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

History and Physical

Identifying Data:

Name: MM
Age: 68 years
Sex: Male
Race: Hispanic
Date & Time: 3/10/2021 11:00 AM - 3/22/2021 4:00 PM
Date Admitted: 3/8/2021
Location: NYPQ
Source of Referral: None
Source of Information: Self
Mode of Transport: Walk in

Chief Complaint:

Difficulty tolerating solids and liquids x3-4 days

History of Present Illness:

68 y/o M with pmh of HTN, HLD, DM, Charcot foot s/p surgery of RLE >10 years ago, currently on PO bactrim for LLE cellulitis and edema, referred from CityMD for dysphagia evaluation. Patient reports that he's been having difficulty tolerating solids and liquids x3-4 days. When he eats, he has a sensation of food feeling stuck after he initiates swallowing and often has refluxing of liquid. Denies nausea/vomiting, abdominal pian, chest pain, shortness of breath, back pain, sore throat, or unintentional weight loss. Denies history of GERD. No smoking history. Reports social ETOH use months ago. Of note, patient had a biopsy for elevated PSA 1 week ago and denies known history of malignancy.

Past Medical History:

Present illness:

- Hypertension x 30 years
- Hyperlipidemia x 25 years
- DM1 x 60 years
- Charcot foot x 10 years

Past illness:

- Unknown

Hospitalizations:

- Patient denies any past hospitalizations

Immunizations:

- Reports that he gets his influenza vaccine annually
- Has not received COVID vaccine at this time

Screening:

- States that he had a colonoscopy 8 years ago, never had abnormal results in the past

Past Surgical History:

- Right foot fixation 10 years ago.
- Denies any other surgeries, injuries, or blood transfusions in the past

Medications:

Metoprolol Tartrate Tab 25 mg Oral q12h
Heparin Inj 5000 UNIT Subcutaneous tid
Atorvastatin Tab 40 mg Oral bedtime
Ezetimibe Oral 10 mg Oral Daily
Insulin Glargine Inj (Lantus) 30 UNIT Subcutaneous bedtime
Pantoprazole Delayed Release Tab +R+ 40 mg Oral Daily
Gadobutrol (Gadavist) 1mmol/ml 15 ml IV PUSH Once

Allergies:

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

Family History:

Patient is unaware of any family medical history.

Social History:

Habits:

States that he does not smoke tobacco or take any illicit drugs to their knowledge. He drinks alcohol socially, last drink was >3 months ago.

Travel:

Denies any recent travel

Marital History:

Is currently married to his wife and has two children.

Sexual History:

Heterosexual, monogamous with wife, denies any use of protection. Denies h/o STDs.

Home:

Lives with wife and two kids in an apartment.

Diet:

MM eats a regular diet and mostly eats home cooked meals made by his wife.

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:

He wears glasses for myopia. He denies visual disturbances, fatigue, lacrimation, photophobia, or pruritus. He is unable to recall his last eye exam.

Ears:

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

Nose/Sinuses:

He denies any discharge, epistaxis, or obstruction.

Mouth and throat:

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

Neck:

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

Breast:

He denies any lumps, nipple discharge, or pain.

Pulmonary:

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

Cardiovascular:

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

Gastrointestinal:

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

Genitourinary:

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

Menstrual and Obstetrical:

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

Obstetrical History: G2P202

Musculoskeletal:

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

Peripheral Vascular:
He denies any intermittent claudication, coldness, trophic changes, or varicose veins.

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

Endocrine:
He denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, and hirsutism.

Nervous System:
He denies any history of seizures, loss consciousness, numbness, paresthesia, loss of strength, or weakness.

Psychiatric:
He 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:
68-year-old well-groomed male. A/O x 3. He appears his 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: 20/20 OD, 20/20 OS, 20/20 OU

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.

Genitourinary:

Not assessed.

Rectal:

Good tone. No obvious signs of bleeding. No hemorrhoids. Fecal occult blood negative.

