H&P #1 – Internal Medicine

Identifying Data:
Full Name: P.V.
Address: Queens, NY
Date of Birth: 3/11/1935
Age: 89
Date: 3/12/2024, 2:00 pm
Location: New York Presbyterian Queens
Religion: Unspecified
Marital Status: Single
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Unknown

CC: "stomach and back pain" x 2 days

HPI:
89-year-old female, with a medical history including hypertension, hyperlipidemia, chronic obstructive pulmonary disease, congestive heart failure, hypothyroidism, and breast cancer, presented to the emergency department with epigastric pain radiating to the back. These symptoms began two days prior, prompting the patient to contact her daughter-in-law, acting as her proxy, who then took her to the hospital. The patient reported feeling well in the days leading up to the onset of pain. Upon initiation, the pain was described as sharp but intermittent, rated at 10/10 in severity, with radiation to two points in the mid-lower back. The pain was positional, improving with standing but worsening with sitting. Nausea accompanied the pain, resulting in four episodes of nonbloody, nonbilious vomiting. Currently, the pain has decreased to a level of 4/10, and the nausea and vomiting have ceased. During the hospital course, the patient underwent several diagnostic tests, including a complete blood count, direct and indirect bilirubin assessment, lipase measurement, ultrasound of the upper right quadrant of the abdomen, and CT scan of the abdomen/pelvis with intravenous contrast. Laboratory results indicated mild leukocytosis with left shift, elevated lipase >3000, LDH at 368, and direct hyperbilirubinemia at 1.7. Imaging revealed acute cholecystitis, acute pancreatitis, and possible choledocholithiasis in the common bile duct (CBD). Treatment measures to date include continuous infusion of lactated Ringer's solution at 100 ml/hr, acetaminophen as needed, enoxaparin 40 mg daily, and intravenous piperacillin-tazobactam 4.5 g every 8 hours. The patient denied experiencing fever, chills, shortness of breath, chest pain, constipation, or diarrhea.

Past Medical History:
Hypertension
Hyperlipidemia

COPD
Diastolic CHF
Right Breast Cancer
Denies any childhood illnesses.

Past Surgical History:
Left Neck Surgery- thyroid disease (from chart)
Right Breast Lumpectomy

Medications:
anastrozole (ARIMIDEX), 1 mg, Oral, Daily
apixaban 5 MG Tablet Take 1 tablet (5 mg) by mouth Every 12 Hours fo 30 days.
atorvastatin 20 MG Tablet 1 tablet, Oral, Daily
Calcium Citrate-Vitamin D 600-400 MG-UNIT 1 tablet, Oral, 2 Times a Day
fluticasone 50 MCG/ACT Suspension nasal spray 1 Spray, Daily
furosemide 20 MG Tablet 1 tablet, Oral, Daily PRN
Hydralazine (APRESOLINE) 50 mg, Oral, Every 8 Hours Scheduled
isosorbide mononitrate ER (IMDUR) 60 mg, Oral, Daily
levothyroxine 50 MCG Tablet 1 tablet, Oral, Daily
montelukast (SINGULAR) 10 mg, Oral, Daily
pantoprazole 20 MG Tablet DR 2 tablets, Oral, Daily 30 mins Before Breakfast
sacubitril-valsartan 97-103 MG Tablet 1 tablet, Oral, Every 12 Hours Scheduled
SYMBICORT 160-4.5 MCG/ACT Aerosol inhaler

Allergies:
Amoxicillin - Rash, Mouth Sores
Ciclopirox - Hives
Moxifloxacin - Shortness Of Breath
Cephalosporins – Rash
Doxycycline- GI Intolerance
Gabapentin

Family History:
Father diseased, unknown.
Mother diseased, at 92 y/o, skin cancer
Sister diseased, at 60 y/o, breast cancer

Social History:
Smoking – former smoker.
Illicit Drugs – Denies use of drugs.
Alcohol – Denies alcohol use.
Diet – Denies a specific diet.
Exercise – Pt. denies exercise.
Caffeine – Does not drink coffee or any energy drinks.
Sleep – Pt. admits to sleeping about five hours per night.

