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

History and Physical

Identifying Data:
Name: PS
Age: 88 years
Sex: Female
Race: Hispanic
Date & Time: 3/08/2021, 3:00 PM
Date Admitted: 3/08/2021
Location: NYPQ
Source of Referral: None
Source of Information: Self
Mode of Transport: EMS

Chief Complaint:
Vision changes in both eyes for 1 hour last night

History of Present Illness:
PS is an 88yo reliable female with PMH of obesity, CAD s/p triple bypass in 2006, Hyperlipidemia, Asthma presented with acute onset of loss of vision in both eyes, left total and right eye temporal field. Episode occurred on 3/7/21 for 1 hour from 10 pm to about 11 pm as she was lying in her bed, she fell asleep after the episode was over. States that her daughter prompter her to come to ED for further evaluation. Denies any current symptoms. Denies any recent COVID infection or possibility of recent exposure.

She denies fever, chills, headache, numbness, weakness, tingling, facial droop, aphasia, prior h/o strokes, seizures, loss of consciousness, trauma, nausea, vomiting, diarrhea, coughing, wheezing, chest pain, palpitations, or any other symptoms.

Past Medical History:
Present illness:
- HLD x 50 years
- Asthma x 70 years

Past illness:
- Unknown

Hospitalizations:
- Denies any past hospitalizations.

Immunizations:
- She received the influenza vaccine and pneumonia vaccine. Is waiting to get COIVD vaccine.

Screening:
- Last mammogram and colonoscopy were both 15 years ago. Denies any abnormal results in the past.

Past Surgical History:
- Triple bypass 2006, unable to recall hospital.

Medications:

1. Advair Diskus 250 mcg-50 mcg inhalation powder 1 puff(s) inhaled 2 times a day - Indication: Asthma
2. Aspirin 81 mg oral tablet 1 tab(s) orally once a day -Indication: CAD
3. IBU 600 mg oral tablet 1 tab(s) orally 4 times a day x 7 days -Indication: Pain
4. Lipitor 40 mg oral tablet 1 tab(s) orally once a day (at bedtime) -Indication: HLD

Allergies:

Denies any known allergies to medications, foods, or environmental factors.

Family History:

Patient states she is unaware of the medical history of her parents. Her daughter has HTN and HLD.

Social History:

Habits:
Denies past or present use of tobacco, alcohol, or any illicit drugs.
Travel:
Denies as recent travel.
Marital History:
PS is a widow.
Sexual History:
Unable to obtain.
Home:
PS lives with her daughter.
Diet:
PS eats a regular diet and mostly cooks for herself.

Review Of Symptoms:

General:

Denies fever, chills, night sweats, fatigue, weakness, loss of appetite, and recent weight loss or gain.

Skin, Hair, Nails:

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

Head:

Denies headache, vertigo, head trauma, or loss of consciousness.

Eyes:

Denies use of prescription glasses. She denies visual disturbances, fatigue, lacrimation, photophobia, or pruritus. Last eye exam was 4 years ago, does not know baseline visual acuity.

Ears:

She denies any deafness, pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses:

She denies any discharge, epistaxis, or obstruction.

Mouth and throat:

She denies any bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures.

Neck:

She denies localized swelling/lumps, stiffness, or decreased range of motion.

Breast:

She denies any lumps, nipple discharge, or pain.

Pulmonary:

She denies dyspnea, SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, and PND.

Cardiovascular:

She has a history of hypertension. She denies chest pain, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, and a known heart murmur.

Gastrointestinal:

She denies any changes in appetite, intolerance to foods, nausea and vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool, or flank pain.

Genitourinary:

She denies any frequency, changes in the color of her urine, incontinence, dysuria, nocturia, urgency, oliguria, polyuria, anorgasmia, sexually transmitted infections, or use of contraception.

Menstrual and Obstetrical:

PS is menopausal and states that her last period was “a long time ago.”

Obstetrical History: G1P101

Musculoskeletal:

She denies any muscle/joint pain, deformity or swelling, redness, or arthritis.

Peripheral Vascular:

She denies any intermittent claudication, coldness, trophic changes, varicose veins, peripheral edema, or color changes.

Hematologic:

She denies any history of anemia, easy bruising or bleeding, lymph node enlargement, or history of DVT/PE.

Endocrine:

She denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, and hirsutism.

Nervous System:

Self-reports an episode of vision loss lasting 1 on 3/7/2021 for which she came to the ED. She denies any history of seizures, aphasia, loss consciousness, numbness, paresthesia, loss of strength, or weakness.

Psychiatric:

She denies any depression/sadness anxiety, obsessive/compulsive disorder, or history of seeing mental health professionals.