Peripheral Vascular:

+3 b/l LE pitting edema with chronic venous stasis changes. **Bandages covering left lower extremity**. Upper extremities are normal in color and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing or cyanosis noted bilaterally. **Right foot plantar heel ulcer and left foot fifth digit ulcer.**

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-20/20 OU. 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:

135 | 98 | 11.0
--------------------< 199 Ca: 8.8 Anion Gap: 8 [03/22 @ 10:12]
4.8 | 29 | 1.70

WBC: 4.96 / Hb: 11.9 (MCV: 85.6) / Hct: 39.8 / Plt: 176 [03/22 @ 10:12]

137 | 99 | 9.8
--------------------< 126 Ca: 8.5 Anion Gap: 11 [03/21 @ 06:45]
5.1 | 27 | 1.64

WBC: 6.00 / Hb: 12.1 (MCV: 85.9) / Hct: 39.0 / Plt: 176 [03/21 @ 06:45]

PT: 12.2 / PTT: x / INR: 1.03 [03/21 @ 06:45]

Imaging:

3/22/21 VL Venous Doppler Bilateral
There is **no evidence of deep or superficial venous thrombosis** in bilateral lower extremities. There is deep venous insufficiency in bilateral lower extremities. There is **severe venous insufficiency** in left great saphenous vein and moderate venous insufficiency of the right great saphenous vein with superficial vein diameters and venous reflux times as tabulated above.

3/22/21 FL speech evaluation - Video Fluoro
Persisting deficits include **mild oral clearance deficits that clear with spontaneous multiple swallows**, delayed initiation of pharyngeal swallow response, impaired soft palate elevation, impaired hyolaryngeal elevation/excursion, partial epiglottic inversion, incomplete laryngeal vestibular closure at the height of the swallow, and impaired base of tongue to posterior pharyngeal wall contact.

Patient with improved hyolaryngeal elevation/ excursion, epiglottic inversion, and base of tongue to posterior pharyngeal wall contact as compared to previous study.

Patient with persisting pharyngeal clearance deficit that continues to be most significant at the level of the valleculae. Patient is sensate to the vallecular and pharyngeal residue. He elicits volitional multiple swallows which, at times, results in return of pharyngeal residue to the oral cavity. Pharyngeal residue eventually clears with cued multiple effortful swallows and/or thin liquid wash. Patient with improved airway protection this study. There is transient laryngeal penetration visualized during the swallow of thin liquid via spoon, thin liquid via cup, and with ground solids. Transient laryngeal penetration is also visualized after the swallow of thin liquid via cup, however, the endolarynx is clear upon completion of the swallow. Superficial laryngeal penetration that remains above the level of the vocal folds and is not ejected from the airway upon completion of the swallow, is visualized during and after the swallow of thin liquid via straw and after the swallow of particulate solids. Deep laryngeal penetration, that contacts the level of the vocal folds and is ejected from the airway upon completion of the swallow, is visualized after the swallow of puree. No aspiration is visualized across all trialed consistencies.

Overall, patient with **improved oral and pharyngeal swallow phases** as compared to previous video fluoroscopic swallow study (3/10/21).

Risk of aspiration remains elevated given oral and pharyngeal swallow deficits described above and persisting pharyngeal clearance deficit. A ground solids diet texture and thin liquids via small, single bites/ sips, use of multiple effortful swallows per bite/ sip, alternating liquids and solids, and with aspiration precautions during p.o. intake was recommended. Results and recommendations of Video Fluoroscopic Swallow Evaluation reviewed with patient who verbalizes understanding.

3/17/21 CT Abdomen Pelvis
Right external iliac and pelvic sidewall lymphadenopathy. A PET-CT scan could be performed when the patient's condition permits to assess for the presence of active malignancy.
Marked prostatic enlargement with probable changes of chronic bladder outlet obstruction.

3/17/21 EE EMG Muscle Test
1. Bilateral sensorimotor axonal/demyelinating median mononeuropathy across the wrist (CTS), R>L. Findings on the right are severe and mild-moderate on the left side.
2. Bilateral ulnar demyelinating and axonal sensorimotor mononeuropathy across the elbow segments (as seen in Cubital Tunnel Syndrome).
3. Superimposed motor demyelinating polyneuropathy, given conduction velocity slowing affecting bilateral ulnar nerves between wrist-below elbow segments and right median nerve between wrist-elbow segment and R ulnar DL; although these finding may possibly be due to the median and ulnar compressive mononeuropathies at the wrist and elbows, with the slowing being secondary to axonal loss of fast conducing fibers.
4. **Repetitive Nerve Stimulation (RNS) of bilateral facial nerves reveals dysfunction across the NMJ as seen in MG.**
5. There is no evidence of cervical radiculopathy or myopathy affecting the left arm.

3/17/ CT Lung
No CT evidence of suspicious mediastinal masses.
Atelectasis at the lung bases, right greater than left.

