Gagandeep Munday H&P#1 Long Term Care

Chief Complaint: Fever and weakness. Admission to New York Presbyterian Queens 6-South.

HPI: OG is a 95 year old White Female living with family at home, dependent on help for bathing, dressing, transferring, toileting, eating, non-ambulatory with PMH of CKD, Hypertension, Hyperlipidemia, Hypothyroidism, Diabetes Mellitus II, Heart Failure, and Dementia, no history of surgeries, alert and oriented x1 to person at baseline. She was brought in by daughter to New York Presbyterian Queens ED on 7/5/21 out of concern for fevers and increased weakness for 1 day. On arrival to ED, OG was febrile at 101.4F and appeared lethargic. She was complaining of abdominal pain prior to arrival to ED.

Initial ED labs revealed that her creatinine was 4.42, PCT was 1.58 ug/L, BNP of 13,000, troponin of 0.376, VBG PCO2 was 25. Collateral information from PCP Dr. EK indicated that the patient's last known creatinine was 4.1 as of thursday 7/1/21 prior to the current ED visit, indicating an AKI on CKD. UA was positive for WBCs, Leukocyte esterase, and E. Coli. Pt was admitted for UTI and AKI/CKD. She was started on cefepime 1 gram IV Q 24 Hrs and metronidazole 500 mg IV Q12 Hrs for UTI. Losartan 5mg was held. TTE planned and patient placed on telemetry. CT abd/pelvis indicated no obstruction. Patient was found to be anemic, likely secondary to CKD, daughter states that she receives darbepoetin every 3 weeks, next dose due on friday 7/9/2021. Daughter admits that the patient was transfused with 2 units of PRBCs 1 week ago for hgb of 6. As per PCP baseline hgb is 9-10 and the patient has had positive FOBT during outpatient visits.

On 7/7/21 the patient was interviewed by the writer. Patient's daughter was at the bedside. Patient appeared to be sleeping in a hospital bed in a semi fowler's position. Patient was arousable, A&Ox1, and endorsed epigastric abdominal pain by pointing to that area of the stomach. Patient is able to tolerate PO food however states that she has been unable to go to the defecate for the past 2 days. Currently denies any subjective fever, chills, headache, nausea, vomiting, change in appetite, palpitations, dyspnea, shortness of breath, weight loss, loss of sensation or paresthesias.

During the interview, the patient periodically kept stating that she was in pain, upon further inquiry the patient pointed to her left knee which appeared to be nonedematous, non erythematous, but associated with persistent pain extending down the calf. Using a picture based scale, the patient indicated that the lower leg pain was 6/10. Patient denied any recent falls or pain with ROM. Daughter denied any past or present trauma or previous surgeries to the affected area.

Patient denies dysuria, incontinence, hematuria, urinary frequency and urinary urgency.

PMH: CKD, Hypertension, Hyperlipidemia, Diabetes Mellitus II, Heart Failure, and Dementia.

PSH: Both patient and patient's daughter deny any previous surgeries.

Medications:

- Amlodipine 5 mg, PO daily for Hypertension
- Losartan 5 mg, PO daily for Hypertension
- Atorvastatin 40 mg, PO daily for Hyperlipidemia
- Carvedilol 12.5 mg, PO BID Hypertension and Heart failure
- Fenofibrate 145 mg, PO daily for Hyperlipidemia
- Donepezil 10 mg, PO take daily for Dementia
- Memantine 10 mg, PO BID for Dementia
- Insulin Glargine, 0.1 Units/kg, Subcutaneous injection nightly for Diabetes Mellitus II
- Insulin Lispro 1-4 units, Subcutaneous injection TID for Diabetes Mellitus II
- Calcium Acetate 667 mg, PO TID for Hyperphosphatemia secondary to CKD
- Levothyroxine 125 mcg, PO every morning for Hypothyroidism
- Trazadone 50 mg, PO nightly as a sleeping aid

Allergies: No known drug allergies, environmental allergies, or food allergies

Social History:
As per patient's daughter, OG is widowed and lives in a house with her daughter, son in law, and her grandchildren. She is unable to ambulate. She is unable to transfer on her own and requires the help of her aide and family members. She has guardrails on her bed at home. Patient's daughter states that the home health aide usually comes 5 days a week from 6 am to 12pm. Daughter has been staying home for the past year due to the pandemic. Daughter states that they have the means to care for their mother at home and do not wish to place her in a nursing home.

