**Identifying Data:**

Full Name: CK
Address: Flushing, NY
Date of Birth: X/XX/1943
Date & Time: 7/27/2021 at 10:30 AM
Location: NYHQ IM 6N, Queens, NY

Religion: Catholic
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Walked in

**Chief Complaint**: I noticed a lot of blood in my toilet. Admission to New York Presbyterian Queens 6-North.

**HPI**: CK is a 78 year old female from home with PMH of hemorrhoids, HTN, DM1, Alzheimer Disease presenting with bright red blood as per rectum first noticed 3 days ago. Pt states that she has a long standing history of hemorrhoids that bleeds every 2-3 months. Would have 1-2 episodes of bleeding during that time, states that these episodes would stop bleeding and resolve on their own without intervention. Most recent episode of bright red blood as per rectum was 3 days ago, the patient was unable to quantify the amount. She came to the ED on 7/26/21 since she had associated symptoms of dizziness. Patient is followed by an outpatient GI, last colonoscopy was 2 years ago and she states that it was “normal”. Patient states that her last outpatient Hgb was 12.

In ED Hbg was 6.1, and was given 1 unit of PRBCs, FOBT negative. Patient was admitted for anemia.

Currently denies any rectal bleeding or dizziness.

Denies history of liver disease, ulcers, NSAID use, alcohol use, chest pain, shortness of breath, palpitations, syncope, abdominal pain, hematuria, melena, hematemesis, chest pain, SOB, recent constipation.

**PMH**: hemorrhoids, HTN, DM, Alzheimer
**PSH**: Denies h/o any surgeries.

**Medications**:

- Amlodipine, 10 mg, orally, daily for HTN
- Atenolol, 25, orally, daily for HTN
- Atorvastatin, 10 mg, orally, at bedtime, for HLD
- Donepezil, 5 mg, orally, daily, for Alzheimer
- Insulin lispro, 1-5 units, subcutaneous, Q6H for DM1

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

**Social History:**
CK lives in a three bedroom apartment with her son, daughter-in-law and her grandchildren. She is able to ambulate and transfer on her own. She does not have guardrails on her bed at home.

ADLs: independent in all
IADLS: independent in all

Visual Impairment: None
Hearing impairment: None
Falls in the past year: None
Assistive devices used: None
Gait Impairment: None
Urinary incontinence: None
Fecal incontinence: None
Osteoporosis: None
Cognitive Impairment: None

Depression: None
Home safety issues: None
Health Care Proxy: Yes – son
Advance directives: full code

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

**Family History**:
Mother, Deceased, Unknown PMH
Father, Deceased, Unknown PMH
Daughter, Alive 51, DM1

## Review of Systems

General: Denies increased weakness, loss of appetite, fever, chills, night sweats, noticeable change in fatigue, 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 h/o hemorrhoids**. Denies rectal bleeding, change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, diarrhea, constipation, change in stool caliber
Genitourinary: Denies change in frequency, urgency, hematuria, nocturia, polyuria, oliguria, dysuria, change in urine color, incontinence, flank pain
Musculoskeletal: Denies deformity, pain, 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 36.8C || BP 132/76 || P 82bpm || RR 16 breaths/min || SpO2 96% ORA || BMI 23.2

General: 78yo female, appears of stated age, A/O x3. Resting comfortably in semi fowlers position in hospital bed in no acute distress. Non-toxic appearing

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

Head: Normocephalic, atraumatic. Nontender to palpation throughout.

Eyes: PERRL. 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. Non-distended. No striae, caput medusa, or abdominal pulsations. Bowel sounds present in all four quadrants. No bruits over aortic/renal/iliac/femoral arteries. Tympanic throughout. Non tender to palpation throughout**.** No masses, no guarding or rebound tenderness noted, no CVA tenderness appreciated. No hepatosplenomegaly. 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. Negative homans sign.

Neurologic: Patellar and Achilles reflexes 2+ in bilateral lower extremities. Light touch, deep touch, pain, temperature sensation equivalent in bilateral upper/lower extremities. Strength 4/5 in bilateral upper/lower extremities.

MSK: Full passive and active range of motion in shoulders, elbows, wrists, hips, knees, and ankles. Patient was able to stand and ambulate without any noticeable gait abnormality.

Rectal: **0.5 cm external hemorrhoid at 3 o’clock, non tender to palpation, not bleeding**. No skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. Rectovaginal wall intact. Trace brown stool present in vault. FOB negative.

GU: Patient declined.

## Labs, Imaging, Diagnostics

Labs:

- CBC: WBC/Hgb/Hct/Plts = 6.12/**6.6**/**21.6**/335
- Na - 141
- K - 4.3
- Cl - 103
- CO2/HCO3 - 23
- BUN - 19.5
- Cr - 1.29
- Glucose - **135**
- AST/ALT 13/14

FOBT: Negative

**Assessment:**

CK is a 78 year old female from home with PMH of hemorrhoids that are self resolving, HTN, DM1, Alzheimer Disease presenting with bright red blood as per rectum first noticed 3 days ago. She came to the ED on 7/26/21 with symptoms of dizziness. In ED Hbg was 6.1, and was given 1 unit of PRBCs, FOBT negative. Patient was admitted for anemia. Patient is followed by an outpatient GI, last colonoscopy was 2 years ago and she states that it was “normal”. Patient states that her last outpatient Hgb was 12. Was admitted for anemia. Patient denies any rectal bleeding and dizziness at this time. Current labs indicate anemia. FOBT was negative. Likely anemia 2/2 hemorrhoidal bleed.

DDx for rectal bleeding:

- Hemorrhoidal bleed
- Diverticulosis
- Diverticulitis
- Vascular ectasia / angiodysplasia
- Inflammatory bowel disease
- Infectious colitis
- Mesenteric Ischemia / ischemic colitis
- Meckel's diverticulum
- Colorectal cancer / polyps

#Anemia 2/2 hematuria

- Hgb 6.1, after 1 unit PRBC, Hgb was 6.6

        - Transfuse 1 unit PRBC, follow up CBC post transfusion
        - Keep Hgb above >8
    - No active bleed, FOBT negative
        - Monitor H/H
    - F/U anemia panel
    - 2 large bore IVs incase rapid transfusion is needed
    - No antiplatelet, anticoagulant, NSAID
    - Consult GI
        - Possible Sigmoidoscopy
        - Place on PPI
        - NPO

#DM1
- Insulin lispro, 1-5 units, Subcutaneous, Q6H

#HTN
- Continue amlodipine 10 mg and atenolol 25 mg

#HLD
- Atorvastatin 10 mg daily

#Alzheimer Disease
- Continue Donepezil 5 mg daily

Nutrition: NPO until for sigmoidoscopy, normal diet after

Code Status: Full

Disposition: Patient will require further evaluation of rectal bleed with sigmoidoscopy and repeat transfusions.