History and Physical Rotation 4
Name: Abd-Manaaf Bakere
Rotation 4: Internal Medicine
Date: 05/13/2024
Rotation Location: NYP Queens.

Name: LA
DOB: xx/xx/66
Age: 68 y/o
Address: Franklyn Ave NY
Date/Time: April 23,2024, 9:10 AM
Location: NYP Queens
Source of Information: Self
Reliability: Reliable
Preferred Language: ENGLISH

MEDICINE ADMISSION HISTORY AND PHYSICAL EXAMINATION

Chief Complaint. “unresponsiveness, elevated blood glucose, found on the floor at Nursing home”.

History of Present Illness:
LA is a 57 year old male with PMHx of Insulin dependent DM, HTN, HLD osteomyelitis s/p bilateral transmetatarsal amputations (Nov 2022), A flutter (previously on digoxin and amiodarone) presents from New Franklin rehabilitation for unresponsiveness, and elevated blood sugar. Per ED note, pt was noted to be unresponsive, NH was concerned about cardiac arrest and 1 round of CPR was done. NO medication was given. Patient does not recall what happened. Patient admits to chest discomfort s/p CPR. Per NH patient was also had nausea, vomiting, hemoptysis and decreased appetite x 1 day. Patients denies cough, chest tightness, wheezing, constipation, bloating, dysphagia, , changes in bowel habits, diarrhea.

IN ED, Tmax 37.5, HR 138, RR 20, BP 123/92, O2 67% (6L), O2 high flow 100% . WBC 14, procalcitonin 8.88, lactate 3.0>2.0, H/H 6.9/23.3, Glucose 573>370, AG 19>13, Beta hydroxybutyrate 0.44, Patient received vancomycin, cefepime 2g, Zofran 4mg x 2, Reglan 10mg. CT H negative, CTA showing No evidence of pulmonary embolus. Multifocal pneumonia, predominantly involving the left lower lobe. Consider follow-up imaging to ensure eventual resolution of imaging abnormalities. Small foci of subcutaneous gas adjacent to the right subclavian vein, presumably from vascular access, correlate with appropriate history.

Past Medical History
Balanoposthitis (9/24/2021),
DM (diabetes mellitus),
HTN (hypertension),
LV dysfunction (11/15/2022),
Peri-rectal abscess (10/25/2020),

Type 2 diabetes mellitus with hyperglycemia, with long-term current use of insulin (12/6/2020).
Hypothyroidism

Surgical History
Right foot transmetatarsal Amputation (11/29/20022)

Family History
Refuses to answer

Social History
Never smoked.
Never used smokeless tobacco.
Denies currently use drugs.
Denies alcohol use.

Allergies:
Penicillins

Outpatient Medications
• Apixaban (ELIQUIS) 5 mg, Oral, Every 12 Hours Scheduled
• Artificial tears ophthalmic solution 1.4 % Solution ophthalmic solution 1 drop, Both Eyes, 2 Times a Day
• Aspirin 81 mg, Oral, Daily
• Atorvastatin (LIPITOR) 40 mg, Oral, Bedtime
• Ferrous sulfate 325 mg, Oral
• Insulin glargine (LANTUS) 15 Units, Subcutaneous, Daily
• Levothyroxine 25 MCG Tablet 0.5 tablets, Oral, Daily
• Melatonin 5 mg, Oral, Nightly
• Metoprolol tartrate (LOPRESSOR) 50 mg, Oral, Every 12 Hours Scheduled
• Mirtazapine 15 MG Tablet 1 tablet, Oral, Nightly
• Mupirocin 2 % ointment 1 Application , Topical, 3 Times a Day
• Pioglitazone 15 MG Tablet 1 tablet, Oral, Daily
• Sitagliptin (JANUVIA) 100 MG Tablet 1 tablet, Oral, Daily

Review of Systems
General: Positive loss of appetite. Denies weight changes, fevers, weakness, fatigue, night sweats, chills, body aches.
• Skin: + for right leg color changes. denies rash, sores, lumps, itching, hair, nails
• Head: **Admits nausea, vomiting.** Denies trauma headache, dizziness.
• Eyes: Denies glasses/contacts, pain, redness, tearing, vision loss, discharge, double/blurred vision, glaucoma
• Ears: denies hearing loss/aid, tinnitus, vertigo, earache, discharge
• Mouth/Throat: denies bleeding gums, dentures, cavities, hoarseness, voice change, sore throat, 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, skin changes, pain, discharge
• Respiratory: **Positive for shortness of breath**. Negative for cough, chest tightness, shortness of breath and wheezing, snoring
• Cardiac: **Positive for chest pain and leg swelling.** Denies palpitations,
• Gl: **Positive nausea, vomiting decreased appetite and hemoptysis**. Negative for constipation, and bloating, dysphagia, , regurgitation, indigestion, changes in bowel habits, diarrhea, bleeding (hemorrhoids, melena, hematemesis, hematochezia), abdominal pain, jaundice.
• Urinary: **Positive frequency, polyuria, nocturia.** Negative for 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, paresthesia, fainting, blackouts, burning, tremors
• Hematological: denies anemia, easy bruising/bleeding, petechiae, purpura, ecchymosis, transfusions
• Endocrine: Positive for cold intolerance and thirst. Negative heat intolerance, sweating/hunger.
• Psychiatric: Positive for altered mental status. Negative psychosis, nervousness, mood, anxiety, depression, or suicidal ideation.