Sexual Hx – not sexually active and no history of STIs.

Immunizations
Up to date on vaccinations including COVID-19 vaccine and the flu vaccine.

ROS:
General– The patient does not describe being in any acute distress. Denies and fatigue, weight loss or gain, loss of appetite, fevers, chills, night sweats.
Skin, Hair, Nails – Denies skin (other than the formation of abscess) or hair changes. Denies discolorations, pruritus, or moles.
Head – Denies trauma or vertigo. Denies headache.
Eyes –Does not have any ocular symptoms or abnormalities. Does not recall last eye exam.
Ears – Denies ear pain or discharge.
Nose/sinuses – Denies pain, discharge, epitaxies, or difficulty nasal breathing.
Mouth/Throat – Denies sores, sore throat, or voice changes. Pt. does not recall the last dentist visit.
Neck – Denies swellings, pain, or neck stiffness.
Respiratory– Denies dyspnea or respiratory changes.
CVS – Denies chest pain, palpitations, irregular HR, or lower extremity swelling.
GI – Pt. admits to abdominal pain in the epigastric region but denies diarrhea, constipation, flatulence, or bloating. Had nausea and vomiting when first admitted but has resolved. Improvement in appetite.
GU –Denies burning, urinary frequency, incontinence, and pelvic pain. Patient denies any flank plain.
Peripheral Vascular System – Denies intermittent claudication, edema, skin changes, or varicose veins.
Musculoskeletal – Denies weakness or muscle pain. Denies deformity, swelling, redness, h/o arthritis.
Nervous – Denies loss of strength or any seizures. Denies numbness, ringing, or sensory disturbances. Denies change in mental status. Denies any changes in cognition, mental status, or memory.
Hematologic system – Denies easy bruising. Denies bleeding or anemia. Denies lymph node enlargement. Denies blood transfusions.
Endocrine – Pt. denies cold intolerance, excess sweating, or abnormal hair growth in any region. Denies polydipsia.
Psychiatric – Admits to dealing with more stress than usual. However, denies any loss of interest in things patient enjoys. Denies any constant worrying. Denies feeling hopelessness and anxiety. Denies any suicidal thoughts or OCD. Doesn't have a history of taking psychiatric medications. Denies seeing a therapist.

Physical:
General: Appears of age, neatly groomed, alert & oriented x 3, responding to all questions thoroughly without trouble or discomfort.

Vitals:
BP: 143/86 mmHg
RR: 17 breaths/min, unlabored, regular rhythm breathing
Pulse: 70 beats/min, regular rate & rhythm
Temp: 97.88 F, oral
Height: 5'2"
Weight: 155 lbs.
BMI: 28.3 kg/m2

Skin: Skin is warm & moist. Good turgor. Non-icteric. No lesions, bruising, or scars on the upper extremities, chest or back. No tattoos noted.

Hair: Normal texture and hair distribution. No dryness, sweating, discoloration, pigmentations, moles, rashes, or pruritus. No lice. No seborrheic dermatitis.

Nails: No clubbing, cap refill <2 seconds in both upper extremities. No splinter hemorrhages noted. No signs of trauma or swelling. No Beau's lines.

Head: Normocephalic, atraumatic. No lesions or discoloration seen on scalp. Non tender to palpation throughout the head. Face symmetrical, no lesions, or unvoluntary movements.

Eyes: Symmetrical OU. PERRLA. EOMs intact with no strabismus, no nystagmus, no lid lag. Normal convergence. No exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink and clear w/o exudates. Visual fields full OU.
Visual acuity uncorrected - 20/20 OS, 20/20 OD, 20/20 OU.
Fundoscopy - Red reflex intact OU. Cup to disk ratio < 0.5 OU. No AV nicking, papilledema, hemorrhages, exudates, cotton wool spots, or neovascularization OU.