Denies current or past smoking history. Denies EtOH use. Denies illicit drug use. Denies any history of STDs.

Family History:
Mother, Deceased, HTN
Father, Deceased, HTN, DM2
Maternal Grandfather, Deceased, HTN, CAD, MI, DM2

Review of Systems

General: Denies fever, chills, increased weakness, night sweats, fatigue, loss of appetite, weight loss

Skin, Hair, Nails : Denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, change in hair distribution

Head: Denies headache, trauma, unconsciousness, coma, fracture, vertigo

Eyes: Denies corrective lenses, visual disturbances, fatigue, photophobia, pruritus,

lacrimation, Last Eye Exam: patient unable to recall

Ears: Denies deafness, pain, discharge, tinnitus, hearing aids

Nose/Sinuses: Denies discharge, epistaxis, obstruction, rhinorrhea

Mouth/Throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures, Last Dental Exam: patient unable to recall

Neck: Denies lumps, swelling, stiffness, decreased range of motion

Breast : Denies lumps, nipple discharge, pain, last mammogram: patient unable to recall

Respiratory: Denies wheezing, hemoptysis, cyanosis, dyspnea, shortness of breath, cough, paroxysmal nocturnal dyspnea

Cardiovascular: Denies palpitations, chest pain, irregular heartbeat, edema, syncope, known heart murmur

Gastrointestinal: **Admits to abdominal pain and constipation**. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, diarrhea, hemorrhoids, change in stool caliber, blood in stool

Genitourinary: Denies change in frequency, urgency, nocturia, polyuria, oliguria, dysuria, change in urine color, incontinence, flank pain

Musculoskeletal: **Admits to pain in left lower extremity**. Denies deformity, weakness, redness.

Peripheral Vascular: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change

Hematologic: Denies anemia, easy bruising/bleeding, lymph node enlargement, history of DVT/PE

Endocrine: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism

Neurologic: Denies seizures, loss of consciousness, sensory disturbances, paresthesia, dysesthesia, hyperesthesia, ataxia, loss of strength, change in mental status, memory loss, asymmetric weakness

Psychiatric: Denies feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideation, anxiety

Physical Exam

Vital Signs :
T 37.0C || BP 134/84 || P 82bpm || RR 14 breaths/min || SpO2 98%RA || BMI 26.09

General: 95yo female, A/O x1. Resting comfortably in a semi fowlers position in hospital bed in no acute distress.

Skin: Warm and moist, good turgor. Nonicteric. No lesions, tattoos.

Head: Normocephalic, atraumatic. Nontender to palpation throughout.

Eyes: No conjunctival injection, pallor, or scleral icterus. EOMS full.

Neck: Trachea midline. No masses, lesions, scars. Supple, nontender to palpation. Full range of motion. No palpable lymphadenopathy.

Chest: Symmetrical. No deformities. No paradoxical respirations or accessory muscle use. Respirations unlabored. LAT to AP diameter 2:1. Nontender to palpation.

Lungs: Resonant to percussion throughout. Clear to auscultation bilaterally. No wheezing, rhonchi, or rales.

Cardiovascular: S1 and S2 normal. Regular rate and rhythm. No S3, S4, splitting of heart sounds, murmurs, rubs.

Abdomen: No surgical scars. *Distended, tender to palpation in epigastric region, otherwise normal in other areas*. No striae, caput medusa, or abdominal pulsations. Bowel sounds present in all four quadrants. No bruits over aortic/renal/iliac/femoral arteries. No masses, guarding, rebound tenderness, or CVA tenderness. Negative Murphy's sign.

