Name: Abd-Manaaf Bakere
Rotation 3: Long term Care
Date: 03/22/2024
Rotation Location: Metropolitan Hospital.

Name: D A
DOB: xx/xx/1948
Age: 75 y/o
Address: Point NY
Date/Time: March 15,2024, 11:45 AM
Location: Metropolitan Hospital
Source of Information: Self
Reliability: Reliable

Chief Complaint (CC): Follow-up after recent hospital discharge due to suspected metastatic pancreatic cancer.

History of Present Illness (HPI):
DA is 75 y/o female with past medical history of HTN, DM, HLD, gastritis, presents to the geriatric office for a follow-up after recent hospital discharge due to suspected metastatic pancreatic cancer. Patient reports epigastric pain that started about 2 months ago. She reports experiencing yellowing of her eyes since February, accompanied by epigastric pain that radiates to her back, which can be severe at times. She rates the pain 8/10. She admits taking Tylenol without relief. She also notes nausea and vomiting, starting with phlegm and progressing to food. Additionally, she mentions difficulty passing small, hard stools, for which she occasionally uses senna. She expresses concerns about undergoing gastrointestinal procedures due to cardiac issues, citing her mother's experience with pancreatic cancer and its poor outcome. She denies drinking, smoking, hemorrhoids, melena, hematemesis, hematochezia.

Past Medical History:

Diabetes mellitus
Gastritis
Hypertension
Low back pain

Past Surgical History:
Cesarean section
Laser ablation (2006)
Total abdominal hysterectomy with bilateral salpingo-oophorectomy (1994)

Medications:

Acetaminophen

Amlodipine
Ammonium lactate
Clobetasol
Clopidogrel
Gabapentin
Glucose blood test strips Lancets
Lubricants
Metformin
Multiple vitamins-minerals
Polyethylene glycol
Rosuvastatin
Sennosides
Sodium chloride

Allergies:
Clindamycin (swelling)
Coconut oil (hives)
Diclofenac (swelling)
Duloxetine HCl (headache, nausea, poor appetite, general malaise)
Sulfa antibiotics (nausea only)
Aspirin (rash)

Family History:
Father: Diabetes
Mother: Cancer
Brother: Diabetes, hypertension
Maternal aunt: Colon cancer

Social History:
Single, a non-smoker, non-drinker, and sexually inactive.
She lives alone and uses a rollator for mobility assistance.
Her son, Ramon, serves as her health care proxy.

Review of Systems (ROS):
General: mild weight loss, denies fevers, weakness, fatigue, night sweats, chills, body aches, sleep
• Skin: admits itching, color changes jaundice. Denies rash, sores, lumps,hair, nails
• Head: trauma, headache, nausea, vomiting, dizziness
• Eyes: glasses/contacts, pain, redness, tearing, vision loss, discharge, double/blurred vision, glaucoma
• Ears: mild hearing loss. denies tinnitus, vertigo, earache, discharge
• Mouth/Throat: has dentures, denies bleeding gums, hoarseness,, dry mouth, difficult/painful
• Nose/Sinuses: Denies stuffiness, rhinorrhea, sneezing, itching, epistaxis, allergies (perennial, seasonal)
• Neck: Denies lumps/masses, goiter, pain, stiffness, swelling
• Breast: Denies lumps/masses, pain, discharge

• Respiratory: Denies cough, SOB, wheezing, sputum (color/quantity), hemoptysis, pleurisy, snoring
Cardiac: Denies palpitations, pain, DOE, orthopnea, paroxysmal nocturnal dyspnea, syncope, lower extremity edema
Gl: **admits epigastric pain, nausea, vomiting, constipation**. Denies dysphagia, regurgitation, indigestion,, changes in bowel habits, diarrhea, , bleeding (hemorrhoids, melena, hematemesis, hematochezia)
• Urinary: Denies frequency, polyuria, nocturia, hesitancy, urgency, dysuria, hematuria, incontinence, reduced caliber of stream
• Vascular: Denies claudication, edema, varicose veins, past clots
• Musculoskeletal: Denies muscle or joint pain, stiffness, arthritis, gout, weakness, swelling, redness, instability.
• Neurological: Denies seizures, numbness, tingling, paralysis, paresthesias, fainting, blackouts, burning, tremors
• Hematological: Denies anemia, easy bruising/bleeding, petechiae, purpura, ecchymosis, transfusions
• Endocrine: Denies heat/cold intolerance, sweating/thirst/hunger
• Psychiatric: **admits depression**. Denies nervousness, mood, anxiety,

Geriatrics Assessment:

ADLs: Independent in all. Dressing, feeding, using toilet.

IADLs: Needs assistance in household chores, transportation and shopping.