Ears: Symmetrical and appropriate in size. No lesions or trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TM's pearly gray, intact, cone of light in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne AC>BC AU.

Nose: Symmetrical nares; no masses, lesions, trauma, discharge, or deviated septum. Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. No foreign bodies or polyps noticed B/L. Septum is midline without lesions, deviation, perforation, or inflammation.

Sinuses - Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Mouth/Throat: Lips- Pink and dry; no lesions.

Oral Mucosa - Pink, moist mucosa. No masses, lesions, erythema.
Palate - Pink; well hydrated. Palate intact with no lesions, masses; scars. Non-tender to palpation; continuity intact.
Teeth- Presence of cavities. Otherwise, good dentition for age, no loose teeth.
Gingivae and Tongue -Pink; moist. No hyperplasia, masses, lesions, erythema, or discharge.
Oropharynx- Well hydrated; no exudate; masses; lesions; foreign bodies. Uvula pink and midline, no deviations, no edema, lesions. Tonsils present, grade 1, with no erythema or exudate.

Neck: Trachea midline. No masses, lesions, scars; pulsations noted. Supple; non-tender to palpation. No carotid artery bruit. No cervical adenopathy noted.

Chest and Lungs: Symmetrical, no deformities, no trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. In the lungs- CTAP bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.

Heart: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, no S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdomen: Abdomen flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Abdomen was tender to palpation in the epigastric and RUQ region only. The rest of the quadrants were non-tender to palpation and tympanic throughout, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated. No murphy's sign.

Rectal: Rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative.

Female Genitalia: External genitalia without erythema or lesions. Vaginal mucousa pink without inflammation, erythema or discharge. Cervix paros (or multiparous), pink, and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. Pap smear obtained. No inhinal adenopathy.

Mental status exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to name, date, time and location. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood.

Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.

Cranial Nerve: CNI correctly identifies coffee and mint odors bilaterally.

CNII visual fields full by confrontation, visual acuity 20/20 OD, OS, OU, uncorrected, red reflex present, cream color discs with sharp borders, no hemorrhages, no exudates or crossing phenomena.

CN III, IV, VI extraocular movements intact, pupil size and shape equal, and reactive to direct and consensual light and accommodation, no ptosis.

CN V face sensation intact bilaterally, corneal reflex intact, jaw muscles are string without any atrophy.

CN VII facial expressions intact, clearly enunciates words, strong eye muscles that hold against resistance.

CN VIII patients can hear hair rubbing between fingers, Weber – no lateralization, Rinne – AC>BC.

CN IX and X uvula midline with elevation of soft palate, gag reflect intake, no difficulty swallowing.

CN XI full range of motion at the neck with 5/5 strength and strong shoulder shrug.

Cn XII tongue midline without fasciculation, good tongue strength.

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Symmetric muscle bulk with good tone. No atrophy, tics, tremors, or fasciculation. Strength 5/5 throughout. Rhomberg negative, no pronator drift noted. Gait steady with no ataxia. Tandem walking and hopping show balance intact. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis

Sensory: Intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally

Reflexes: 2+ throughout, negative Babinski, no clonus appreciated

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

Extremities: No soft tissue swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. Non-tender to palpation, no crepitus noted

throughout. Full range of motion of all upper and lower extremities bilaterally. No evidence of spinal deformities.

Peripheral Vascular: The 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. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy.

Assessment:
The 89-year-old female, presented to the emergency department with epigastric pain that radiated to the back x 2 days. Currently, two since admission, the pain had diminished to a level of 4/10, and the nausea and vomiting had ceased. Upon physical examination, the patient only shows mild tenderness in the epigastric and right upper quadrant region only. Lab showed mild leukocytosis with left shift, direct hyperbilirubinemia, lipase > 3000, LDH 368. US showed acute cholecystitis, showing multiple gallstones including nonmobile calculus in the gallbladder measuring 11 mm. CT showed acute pancreatitis and with a possible CBD stone.

