CUNY York College Physician Assistant Program Spring 2021
Gagandeep Munday
Internal Medicine Rotation – NYPQ

History and Physical 1

Identifying Data:
Name: JP
Age: 64 years
Sex: Male
Race: African American
Date & Time: 3/15/2021, 10:00 AM
Date Admitted: 3/6/2020
Location: NYPQ
Source of Referral: None
Source of Information: NH/ family (when available)
Mode of Transport: EMS

Chief Complaint:
Sent by NH for large suspicious neck mass

History of Present Illness:
JP is a 64-year-old unreliable non-verbal African American male with a significant past medical history of seizure disorder, BPH, DM2, ICH after a fall, s/p craniotomy and left lobectomy, Trach to Vent with a PEG, recurrent MDR UTI & PNA, recurrent epistaxis sent from NH to ED on 3/5/21 for acute episode of epistaxis x1 day and a right neck mass of unknown duration. JP was taken for outpatient CT by NH on 3/4/21 which was suspicious for carcinoma. He was admitted on 3/6/21 for poor condition, nasopharyngeal mass, low H/H, and elevated WBCs 2/2 *Providencia Stuartii* UTI. At baseline JP is bedbound, awake but unresponsive and non-verbal. Information included in the HPI was obtained from NH and from patient's brother (LP) and sisters (JP & TS).

Past Medical History:
Present illness:
- Seizure disorder x unknown years
- DM2 x unknown years
- BPH x unknown years

Past illness:
- Unknown

Hospitalizations:
- NH states that patient has been previously hospitalized 2x last year for recurrent UTIs and recurrent epistaxis.

Immunizations:
- NH states that JP has received influenza and pneumococcal vaccine

Screening:
- JP's family is unsure the dates of his last colonoscopy.

Past Surgical History:
- 2008 craniotomy and left lobectomy

- Remote trach to vent
- Remote PEG

Medications:

1. **Ipratropium-albuterol** 0.5 mg-2.5 mg/3 mL inhalation solution: Hx, 3 milliliter(s) inhaled 4 times a day -Indication: chronic respiratory failure
2. **Senna** 8.6 mg oral tablet: Hx, 1 tab(s) by gastrostomy tube 2 times a day -Indication: constipation
3. **Flomax** 0.4 mg oral capsule: Hx, 1 cap(s) by gastrostomy tube once a day -Indication: urinary retention
4. **Lactulose** 10 g/15 mL oral solution: Hx, 30 milliliter(s) by gastrostomy tube every 48 hours -Indication: constipation
5. **Ativan** 2 mg/mL injectable solution: Hx, 2 milligram(s) injectable once, As Needed -Indication: Status Epilepticus
6. **metFORMIN** 500 mg oral tablet: Hx, 1 tab(s) by gastrostomy tube 2 times a day -Indication: DM
7. **Lantus** 100 units/mL subcutaneous solution: Hx, 14 unit(s) subcutaneous once a day (at bedtime) -Indication: DM
8. **NovoLOG FlexPen** 100 units/mL injectable solution: Hx, 1 dose(s) injectable 3 times a day (with meals) -Indication: DM Sliding Scale
9. **Famotidine** 20 mg oral tablet: Hx, 1 tab(s) by gastrostomy tube 2 times a day -Indication: Gastritis
10. **Acetaminophen** 325 mg oral tablet: Hx, 2 tab(s) by gastrostomy tube 4 times a day, As Needed -Indication: pain
11. **Vimpat** 50 mg oral tablet: Hx, 1 tab(s) by PEG tube 2 times a day -Indication: seizures
12. **Vimpat** 200 mg oral tablet: Hx, 1 tab(s) orally 2 times a day -Indication: seizures

Allergies:

JP's family and NH deny any known allergies to medications, foods, or environmental factors.

Family History:

JP's family states that their parents had HTN and DM, however they deny any h/o cancer.

Social History:

Habits:

Family denies any history of drinking, smoking, or illicit drug use.

Travel:

No recent travel.

Marital History:

JP is a widower, has one daughter.

Sexual History:

Unable to obtain.

Home:

JP lives in skilled nursing facility.

