Spine. No deformity, no paravertebral tenderness, no midline tenderness, no spasm, no bilateral LE edema or swelling, or focal tenderness.

A:

52 yo male with constant right flank pain and CVA tenderness appearing on exam. Likely nephrolithiasis.

Differential Diagnosis:

- AAA
- Acute mesenteric ischemia
- Appendicitis
- Pyelonephritis
- Cystitis
- Nephrolithiasis

P:

Labs: UA, UC, CBC with diff, CMP, Lipase, Lactate WB venous, COVID
Imaging/Tests: CT w/o contrast to r/o AAA

Nephrolithiasis:

- 1000 mL of normal saline
- Tamsulosin 0.4mg PO QHS until stone is cleared

Pain:

- Ketorolac 15mg

Nausea:

- Ondansentron 4 mg

Initial DDx Based on CC:

- AAA
- Renal artery embolism
- Renal vein thrombosis
- Aortic dissection
- Mesenteric ischemia
- Pyelonephritis
- Renal cell carcinoma
- Renal infarction
- Renal hemorrhage
- Nephrolithiasis
- Blood clot
- Stricture
- Cystitis
- Biliary colic
- Pancreatitis
- Perforated peptic ulcer
- Appendicitis
- Inguinal Hernia
- Diverticulitis
- Cancer
- Bowel obstruction
- Gynecologic
- Ectopic Pregnancy
- PID/TOA
- Ovarian cyst
- Ovarian torsion
- Endometriosis
- GU
- Testicular torsion
- Epididymitis
- Other
- Shingles
- Lower lobe pneumonia
- Retroperitoneal hematoma/abscess/tumor
- Epidural abscess
- Epidural hematoma

Adjusted DDx After H&P:

- AAA
- Acute mesenteric ischemia
- Appendicitis
- Pyelonephritis
- Cystitis
- Nephrolithiasis

SOAP #7

S:

how many times

PR is a 72 y/o M with PMH of 2 MIs presenting w/ SOB and CP since last night. Pt noted acute onset of SOB w/ associated centralized CP beginning around 10pm until now. Additionally endorses worsening exertional dyspnea, PND, leg swelling, & abdominal distension. Spoke w/ granddaughter over phone. She states that he had two admissions for "heart problems" in the past and confirms that he does not take regular meds but she doesn't know his medical problems.

describe nature of pain, duration, aggravating + alleviating factors

Denies abdominal pain, fever, chills, body aches, cough, nausea, vomiting, diarrhea, sick contacts or recent travel.

PMH: Two myocardial infarctions (when?), denies any other PMH at this time and does not have with a primary doctor
PSH: Denies any surgical history
Allergies: NKDA
Medications: Denies intake of prescription medications
FHx: Non-contributory
SHx: Non-Smoker, Denies past of present EtOH use or drug use

O:

T 36.2C | BP 208/140 mmHg | P 88 BPM, regular | RR 24 breaths/min, unlabored | SpO2 94% on NRB
H 68in | W 230 lb. | BMI 35

Obese!

Gen: Slender, neatly groomed, looks his stated age of 72 years. AxO x3. Appears in no acute distress.
Skin: warm, dry, non-icteric
Head: Normocephalic atraumatic
Eyes: PERRL, EOMI

Neck: ? JVD

Ear, nose, mouth, throat: Mucous membranes moist, no erythema, airway patent, no stridor
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs, or gallops.
Pulm: ***Bibasilar crackles***. Chest expansion symmetrical. No wheezing, rhonchi, rales, dullness.
Abdomen: ***Mild distention***, otherwise abdomen soft, non-tender to palpation throughout, no guarding, no rebound tenderness ? pulsatile masses
Extremities: ***2+ pitting edema.*** No tenderness, FROM

A:

72 y/o M with no reported PMH presenting with respiratory distress w/ s/s of fluid overload, hypertensive to >200s systolic. Likely hypertensive emergency and CHF exacerbation.

Differential Diagnosis:

- MI
- Aortic Dissection
- PE
- Pericardial Tamponade
- Dysrhythmia
- Pneumonia
- Hypertensice Emergency
- CHF exacerbation

P:

Labs: eGFR, ABG, BMP, Blood culture x2, CBC with diff, Flu, Liver function panel, proBNP, procalcitonin, Covid, Troponin

Imaging/Tests: Bedside US, CXR, EKG ? echo

Hypertensive emergency:

- Nitro gtt goal BP of 140s systolic, at which point gtt titrated off.