Differential Diagnosis:
Gall Stone Pancreatitis - the passage of gallstones through the biliary tract can trigger acute pancreatitis either by obstruction of the flow from the pancreatic duct or by obstructing the ampulla, causing bile to reflux back into the pancreatic duct. Patients present with acute pancreatitis and can have elevations in liver chemistries (bilirubin, alkaline phosphatase, and transaminases).

Peptic ulcer disease – Pain in patients with peptic ulcer disease is often limited to the epigastrium. Patients may have associated bloating, abdominal fullness, heartburn, or nausea.

Acute cholecystitis – Acute cholecystitis is characterized by right upper quadrant pain, fever, and leukocytosis associated with gallbladder inflammation that is usually related to occlusion of the cystic duct or impaired emptying of the gallbladder due to stones or biliary sludge. Will exhibit positive murphy sign. The pain in patients with biliary colic is well localized and patients do not exhibit a positive Murphy's sign on physical examination.

Choledocholithiasis – Patients with a stone in the common bile duct (choledocholithiasis) may have typical biliary colic. However, the pain is usually more prolonged than is seen with uncomplicated gallstone disease. If the stone is not passed, a cholestatic pattern may develop (increased bilirubin, alkaline phosphatase, and gamma-glutamyl transpeptidase out of proportion to the elevation in the aminotransferases). Patients who have developed acute cholangitis may also present with fever, leukocytosis, hypotension, or mental status changes. Transabdominal ultrasound may reveal a stone in the common bile duct or a dilated common bile duct.

Myocardial infarction- older patients or those with diabetes may have atypical presentations of myocardial infarction. These patients often present with symptoms such as dyspnea alone, weakness, nausea and/or vomiting, epigastric pain or discomfort, palpitations, syncope, or cardiac arrest.

Plan:
NPO/ Fluid resuscitation – oral nutrition can usually be started within 24 hours. In severe cases, enteral feeding is initiated with a tube that extends to jejunum. IV fluids using saline or lactated ringer solution at a rate of 5 to 10 milliliters per kilogram per hour for the first 12 to 24 hours, then adjusted based on hydration status.

Pain control- IV opioids such as hydromorphone or fentanyl.

Up to date states: Prophylactic antibiotics and selective decontamination of the gut are not recommended in patients with acute pancreatitis regardless of disease severity.

Endoscopic retrograde cholangiopancreatography – ERCP, recommended for patients with gallstone pancreatitis and cholangitis to remove the stones. After the pancreatitis resolves a cholecystectomy may be performed.

Patient Education:
Explain to the patient that an ERCP is a procedure that uses endoscopy and X-rays to not only find problems of the bile and pancreatic ducts but also to treat by removing stones that are blocking those ducts. Sometimes a stent will be placed in the ducts to maintain the duct patent and when this is done a second ERCP procedure needs to be completed later to remove those stents. Suggest that surgery (gall bladder removal) is likely necessary after her pancreatitis resolves to prevent recurrent pancreatitis. Emphasize the importance of managing her hyperlipidemia (HLD), especially hypertriglyceridemia, as it is a risk factor for pancreatitis. Mention that pancreatitis may lead to exocrine insufficiency, where the pancreas no longer produces enough insulin to maintain glucose levels, and advise her to follow up with her primary care provider for regular blood tests. Discuss dietary modifications to prevent future pancreatitis episodes, such as abstaining from alcohol, drinking at least 1.5 liters of water daily, and consuming small, low-fat meals. Also, inform the patient about potential late complications of pancreatitis that may develop over weeks to months. These complications include pancreatic pseudocysts, which are fluid collections outside the pancreas enclosed by a wall, and walled-off necrosis, which is necrotic tissue also contained within a well-defined wall. Instruct the patient to seek medical attention if either of these complications becomes infected, as it may present with fever and requires treatment.