Andres Hernandez

H&P #2 – Long-Term Care

Chief Complaint: "Fall" x Last night

HPI:
66-year-old female with a past medical history of hypertension and asthma is being evaluated by the geriatrics team after presenting to the emergency department, accompanied by her son, following a fall the previous night. Patient reported she slipped and fell on the bathroom floor while trying to get in the bathtub where she remained until this morning when her son called EMS. During the fall the patient admits to hitting her head but does not recall if she lost consciousness. Collateral information was obtained from son, admits that his mother lives alone, has no home health aid, and is completely independent but son visits daily. Son admits mother was conscious when he found her and denies seeing any blood, lacerations, or bruising on scene. Son admits that mother has been deteriorating over the past year and has noticed changes in her memory, personality, coordination, and ambulation. Son reports mother is echoing her speech and also having hallucinations; both occurring for approximately a year. Son says mother is has only seen her PCP and has upcoming appointment in the neurology clinic. Son also admits to mother having frequent falls, confirmed by medical records which show patients have visited ED four times over the past year for falls and denies the use of any walking aids. Patients denies to any other complaints or pain. Denies blurry vision, chest pain, palpitation, shortness of breath. Patient denies any alcohol or drug use.

Past Medical History:
Asthma – Age of onset unknown, controlled with Albuterol prn.
Hypertension – Age of onset unknown, controlled with Losartan 1 tablet daily.

Past Surgical History:
none

Medications:
- Albuterol 108 (90 Base) MCG/ACT inhaler - 2 puffs every 6 hours prn.
– Losartan (Cozaar) - 1 tablet (50 mg total) by mouth daily.

Allergies:
NKDA
No food allergies
No environmental allergies

Family History:
Father: Passed away at age 78 from complications related to congestive heart failure. Known history of hypertension. No history of cancer.
Mother: Passed away at age 80, with a history of stroke, hypertension and asthma. No history of breast or colon cancer.
Older brother: age 70, hypertension and type 2 diabetes, with no known neurological conditions or history of cancer.
Younger sister: age 63, diagnosed with asthma and osteoarthritis, with no known cognitive or neurological issues and no history of breast or colon cancer.

Son: age 42, in good health without any significant medical history.

Social History:
Previously she worked as a teacher assistant, currently retired and living alone, though her son visits daily for assistance.
Substances: Denies history of substance abuse. Never smoked cigarettes, used smokeless tobacco, or vaped. Denies use of recreational drugs. Does not consume alcohol.
Travel: Denies any recent travel, both domestic and international.
Diet: Follows a strict vegetarian diet.
Sleep: Son says patient doesn't get much sleep and at times stays awake all night.
Exercise: Denies formal exercise.
Sexual History: Heterosexual, not currently sexually active. Denies history of sexually transmitted diseases (STDs).

ROS:
General – Denies fever, headache, weakness, changes in appetite or recent weight loss.

Skin, hair, nails –No changes in texture, excessive dryness or sweating, discolorations, pigmentations, lacerations, moles/rashes, pruritus, or changes in hair distribution.

Head – Denies headache, vertigo, or head trauma

Eyes –Denies visual disturbance, blurred vision, photophobia, lacrimation or pruritus. Last eye exam is unknown.

Ears – Denies ear pain, muffled sound, deafness, discharge, or sensation of fullness.

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies sore throat, bleeding gums, mouth ulcers, voice changes. Last dental exam, unknown.

Neck - Denies localized swelling/lumps or stiffness/decreased range of motion.

Pulmonary System – Denies cough, shortness of breath, dyspnea on exertion, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

Cardiovascular System – Denies chest pain, palpitations, HTN, syncope, or known heart murmur.

Gastrointestinal System – Denies dysphagia or odynophagia. Denies nausea, vomiting, diarrhea, constipation, abdominal pain, or jaundice.

Genitourinary System – Denies urinary frequency, nocturia, urgency, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate, or flank pain. Urine is yellow/clear.