Moderate coronary arterial calcifications.

3/17/21 IR Lumbar Puncture
Successful lumbar puncture under fluoroscopic guidance.

3/12/21 MRI Cervical Spine
Study degraded by motion.
Mild subluxation at the t1-2 level.
Central disc/osteophyte complex at the c3-4 level with minimal anterior cord flattening.
Disc/osteophyte complexes at the c7-t1 level resulting in mild bilateral foraminal stenosis.
Grossly unremarkable spinal cord.

3/12/21 MRI Brain
Unremarkable mri of the brain without contrast.
Left frontal scalp lipoma

3/10/21 FL speech Eval- Video Fluoro
There is **diffuse pharyngeal residue that remains after the primary swallow**, most significant at the level of the valleculae. Patient is sensate to vallecular residue and elicits volitional multiple swallows with return of pharyngeal residue to the oral cavity. Pharyngeal residue eventually clears with spontaneous multiple swallows. **Solid trials are deferred given pharyngeal clearance impairment**. There is evidence of esophageal retention with diffuse hypoperistalsis, as per the radiologist. Deep laryngeal penetration, that contacts the level of the vocal folds and is ejected from the endolarynx upon completion of the swallow, is visualized after the swallow of thin liquid via spoon. Superficial laryngeal penetration, that remains above the level of the vocal folds and is not ejected from the endolarynx upon completion of the swallow, is visualized after the primary swallow of thin liquid via single cup sip. Supraglottic Swallow strategy, Three Second Bolus Hold strategy, Chin Tuck head posture, and Head Tilt Back head posture does not eliminate laryngeal penetration during/ after the swallow of thin liquid. There is deep laryngeal penetration that occurs after the primary swallow of nectar thick liquid via spoon and via cup sip. Nectar thick barium clears from the endolarynx upon completion of the swallow with nectar thick liquid via spoon. Residual nectar thick barium remains within the endolarynx with nectar thick liquid via cup. The patient is sensate and produces volitional multiple swallows when there is nectar thick liquid barium in the endolarynx, however this is ineffective in clearing the nectar thick barium from the endolarynx. Effortful swallow strategy with nectar thick liquid via cup does not eliminate laryngeal penetration, however partially improves pharyngeal clearance. Aspiration is visualized after the swallow of nectar thick liquid via straw. The patient is sensate and produces a volitional cough response when there is nectar thick liquid barium in the airway, however this is ineffective in clearing the aspirated material from the airway. Superficial laryngeal penetration is visualized after the primary swallow of honey thick liquid via spoon and is not ejected from the airway upon completion of the swallow. Deep laryngeal penetration, that contacts the level of the vocal folds and is ejected from the airway upon completion of the swallow, is visualized during and after the swallow of honey thick liquid via cup. Multiple effortful swallows strategy does not eliminate laryngeal penetration, however partially improves pharyngeal clearance. Head tilt back head posture with honey thick liquid via cup reduces laryngeal penetration. No laryngeal penetration or aspiration is visualized with puree throughout this evaluation. No aspiration is visualized with thin liquid nor honey thick liquid throughout this evaluation.

Etiology of dysphagia is unclear at this time. A neurological work up, specifically neuromuscular assessment, is recommended to determine etiology of acute onset of dysphagia.

3/8/21 XR RT Foot 2 views
On the right, there is sclerosis and fusion across the intertarsal as well as tarsometatarsal joints. In addition, there is lateral dislocation of the second through fifth tarsometatarsal joints, most likely chronic in nature, given the presence of fusion at that location**. A pes planus deformity is also appreciated Diffuse marked swelling of the soft tissues is noted, along with plantar ulcers**. **Faint cortical erosion is noted involving the tarsal bones in the medial aspect of the fluid, raising the possibility of osteomyelitis**. This diagnosis could be confirmed with a triple phase bone scan or MRI.
On the left, there is moderate degree of soft tissue swelling, with questionable ulcers in the lateral aspect of the foot. There are some degenerative changes in the intertarsal and tarsometatarsal joints, as
well as some fusion across the tarsometatarsal joints. Destructive changes are noted involving the distal aspect of the fifth proximal phalanx, fifth middle phalanx and possibly the fifth distal phalanx, uncertain if related to prior surgical resection or osteomyelitis.
Again, these findings could be confirmed with MRI and/or triple phase bone scan.

