

H&P #3 – Long-Term Care

Chief Complaint: “Cough” x 3 months

HPI:

The patient is a 76-year-old male with a past medical history of hypertension, hyperlipidemia, and prostate cancer presents to the geriatric clinic for consultation regarding a cough that has persisted for the past 3 months. He describes the cough as unproductive, with no associated sputum production. He reports that the cough is often worse in the morning or after lying down and typically improves a couple of hours after waking up. Along with the cough, he experiences mild throat discomfort, rated 3 out of 10 in intensity, which he compares to a sore throat, as though he were coming down with an illness. Similar to the cough, the throat discomfort resolves a few hours after waking. The patient has tried Tums chewable tablets, with only minimal improvement in his symptoms. His current medications include aspirin and amlodipine, though he is unsure if they may be contributing to his cough. He rates the severity of the cough as mild to moderate, noting that it is bothersome but does not significantly impact his daily activities. He denies any fever, chills, shortness of breath, chest pain, nausea, vomiting, or constipation. He also denies any recent travel or sick contacts.

Past Medical History:

Hypertension- diagnosis unknown, managed with amlodipine.

Hyperlipidemia – diagnosis unknown, no medications taken

Prostate cancer – remission after prostate surgery in 2021

Past Surgical History:

Prostate Surgery – 2021

Medications:

- Amlodipine (Norvasc) - 1 tablet (5 mg total) by mouth daily.

- Aspirin (Bayer) - 1 chew tablet (81 mg total) daily.

Allergies:

NKDA

No food allergies

No environmental allergies

Family History:

Mother: Deceased at age 82, history of osteoporosis and hypertension.

Father: Deceased at age 78, history of coronary artery disease and prostate cancer.

Sister, age 74, living with hypertension and type 2 diabetes.

Brother, deceased at age 70, history of lung cancer.

Daughter, age 50, healthy with no significant medical history.

Son, age 48, history of hyperlipidemia.

Social History:

Ex-electrician, but now retired. Married for over 50 years.

Substances: Denies use of tobacco, alcohol, or recreational drugs.

Travel: Denies any recent travel, both domestic and international.

Diet: Reports a balanced diet, aiming to include fruits, vegetables, and lean proteins, though he occasionally indulges in high-sodium foods. He tries to limit his intake of red meat and prefers fish and poultry.

Sleep: Sleeps an average of 6-7 hours per night, though he sometimes wakes up with throat discomfort related to his cough.

Exercise: Walks daily for approximately 30 minutes to maintain mobility and cardiovascular health. Denies any other regular exercise regimen.

Sexual History: Monogamous, no changes or concerns.

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, 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 – **Admits to cough.** Denies 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.

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.

Physical Exam:

Vital Signs:

BP: 119/60 mmHg, left arm sitting

P: 68 beats/min, regular

RR: 18 breaths/min, unlabored

T: 97.9 degrees F (oral)

O2 Sat: 98% room air

Weight: 138 lbs

Height: 5'8"

BMI: 20.98 kg/m²

General: 76-year-old male, awake, alert, and oriented to person, place, and time (AOx3). Patient appears well groomed and younger than stated age. Patient ambulate well without assistance. He is sitting comfortably on the exam table, in no acute distress. Patient was not coughing during exam. He is cooperative and responsive during history taking and the physical examination.

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 strabismus, exophthalmos 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 deformities, 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.

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:

GERD – GERD is believed to be a problem associated with the lower esophageal sphincter, where symptoms happen in the recumbent position. Many patients with a chronic cough complain of symptoms associated with GERD such as dysphonia, nasal symptoms, heartburn, and a sour taste in the mouth. GERD may induce cough through stimulation of the vagal afferent nerves, as acid reflux into the distal esophagus can trigger an esophageal-tracheobronchial reflex, significantly increasing cough frequency.

Laryngopharyngeal reflux – is the retrograde movement of the gastric contents such into the laryngopharynx. Most patients are asymptomatic with only around 35% reporting heartburn. The typical symptoms are dysphonia/hoarseness, chronic cough, dysphagia, and throat clearing that is nonproductive. In contrast to GERD, LPR primarily involves the upper esophageal sphincter and is more common in the upright position, often during physical exertion. In LPR patients, pH monitoring alone may be inadequate for diagnosis, and some may require antireflux surgery for symptom control.

Post-Nasal Drip – Nasal secretions that flow into the nasopharynx are caused by allergies or rhinosinusitis. Several studies suggest that a persistent postnasal drip is a common cause of subacute and chronic cough. Patients often experience constant mucus drainage at the back of the throat and frequent throat clearing. Examination typically reveals a cobblestone appearance of the pharyngeal mucosa.

Nonaesthetic eosinophilic bronchitis – is often a diagnosis in thought who lack the risk factors that are associated with causes of a chronic cough. Bronchial mucosal biopsy reveals airway eosinophils and membrane thickening without the mast cell infiltration characteristic of asthma. NAEB does not present with wheezing or dyspnea, which helps differentiate it from asthma.

Asthma – Asthma is a leading cause of persistent cough in adults and is usually accompanied by episodic wheezing and dyspnea. Asthma-induced cough often responds to bronchodilators and corticosteroids, aiding in diagnosis and management.

ACE inhibitors and other medications – ACE inhibitors can cause a non-productive cough, typically presenting one week after therapy initiation, though onset can be delayed up to 6 months. Symptoms generally resolve within one to four days after discontinuation. ACE inhibitor cough is usually accompanied by a tickling, scratchy, or itchy sensation in the throat. Other medications, such as calcium channel blockers and bisphosphonates, can exacerbate reflux and may contribute to cough. Additionally, certain glaucoma medications (e.g., latanoprost, a prostaglandin analog) may stimulate cough receptors if they reach the nasopharynx through the lacrimal ducts. Timolol, a non-selective beta-blocker, can cause bronchoconstriction and cough in patients with asthma.

Assessment:

76-year-old male with a history of hypertension, hyperlipidemia, and prostate cancer, presenting with a chronic, unproductive cough for 3 months. Symptoms are suggestive of gastroesophageal reflux disease, with cough worsening in the morning and after lying down, and mild throat discomfort that resolves a few hours. GERD is most likely exacerbated by his current use of amlodipine, that can aggravate acid reflux. Physical examination and vital signs are within normal limits, and no other concerning symptoms are reported.

Plan:

GERD Management: Initiate GERD therapy with a proton pump inhibitor (PPI) or H2 blocker, with a trial of half dose to see if effective, along with lifestyle modifications such as elevating the head of the bed and avoiding meals or liquids close to bedtime.

Hypertension Medication Adjustment: Discontinue amlodipine and consider switching to an alternative antihypertensive that has a lower risk of exacerbating acid reflux, such as an ACE inhibitor or ARB, to prevent potential GERD symptoms.

Follow-Up: Schedule follow-up in 4-6 weeks to evaluate the response to treatment and reassess the need for further intervention if symptoms persist.