Nervous System –Denies seizures, loss of consciousness, sensory disturbances (numbness, paresthesia, dysesthesia, hyperesthesia), or weakness. **Positive for headaches, falls, ataxia, and changes in cognition/mental status/memory.**

Musculoskeletal System: Denies any muscle, joint pain, joint deformity, swelling, redness, or any arthritis.

Endocrine System – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating.

Psychiatric – Denies depression, feelings of helplessness or hopelessness, lack of interest in usual activities, anxiety, or suicidal ideations. **Positive for hallucinations both auditory and visual hallucinations, and insomnia.**

Physical Exam:
Vital Signs:
BP: 123/93 mmHg, right arm sitting
P: 84 beats/min, regular
RR: 18 breaths/min, unlabored
T: 98.1 degrees F (oral)
O2 Sat: 98% room air
Weight: 123 lbs
Height: 5'0.98"
BMI: 23.3 kg/m2

General: 66-year-old female, awake, alert, and oriented to person, place, and time, though off by one day (AOx3). She was evaluated at the bedside, lying comfortably on the hospital bed, in no acute distress. She is cooperative but easily distracted during history taking and the physical examination. Echolalia was noted during speech. The patient moves very slowly, ambulates well with assistance but is otherwise ataxic.

Nose: Symmetrical. No masses, deformities, or discharge. No lesions, masses, or trauma. Nares patent bilaterally. Nasal mucosa pink and well hydrated. No discharge noted on anterior rhinoscopy. No epistaxis.

Eyes: Symmetrical OU. No strabisumus, exopthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.

Ears: No discharge/foreign bodies in external auditory canals AU. TMs pearly white/intact with light reflex in good position AU.

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

Mouth: No cyanosis of lips, white teeth, with no loose, or broken teeth. Gums pink in color, no swelling, bleeding, or pain. Oral mucosa pink. No discoloration, lesions, nodules, swelling. Tonsils visible but not enlarged.

Skin: No lacerations, masses, no bruising, or petechiae.

Cardiac: Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, gallops, or rubs. Chest is symmetrical, no derformities, no trauma. Lat to AP diameter 2:1. Nontender to

palpation.

Pulmonary: No wheezing, rales, rhonchi, crackles, heard. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. No clubbing noted.

Abdomen: Abdomen flat and symmetric with no scars, striae, or pulsations noted. Nontender to palpation and tympanic throughout, no guarding or rebound noted. No evidence of hernias.

Neurological:
Mental Status: Alert and oriented to person, place, and time. MOCA (Montreal Cognitive Assessment): skipped serial 7s because of pt's reported poor history with arithmetic, Visuospatial/executive 1/5, Naming 1/3, Memory 0/5, Attention 0/3, Language 2/3, Abstraction 0/2, Orientation 6/6, Total 10/27 indicating severe cognitive impairment.

Cranial Nerves: Intact

Motor: Good muscle bulk and tone with 5/5 strength on bilateral upper extremities and lower extremity. No fasciculations.

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

Cerebellar**: finger to nose intact, slow bilaterally. Unstable gait. Positive Romberg sign.**

Reflexes
2+ throughout in the upper extremities, hyperreflexia in the lower extremities, negative Babinski, no clonus appreciated

	R	L		R	L
Brachioradialis	2+	2+	Patellar	3+	3+
Triceps	2+	2+	Achilles	3+	3+
Biceps	2+	2+	Babinski	neg	neg
Abdominal	2+/2+	2+/2+	Clonus	negative	

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.

Differential Diagnoses:

Fronto-Temporal Dementia – Characterized by focal degeneration of the frontal and/or temporal lobes, frontotemporal dementia presents with early alterations in personality, social and emotional behavior, and executive function. Speech impairment is a common clinical feature. Some patients with frontotemporal dementia may also develop motor syndromes such as parkinsonism or motor neuron disease. Frontotemporal dementia is one of the most common causes of early-onset dementia, with an average age of onset in the sixth decade.