Diet:
JP receives tube feedings of Glucerna, 1560 mL over 24 hours, Juven 1 pack via PEG BID, and 200 mL of water every 8 hours.

Review Of Symptoms:
Unable to obtain due to patient's baseline status of A&O x 0

Physical Exam:
Vital Signs:
Blood Pressure: 125/76 (right arm, supine)
Heart Rate: 61 beats/minute (regular)
Respiration Rate: 20 breaths/minute (nonlabored)
Temperature: 97.5F (oral)
O_2 Sat: 100% (on vent)
Height: 5'9''
Weight: 173 lbs
BMI: 25.5

General Appearance:
64-year-old well-groomed male lying supine in hospital bed. At baseline. A/O x 0. Unresponsive, chronically bed bound. No indications of acute distress.

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

Nails: No clubbing, no infection, capillary refill <2 sec throughout.
Hair: Average quantity and distribution, no signs of alopecia, seborrhea, or lice.

Head:
Normocephalic, atraumatic; nontender to palpation throughout. No signs of alopecia, seborrhea, or lice.

Eyes:
Symmetrical OU without evidence of strabismus or ptosis. Sclera white, conjunctiva and cornea clear. PERRL.
Visual Acuity: Unable to conduct due to patient's baseline mental status.
Fundoscopy: Not assessed.

Ears:
Symmetrical and normal size. No evidence of lesions, masses, or trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TMs pearly gray and intact with light reflex in appropriate position AU. Auditory acuity intact to whisper AU.

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

Sinuses:
Nontender to palpation and percussion over bilateral frontal and maxillary sinuses.

Mouth and Pharynx:

Lips: Pink, moist, no evidence of cyanosis or lesion.
Mucosa: Pink; well hydrated. No masses. Lesions noted. No evidence of leukoplakia.
Palate- Pink, well hydrated. Palate intact with no lesions, masses, or scars.
Teeth: **Poor dentition**
Gingiva: Pink and moist without evidence of hyperplasia, masses, lesions, erythema or discharge.
Tongue: Pink, well papillated. No masses, lesions or deviation noted.
Oropharynx: Well hydrated without evidence of injection, exudate, masses, lesions, or foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink without edema or lesions.

Neck:
Large mass on the right side of the neck.
Tracheostomy in place, no bleeding.
Trachea midline. No lesions, scars, pulsation noted. Supple, nontender to palpation. FROM no stridor noted. Thyroid non-tender, no thyromegaly.

Chest:
Normal breathing effort. Symmetrical, no deformities, no signs of trauma. Lateral:AP diameter 2:1. Non-tender to palpation.

Lungs:
Clear to auscultation bilaterally without rales, rhonchi, or wheezes.

Cardiovascular:
Regular rate and rhythm (RRR); S1 and S2 are normal. **Soft systolic murmur at apex**. No S3, S4, splitting of heart sounds, friction rubs or other extra sounds. Carotid pulses are 2+ bilaterally without bruits.

Abdomen:
Flat and symmetrical without evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. 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.

Genitourinary:
Not assessed.

Rectal:

Not assessed.

Peripheral Vascular:

Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. **Non-pitting Edema to B/L ankles**. No clubbing or cyanosis noted bilaterally. No stasis changes or ulcerations noted.

Musculoskeletal:

No soft tissue swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. Non-tender to palpation and without crepitus throughout. FROM in all upper and lower extremities bilaterally.

Neurological:

Mental Status:

Alert and oriented x 0

Cranial Nerves:

I – Not assessed.
II- Unable to assess due to mental status
III-IV-VI- PERRL, unable to assess EOM due to mental status.
V- Unable to assess due to mental status.
VII- Unable to assess due to mental status.
VIII- Unable to assess due to mental status.
IX-X-XII-XI- Unable to assess due to mental status

Motor/Cerebellar:

Full passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. No limb drift. Unable to assess gait or fine finger movements.

Sensory:

Unable to assess due to mental status.

Reflexes: 2+ throughout.

Meningeal Signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative.