3/8/21 CT Neck, Soft Tissue w/ contrast
No evidence of acute pathology within the neck.
Small amount of gas is noted within the esophagus. Please note evaluation of the esophagus is limited on CT scan.

Assessment:

58 y/o M with a medical history of HTN, HLD, DM, Charcot foot s/p surgery of RLE >10 years ago, at ED visit was on PO bactrim for LLE cellulitis and edema, referred from CityMD for dysphagia evaluation on 3/7/21. Patient reports that he has been having difficulty tolerating solids and liquids x3-4 days. When he eats, he has a sensation of food feeling stuck after he initiates swallowing and often has refluxing of liquid. No nausea/vomiting, abdominal pian, chest pain, shortness of breath, back pain, sore throat or unintentional weight loss. Denies history of GERD. No chest pain or smoking history. Denies previous h/o upper endoscopy but reports having a colonoscopy on 11/2020 revealing polyps which were removed. Denies current ETOH use. Reports social ETOH use months ago. Patient admitted on 3/7/21 for workup of oropharyngeal dysmotility. Nerve conduction velocity of the face consistent with MG. Noted to have right foot plantar heel ulcer and left foot fifth digit ulcer, non-infected and bilateral lower extremity lymphedema, no acute interventions were needed as per podiatry.

Plan:

#MG, presenting with oropharyngeal dysphagia
- NCV face +ve for MG w/ abnormal NCS/EMG of the arms and RNS of bilateral facial nerves
- No Need of IVIG
- LP done and CSH Negative for malignant cells, Few lymphocytes and degenerative cells
- CSG protein 232
- EGD on 3/10 initially demonstrates diffuse hypoperistalsis, neg lesions as per the radiologist.
- Esophageal biopsy = benign squamous epithelium, negative for significant pathology

- Tolerating modified diet of ground solids diet texture (dysphagia 2) with thin liquids as indicated by speech pathology, with some difficulty
- ENT eval done, no upper airway pathology noted on exam, CT Neck reviewed, advised to f/u GI and Neurology recommendations as listed below
- Continue PPI pantoprazole 40 mg
- Monitor CMP, FS, BS
- Wound care for ulcers, see podiatry recc below
- DVT prophylaxis

Neurology was consulted and recommended the following:
- Mestinon 60mg: 1.5 tab tid, showing improvement
-As outpatient Artane 1mg bid to counteract peripheral cholinergic effects of Mestinon, Artane is non formulary and now on Glycopyrrolate
-Supportive care

Gastroenterology consulted and recommended the following:
-Po diet as tolerated
-S/S f/u
-Mestinon
-Add Loperamide 2mg qam for diarrhea
-f/u Ach ab

Speech pathology consulted and recommended the following:
1. Ground solids diet texture (dysphagia 2) with thin liquids
2. Small bites/ sips
3. Multiple effortful swallows per bite/ sip to facilitate oropharyngeal clearance
4. Alternate liquids and solids to facilitate pharyngeal and esophageal clearance
5. Aspiration precautions
6. Dysphagia improved from severe to moderate dysfunction on 3/22

#Right foot plantar heel ulcer and left foot fifth digit ulcer, non-infected and bilateral lower extremity lymphedema
Podiatry consulted and recommended the following:
- AVSS, no leukocytosis
- X-rays results: cortical erosions likely due to chronic osteomyelitis vs Charcot
- Wounds flushed with saline and dressed with DSD.
- Rec daily dressing changes by nursing, order placed, instructions below.
- Rec finishing 14 day course of PO Bactrim
- No acute signs of infection
- No acute podiatric surgical intervention
- Patient to follow up with Dr. Cohn upon discharge

#superficial venous insufficiency without evidence of DVT
Vascular was consulted and recommended the following:

- No acute surgical intervention
- Patient may continue with his current compressive therapy vs application specific wound management with his outpatient podiatrist.
- He is a candidate for venous ablation based on current reflux study, which can be planned on an outpatient basis.
- He wishes to discuss intervention with his podiatrist before proceeding
- He may follow up with Dr Sundaram on an outpatient basis in the vascular surgery clinic to discuss further.
Office address: 75-68 187th St 1st Floor, Queens, NY 11366, Office #: 718.303.6100

#AKI
-cr on admission 1.71, unknown baseline
-hold home med ramipril, start IVF

#COVID status
-LOW RISK, stable on RA, covid pcr neg.

#GI/DVT
-start hepsq and protonix

#Ethics
-FULL CODE.