Physical Exam:

Vital Signs:

Blood Pressure: 125/79 (right arm, sitting)
Heart Rate: 74 beats/minute (regular)
Respiration Rate: 18 breaths/minute (nonlabored)
Temperature: 97.7F (oral)
O_2 Sat: 97% (room air)
Height: 5’5’’
Weight: 154 lbs
BMI: 25.6

General Appearance: 88-year-old well-groomed female. A/O x 3. She appears her stated age. In no 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. Visual fields full bilaterally. PERRLA. EOMI without nystagmus.

Visual Acuity: Unable to identify the letters on the Snellen Eye chart; appears frustrated because she feels like she should know them.

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: Good dentition without obvious dental caries.
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:

Trachea midline. No masses, lesions, scars, pulsation noted. Supple, nontender to palpation. FROM no stridor noted. Thyroid non-tender, no palpable masses, 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. There are no murmurs, 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.

Breast:

Not assessed.

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. No clubbing, cyanosis or edema 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 to person, place, and time. Patient dressed in a hospital gown. Patient is cheerful with insight and judgement intact. Memory and attention are intact. Digit span and serial 7s were accurate. Remote memory intact. Receptive and expressive abilities intact. Communication coherent, audible, clear & distinct with even rhythm. Conversation progressed logically. Able to follow two stage commands, repeat words, name objects, and write a sentence. No dysarthria, dysphonia, or aphasia noted. Clock drawing is good. Calculations intact. No evidence of delusions, hallucinations, phobias, or obsessions. Denies suicidal ideation, extreme emotions, depression, and anxiety

Cranial Nerves:
I – Not assessed.
II- OD =20/40, OS = 20/40, OU = 20/40. Visual fields by confrontation full. Fundoscopy not assessed.
III-IV-VI- PERRLA, EOM intact without nystagmus.
V- Facial sensation intact, strength good.
VII- Facial movements symmetrical and without weakness.
VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.
IX-X-XII- Swallowing intact. Uvula elevates midline. Tongue movement intact without deviation. XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar:
Full active and passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength 5/5 throughout. No limb drift. Gait normal with no ataxia. Fine finger movements intact.

Sensory:

Intact to light touch, sharp/dull, and vibratory sensation.

Reflexes: 2+ throughout.

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

Labs:

138 | 102 | 23.1
----------< 86 Ca: 9.4 Anion Gap: 10 [03/08 @ 09:51]
x | 26 | 1.11

WBC: 6.89 / Hb: 15.1 (MCV: 91.9) / Hct: 47.5 / Plt: 265 [03/08 @ 09:51]
-- Diff: N:61.0% L:28.30% Mo:7.5%

Prot: 7.0 / Alb: 4.1 / Bili: 0.5 / AST: x / AlkPhos: x [03/08 @ 09:51]

EKG- A-fib

Imaging:

MRI brain without gad(3/8/2021):
No acute intracranial abnormality. Mild chronic microvascular disease. Nonspecific and ill-defined foci of T2 signal within the calvarium. Recommend further evaluation with nuclear medicine bone scan.

CTA head/neck with contrast(3/8/2021):
No significant vascular stenosis in the neck. No significant vascular stenosis or occlusion in the head.

CTA Head CT Head/Brain without contrast(3/8/2021)
Unremarkable CT examination of the head without contrast. No evidenceof acute intracranial hemorrhage.

Assessment:
Patient is 88yo Spanish speaking female with PMH of obesity, CAD s/p triple bypass in 2006, Hyperlipidemia, Asthma presented with acute onset of loss of vision in both eyes left total and right eye temporal field on 3/8/2021. Patient evaluated by Ophthalmology who recommended stroke referral. On initial stroke evaluation BP noted to be 154/84, NIHSS = 0. CT Head negative for ICH, CTA head and neck without high grade stenosis or LVO. Patient not candidate for tPA as out of time window from LKW. Patient was also found with new onset Afib, CHA2DS2-VASc = 3, and started on eliquis, MRI without acute infarct. HbA1c 5.3, LDL 123. TTE pending. Etiology likely cardioembolic from underlying afib. Patient admitted for further stroke workup.

Plan:
1. Possible acute transient ischemic cerebrovascular event in setting of newly dx AF (IN ED on ECG)
2. ABCD-4 for age, BP, duration, loss of vision

3. Admit to stroke unit
    a. Telemetry while in house
    b. Neuro check q4hr
    c. Permissive HTN with SBP 130-160
4. TTE without bubble study
5. Labs:
    a. HbA1c, CBC, CMP, Coags, T&S, Lipid panel with LDL, TSH, B12/folate, homocysteine
6. For new onset of AF- f/u CE, pro-BNP, ESR, CRP, TSH
7. A-fib
    a. Eliquis 5 mg BID, continue Lipitor 40mg
    b. DVT ppx- on Eliquis
8. Does not need speech and swallow evaluation, swallow screening passed in ED