Extremities/Peripheral Vascular: Bilateral upper and lower extremities symmetric in color, size, and temperature. Radial and brachial pulses are 2+ bilaterally in upper extremities. DP/PT +2 bilaterally. No clubbing, cyanosis, stasis changes or ulcerations in bilateral upper and lower extremities. No edema, warmth, or purulent drainage. Moderate tenderness to palpation to upper LT knee and left calf. Negative homans sign.

Neurologic: Patellar and Achilles reflexes 2+ in bilateral lower extremities. Light touch, deep touch, pain, temperature sensation equivalent in bilateral lower extremities. Strength 5/5 in bilateral lower extremities. Full passive, but not active 2/2 to pain, range of motion in left knee. Full passive and active range of motion in the right knee. Patient was unable to stand.

Labs, Imaging, Diagnostics

CBC: WBC/Hgb/Hct/Plts = 8.51/**7.8**/**25.1**/276
CHEM: BUN/Cr/glu/ALT/AST/aml/lip = **125.5/3.28**/232/51/65/--/--
LYTES: Na/K/Cl/CO2 = 138/4.8/109/16

EKG: No ST segment changes
FOBT: Positive
CT ABD/PELVIS: No bowel obstruction. Cholelithisasis with questioned gallbladder wall thickening
US renal/bladder: no evidence of calculus or hydronephrosis

Assessment:

OG is a 95 year old White Female with PMH of CKD, Hypertension, Hyperlipidemia, Hypothyroidism, Diabetes Mellitus II, Heart Failure, and Dementia, no history of surgeries, alert and oriented x1 to person at baseline. She was brought in by daughter to New York Presbyterian Queens ED on 7/5/21 out of concern for fevers and increased weakness for 1 day. Pt was admitted for UTI and AKI/CKD. She is currently complaining of epigastric abdominal pain and persistent left lower extremity pain. Had no urinary symptoms at admission and endorsed none at the current interview. Denies fever at this time. Labs currently indicate anemia. FOBT was positive. CT abdomen and pelvis indicating questionable gallbladder disease.

#UTI
- Continue with cefepime 1g daily for now
- Monitor urine cultures

#AKI on CKD, Metabolic acidosis
- BUN/Cr: 125.5/3.28, PCO2 on VBG: 25
- Last creatinine done at PCP on thursday 7/1/2021, was 4.1
- Hold Losartan due to AKI
- US renal/bladder: no evidence of calculus or hydronephrosis
- Consulted nephrology
    - CKD 2/2 diabetic nephropathy and/or hypertensive nephrosclerosis. AKI is secondary to decreased renal perfusion

#Possible HF
- BNP: 13,000, troponin 0.376 possibly 2/2 CKD
- No ST segment changes on ECG
- Per daughter, no complaints of SOB or worsening swelling of extremities, states that pt does not follow up with a cardiologist
- Consulted with cardiology: TTE and telemetry

#Abdominal pain
- Per ED, pt had some complaints of abdominal pain on arrival, which have since resolved
- CT A/P showed no bowel obstruction. Cholelithisasis with questioned gallbladder wall thickening
- Negative murphy's sign
- Will need to follow up with US of RUQ

#Anemia

- Consult with Hematology, likely 2/2 CKD
- Will receive darbepoetin on 7/9/21
- Recently transfused with 2 units PRBCs, 1 week ago as outpatient for hbg of 6, baseline is 9-10, FOBT has been positive as out patient.
- Hbg was 6.9 on 7/7, transfused with 1 unit of PRBC, labs on 7/8 indicate hgb is 7.8

#Left lower leg/knee pain
- US of left lower leg
- DVT Prophylaxis: Heparin 5000 units, subcutaneous, every 8 hours

#Positive FOBT
- FOBT positive as outpatient as per PCP
- Need to discuss with patient and daughter about colonoscopy
- Consult GI

Nutrition: low carb diet, 60 gm/meal

Code Status: Full

Disposition: Patient will require further evaluation of possible DVT and acute cholecystitis will likely require a minimum 1-2wk stay.