Visual impairment: Yes - decreased vision - pending ophthalmology

Hearing impairment: None

Falls in the past year: Yes - left ankle Fx due to fall

Assistive devices used Yes - rollator

Gait impairment: Yes - antalgic

Urinary incontinence: None

Fecal incontinence None

Osteoporosis None
Dexa normal 9/2023

Cognitive Impairment: None
Mini-Cog 5:5

Depression: yes

Home safety issues: Yes - Lives alone

Health Care Proxy: Yes - Son Ramon

Advance directives have Full code

Physical Examination:

Vital Signs:
Blood Pressure: 114/59 mmHg
Pulse: 77 bpm
Respiratory Rate: 18 breaths/min
Temperature: 97.2°F
SpO2: 97%
Wt 64.9 kg (143 lb)
BMI 27.93 kg/m²

General: Well-developed, well-nourished female in mild distress.
Skin: jaundice
HENT:
Head: Normocephalic and atraumatic.
Pharynx: oropharynx is clear.
Right Ear: External ear normal.
Left Ear: External ear normal.
Eyes: Icterus noted. EOM intact
Pupils: Pupils are equal, round, and reactive to light.
Neck: No lymphadenopathy, ROM intact.
Cardiovascular: Regular rate and rhythm. No murmurs, rubs, or gallops.
Respiratory: Non-labored breathing. Clear to auscultation bilaterally.
Abdomen: Mild distension, tender epigastrium on deep palpation.
Neurological: +3 strength, Normal cranial nerves, intact cognition function and memory
Extremities: No edema. Normal pulses.

Labs and Imaging.
CBC: Normal
CMP, Normal except
Sodium: 122
ALT: 211, AST: 240
Total Bili: 12.0
Alk Phos: 1528, repeated, Range: 40-120
Anion Gap: 14
eGFR: 94
PT: 20, Range 9.4-12.3 sec
INR: 1.8
Lipase: elevated 268, Range 0-160.

EKG: NSR
CA19.9: <2 : Result cannot be interpreted as absolute evidence of the presence or absence of malignant disease.
US Upper quadrant: Impression: intra and extrahepatic biliary dilation. Cholelithiasis suggestion of pancreatic mass.
CT abdomen: Impression: Hypoattenuation complex mass at the pancreatic head measuring 3.7*2.9 cm producing obstruction of the bile ducts at that level.

Assessment:
D.A., a 75-year-old female with a history of hypertension, diabetes mellitus, hyperlipidemia, gastritis, and low back pain, presents with symptoms suggestive of metastatic pancreatic cancer, including jaundice, epigastric pain, nausea, vomiting, and constipation. Recent hospital discharge against medical advice underscores potential challenges in continuity of care and patient compliance, compounded by recent stressors following the loss of her only nephew. Laboratory findings reveal significant abnormalities, including elevated liver enzymes (ALT, AST), elevated bilirubin, elevated alkaline phosphatase, low sodium, elevated lipase, prolonged PT, elevated INR, US Upper quadrant shows intra and extrahepatic biliary dilation and CT abdomen Hypoattenuation complex mass at the pancreatic head measuring 3.7*2.9 cm further supporting the suspicion of pancreatic pathology.

Differential Diagnoses:

Metastatic pancreatic cancer: Given the patient's history of chronic epigastric pain, jaundice, nausea, vomiting, and recent weight loss, metastatic pancreatic cancer is the leading consideration. The symptoms align closely with pancreatic cancer's clinical presentation, and the elevated liver enzymes, bilirubin, and alkaline phosphatase are consistent with biliary obstruction secondary to pancreatic malignancy.

Cholecystitis: The patient's symptoms of epigastric pain, jaundice, and nausea could also indicate acute cholecystitis, particularly considering the presence of gallstones commonly associated with this condition. However, the absence of fever and Murphy's sign on physical examination makes this diagnosis less likely.

Choledocholithiasis: Another potential cause of the patient's symptoms is choledocholithiasis, where gallstones obstruct the common bile duct, leading to jaundice and biliary colic. Although the patient has a history of gallstones, the absence of fever and right upper quadrant tenderness makes this diagnosis less probable.
Biliary obstruction: Jaundice and the patient's history of suspected pancreatic cancer raise concerns for biliary obstruction, potentially leading to hepatic enzyme elevation.
Gastrointestinal (GI) bleeding: The patient's gastrointestinal symptoms, including epigastric pain and vomiting, may be indicative of GI bleeding, possibly related to the underlying malignancy.
Hepatic dysfunction: Abnormal liver enzymes and jaundice suggest possible hepatic dysfunction, which could be secondary to metastatic disease or biliary obstruction.
Hepatitis: The elevated liver enzymes (ALT, AST), bilirubin, and alkaline phosphatase could also indicate acute or chronic hepatitis. However, the absence of significant risk factors such as

intravenous drug use or recent travel to endemic areas, coupled with the presence of chronic epigastric pain, makes pancreatic pathology a more likely consideration.
Cardiac complications: Considering the patient's cardiac history and reluctance to undergo invasive procedures, it's important to consider potential cardiac complications contributing to her symptoms, such as heart failure or ischemic heart disease.

Plan:

Follow-up with gastroenterology for consideration of GI procedures such as EUS/ERCP/stent placement.
Referral to oncologist.
Focusing on symptom management and improving quality of life.
Counsel patient on Plavix - hold for 7 days prior procedures, consider holding if abnormal platelets or abnormal INR.
Icterus - follow with GI - follow up in April
Nausea / epigastric discomfort management - start low dose Zofran
Pain management: start low dose fentanyl patch, PRN Oxycodone 5mg oral Q 6 hours PRN for pain
Add narcan as rescue therapy in case of overdose.
Increase senna / Miralax,
Follow up in 4 weeks , after her return from DR.
Laboratory monitoring: Monitor liver function tests, electrolytes, and glucose levels closely
Supportive measures: Continue social work involvement to arrange home services or hospice care as needed.
Consideration for mental health support: Given recent stressors, consider referral for counseling or support groups to address the patient's emotional needs.