CHF exacerbation

- Lasix after Nitro gtt
- Admit to hospitalist for CHF exacerbation

Dyspnea

- BIPAP

Initial DDx Based on CC	Adjusted DDx After H&P:
• ACS/MI • Acute Valve Dysfunction • Aortic Dissection • Dysrhythmia • Endocarditis • Hypertensive Emergency • Pericardial Tamponade • COPD • PE • Pneumonia • Pneumothorax • Pure volume overload • Renal Failure • Post-Transfusion • Sepsis • Anaphylaxis	• MI • Aortic Dissection • PE • Pericardial Tamponade • Dysrhythmia • Pneumonia • Hypertensice Emergency • CHF exacerbation

SOAP #8

S:

? duration ? witnessed ? prodrome ? why

JL is 50 y.o F w/ PMHx of HLD and DM, who presents for an episode of syncope. Patient reports that prior to arrival she was arguing with her son who was drunk at home, breaking things, and being aggressive. States that she was sitting in a chair when she passed out due to her emotional state. Reports having headache afterwards, which has now almost resolved, and some nausea.

Denies chest pain, sob, dizziness, weakness, numbness, tingling, trauma, abdomen pain, vomiting, constipation, diarrhea, dysuria, hematuria, urinary frequency/urgency, fever, chills, cough, sore throat, congestion, ear pain, suicidal/homicidal ideation or Covid19 sick contacts.

PMH: HLD, DM2
PSH: Appendectomy, C-section (years)
Allergies: NKDA
Medications: Jardiance, Janumet
FHx: Non-contributory
SHx: Married, lives at home, non- Smoker, Occasional EtOH use, Denies illicit drug use

O:

T 36.8C orally | BP 127/85 mmHg | P 72 BPM, regular | RR 18 breaths/min, unlabored | SpO2 95% RA
H 61in | W 160 lb. | BMI 30.23

Gen: Obese, neatly groomed, looks her stated age of 50 years. AxO x3. Appears in no acute distress.
Skin: Warm, dry, non-icteric, no cyanosis, no rash
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Head: Normocephalic atraumatic, no swelling, no tenderness, no bogginess
Eyes: PERRL, EOMI, no conjunctival pallor, no scleral icterus
Ear, nose, mouth, throat: Mucous membranes moist, no erythema, airway patent, no stridor
Neck: No c-spine tenderness, no stiffness
Back: No paravertebral muscle tenderness, midline tenderness, no spasm
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion symmetrical. No wheezing, rhonchi, or rales.
Musculoskeletal: FROM. No deformity, lower extremity edema, calf tenderness.
GI: Soft, non-tender to palpation throughout, no guarding, no rebound tenderness, no CVA tenderness
Neurological: Cranial nerves II-XII intact. Strength 5/5 in upper and lower extremities. Sensation intact to light touch in all extremities. Cerebellar testing normal. Gait normal. No meningismus.
Psych: Patient states that they feel safe at home. Denies depression/sadness (feelings of helplessness, lack of interest in usual activities, suicidal/homicidal ideation), anxiety, OCD or ever seeing a mental health professional. Denies past or present usage of psychiatric medications

A:

50 yo female ~~with appearing~~ with syncopal episode secondary to acute stressful event. Likely vasovagal syncope.

Differential Diagnosis:

- MI
- SAH
- TIA
- Dysrhythmia
- CHF
- Hypoglycemia
- Vasovagal Syncope

P:

Labs:

- CBC with diff
- BMP
- ProBNP
- HCGQual
- Troponin x2, r/o MI

Hypoglycemia:

- Fingerstick r/o hypoglycemia

Vasovagal Syncope:

- IV access; Normal Saline 1000 mL over 1 hr

Headache:

- Acetaminophen 650 mg

Imaging/Tests:

- ECG ro MI
- CXR

Initial DDx Based on CC:

- Dysrhythmias:
- Valvular Disease (AS, MS, tricuspid stenosis)
- Aortic Dissection
- Myocardial Infarction
- CHF
- Hypertrophic Cardiomyopathy
- PE
- Pericardial Tamponade
- Myxoma
- Pulmonary Hypertension
- Pacemaker malfunction
- Vasovagal Syncope
- Situational Syncope
- Carotid sinus stimulation
- Orthostatic hypotension-mediated syncope
- Dehydration (vomiting, diarrhea)
- Hemorrhage
- Sepsis
- Stroke
- SAH
- TIA
- Subclavian steal
- Heat syncope
- Hypoglycemia
- Asphyxiation
- Seizure
- Narcolepsy
- Psychogenic
- Toxic

Adjusted DDx After H&P:

- MI
- SAH
- TIA
- Dysrhythmia
- CHF
- Hypoglycemia
- Vasovagal Syncope