Labs:

143 | 111 | 16.5
----------< 99 Ca: 8.5 P: 3.2 Mg: 2.2 Anion Gap: 9 [03/15 @ 07:37]
3.8 | 23 | 0.90

WBC: 13.93 / Hb: 7.7 (MCV: 77.6) / Hct: 27.7 / Plt: 382 [03/15 @ 07:37]

Prot: 7.0 / Alb: 3.3 / Bili: 0.2 / AST: 28 / AlkPhos: 69 [03/15 @ 07:37]

WBC: 13.52 / Hb: 7.4 (MCV: 76.0) / Hct: 25.7 / Plt: 383 [03/14 @ 20:11]

144 | 112 | 16.4
----------< 110 Ca: 8.4 P: 4.0 Mg: 2.3 Anion Gap: 13 [03/14 @ 08:09]
4.9 | 19 | 0.80

Prot: 7.5 / Alb: 3.4 / Bili: 0.3 / AST: 37 / AlkPhos: 76 [03/14 @ 08:09]
WBC: 13.60 / Hb: 8.3 (MCV: 73.5) / Hct: 28.3 / Plt: 435 [03/13 @ 13:28]

Urinalysis:
Color light yellow / Appearance clear / SG 1.027
Ketones negative / Bili negative / Urobili negative
Protein negative / Nitrite negative
Leuk Esterase positive / RBCs 2/ WBC 1/ Bacteria positive

Urine culture: *Providencia Stuartii* susceptible to meropenem

FNA of neck mass: findings positive for malignant cells, cytomorphologically consistent with carcinoma

Imaging:

CT Neck - Large lobular enhancing mass in the pharynx extending from oropharynx to infraglottic region causing complete occlusion of the upper airways measuring up to 4.2 x 5.0 x 9.8 cm, possibly a primary pharyngeal carcinoma. Right lateral neck mass measuring up to 8.5 x 6.8 x 6.4 cm, possibly metastatic nodal mass. Additional scattered bilateral subcentimeter short axis lymph nodes.

CXR:
Study limited by low lung volumes/poor inspiration. Tracheostomy in situ. Mild diffuse reticular opacities are again appreciated throughout both lungs. Stable bandlike atelectasis or linear scar in the right midlung. No pleural effusion or pneumothorax.

Assessment:
Patient is 64 y/o nonverbal M with PMH seizure disorder, BPH, DM2, ICH after a fall, s/p craniotomy and left lobectomy, Trach to Vent with a PEG, recurrent MDR UTI & PNA, recurrent epistaxis, sent from NH to ED for right neck mass. Patient s/p trach and vent dependent for chronic respiratory failure in the past. Patient completed an outpatient CT which showed a large mass suspicious for carcinoma. Patient is non verbal at baseline. Likely Head/Neck cancer.

Plan:
Nasopharyngeal mass 2/2 to Locally Advanced Head/Neck Cancer

- CT Neck - Large lobular enhancing mass in the pharynx extending from oropharynx to infraglottic region causing complete occlusion of the upper airways measuring up to 4.2 x 5.0 x 9.8 cm, possibly a primary pharyngeal carcinoma. Right lateral neck mass measuring up to 8.5 x 6.8 x 6.4 cm, possibly metastatic nodal mass. Additional scattered bilateral subcentimeter short axis lymph nodes.
- ENT consulted: FNA of right neck mass done, findings positive for malignant cells, cytomorphologically consistent with carcinoma
- Hematology/oncology consulted and concluded that patient is with locally advanced head/neck cancer with very poor performance status, patient is not candidate for systemic/definitive oncology treatment.
- Palliative care consulted, current diagnosis and prognosis was discussed with the family. Family decision was to continue all current treatment.

Anemia, possibly in setting of recurrent epistaxis at NH, multifactorial

- Patient was transfused and responded appropriately
- Occult negative, Iron deficient started on ferrous sulfate tabs
- H/H on discharge

Providencia Stuartii UTI, completed course of meropenem and ceftriaxone, no further treatment necessary.

Chronic respiratory failure s/p ICH

- AC VC vent support 12/400/40 % PEEP - 5
- Suction airways as per routine
- Bronchodilators prn

Seizure disorder

- Continue Lacosamide 250mg BID via PEG

DM2

- Continue present regimen

BPH

- Continue Tamsulosin 0.4mg daily per PEG.