Vascular dementia – Vascular dementia is not a specific disease but a syndrome caused by cerebrovascular disease, such as ischemic or hemorrhagic stroke. It may follow a clinical history of stroke or be identified through brain imaging showing vascular brain injury in a patient with dementia. Patients often experience stepwise cognitive decline, with impairments in executive function and processing speed. Neuropsychiatric signs, such as depression, apathy, and psychosis with delusions or hallucinations, may accompany vascular dementia.

Lewy Body Dementia – A degenerative dementia associated with clinical features such as visual hallucinations, parkinsonism, cognitive fluctuations, and sleep disorders. Early symptoms include loss of attention, executive function, and visuoperceptual function, distinguishing it from Alzheimer's disease, which typically presents first with memory loss. Memory impairment in Lewy body dementia appears later in the disease. Early symptoms may include difficulty driving and impaired job performance. Impaired figure copying (e.g., clock drawing) and challenges with tasks such as serial sevens are suggestive of Lewy body dementia, while Alzheimer's patients generally show early short-term memory deficits. Recurrent falls occur in up to one-third of patients and may be among the earliest symptoms.

Normal Pressure hydrocephalus – Pathologically enlarged ventricular size with normal opening pressure on lumbar puncture where there is a structural blockage of CSF, therefore patients often lack the notable signs and symptoms of increased ICP. Produced a decline in cognition, slowed gait, and urinary incontinence that can mimic symptoms of vascular dementia. These features are thought to arise from dysfunction in the motor areas of the frontal lobe. Characterized by pathologically enlarged ventricular size with normal opening pressure on lumbar puncture. A structural blockage of cerebrospinal fluid leads to symptoms without notable signs of increased intracranial pressure. Normal pressure hydrocephalus presents with cognitive decline, slowed gait, and urinary incontinence, which can mimic symptoms of vascular dementia. These symptoms are thought to result from dysfunction in the motor areas of the frontal lobe.

Alzheimer disease – Alzheimer's disease typically shows more pronounced impairment in episodic memory compared to other dementias. Onset before age 65 is rare. Memory of recent events is often affected, whereas immediate memory and long-term memory remain relatively intact early on. Executive dysfunction and visuospatial skills are affected early, with language and behavioral symptoms manifesting later in the disease.

The differential diagnosis includes Lewy body dementia, which is supported by her visual hallucinations and motor findings, as well as vascular dementia given her hypertension and stepwise decline. Frontotemporal dementia is also considered, given the reported changes in personality, language impairment, and echolalia. Normal pressure hydrocephalus remains a possible diagnosis, particularly due to her gait instability and cognitive impairment. Alzheimer's disease is less likely given the predominance of hallucinations and motor findings early in the course.

Assessment:
66-year-old female with a past medical history of hypertension and asthma, presenting with a year-long history of multiple falls along with progressive cognitive and functional decline. The patient's son reports notable changes in her memory, personality, coordination, and ambulation, along with insomnia, and visual and auditory hallucinations. Montreal Cognitive Assessment score of 10/27

suggests severe cognitive impairment. Physical examination revealed a positive Romberg sign, hyperreflexia in the lower extremities, and slow but intact finger-to-nose testing bilaterally. She demonstrates an unstable gait and requires assistance to ambulate safely. Further workup with neuroimaging and follow-up with neurology is warranted to refine the diagnosis and guide management.

Plan:
#Dementia/Unsteady Gait Workup
Finger Stick, EKG, CBC, CMP, Liver Function Tests, Syphillis, HIV Screening, Vitamin B12, Folate, Urinalysis and Urine Toxicology, CT of the head without contrast.

#Social determinant of health
Lives alone, no home health aid, not able to look after herself alone
Pt not safe to be alone due to unsteady gait and multiple falls
Patient requires 24 hours supervision. Consider SAR or long term facility.
Discharge home is feasible, if family and home-aid are available to provide the needed 24 hours services.