Physical Examination:
Recent Vital Signs:
Temp: 37.5 °C, Pulse: 138, Resp: 14, BP: (136/92), SpO2: 92 %, Height: 5' 11" (180.3 cm), Weight: 190 lb (86.2 kg), BMI: 26.5

Physical Exam
Constitutional:
  Comments: Pt noted to be removing high flow placing on his forehead despite education
HENT:
  Head: Normocephalic and atraumatic
  Right Ear: External ear normal.
  Left Ear: External ear normal.
  Nose: Nose normal.
  Mouth/Throat:
  Mouth: Mucous membranes are moist.
  Pharynx: Oropharynx is clear.
Eyes:
  Pupils: Pupils are equal, round, and reactive to light.
Cardiovascular:
  Rate and Rhythm: Regular rhythm. Tachycardia present.
  Comments: Refused cardiac exam
Pulmonary: No respiratory distress.
  Comments: On high flow, refused lung exam
Abdominal:
  General: Abdomen is flat. Bowel sounds are normal.

Tenderness: There is no abdominal tenderness.
Musculoskeletal:
Cervical back: Normal range of motion.
Right lower leg: Edema present.
Comments: Refused lower extremity exam
S/p right foot metatarsal amputations
Skin:
General: Skin is warm. Right heel ulcers wound
Capillary Refill: Capillary refill takes less than 2 seconds.
Coloration: Skin is pale.
Comments: **Unable to assess ulcers**, pt refused.
Neurological:
Mental Status: He is alert and oriented to person, place, and time.

Laboratory Studies:

Recent 04/23/24

CBC			**BMP**			**Hepatic Panel**	
HGB	6.9*	7.0*	NA	131*	132*	TP	9.3*
CRIT	23.2*	22.7*	K	6.2*	5.4*	ALB	3.3*
PLT	372	381	CL	93*	95*	SGOT	116*
WBC	12.49*	14.08*	CO2	19*	23	SGPT	84*
NEUTP	88.8*	82.0*	BUN	39.3*	37.7*	TBILI	0.6
LYMPHP	4.60*	9.80*	CREATININE	3.46*	3.29*	DBILI	0.2
EOSP	0.00	0.00	GLU	550*	418*	ALK	191*
			ANOINGAP	19*	14		
			CA	9.0	9.2		
			MAGNESIUM		2.1		
			PHOS	6.7*			

Coags Studies		PROCALCITONI	8.88	**Microbiology Results**
APTT	31.3	D-dimer 3K		RESPIRATORY PATHOGEN PCR PANEL
INR	1.32*	Cardiac:		Specimen: Nasopharyngeal Swab, for PCR Negative
		Trop 113>103		**UA**: cloudy, negative ketones, small leukocyte esterase
		PBNP	9,645*	WBC 6, present yeast, 5 squamous cells
		CK	141	

Imaging Studies:
Point of care ultrasound
IMPRESSION: Successful ultrasound guided peripheral IV insertion in the

right Upper Arm.

CT Chest Only with IV Contrast - Pulmonary Embolus
Narrative: HISTORY: A41.9: Sepsis, unspecified organism.

TECHNIQUE: **Contrast-enhanced CT pulmonary angiogram of the chest** was performed, with coronal and sagittal and MIP reformats.

COMPARISON: Chest radiograph 7/25/2023.

FINDINGS:

Pulmonary Arteries:
Opacification: Satisfactory
Emboli: No filling defects within pulmonary arterial tree

Lungs: Left lower lobe consolidative opacity. Additional nodular groundglass opacities in the lingula, right lower lobe, and right middle lobe likely representing an infectious etiology. Linear atelectasis/scarring in the right middle lobe. No pleural effusion. Patent central airways/trachea.

Chest Wall/Soft Tissues: Gynecomastia.

There are small foci of subcutaneous gas adjacent to the right subclavian vein, presumably from vascular access, correlate with appropriate history.

Musculoskeletal: Scattered degenerative changes.

Impression:
No evidence of pulmonary embolus.
Multifocal pneumonia, predominantly involving the left lower lobe.
Consider follow-up imaging to ensure eventual resolution of imaging abnormalities.

Small foci of subcutaneous gas adjacent to the right subclavian vein, presumably from vascular access, correlate with appropriate history.

CT Abdomen and Pelvis with IV Contrast
Sepsis, unspecified organism. Nausea and vomiting, abdominal pain. Found unresponsive on ground at nursing home.

TECHNIQUE: Contrast-enhanced CT of abdomen and pelvis was performed, with coronal and sagittal reformats.

COMPARISON: CT abdomen and pelvis 7/25/2023.

FINDINGS:

Liver: Enlarged, measuring 20 cm craniocaudal. No focal mass. Patent portal vein. Mild periportal edema.
Lymph nodes: Developing right inguinal lymphadenopathy, measuring up to 2.4. Multiple enlarged right pelvic sidewall lymph nodes along both internal and external iliac chains measuring up to 1.2 cm in short axis.
Soft tissues: Gynecomastia.
Impression: Developing right inguinal and pelvic sidewall lymphadenopathy. While possibly reactive to inflammatory process of the lower extremity, malignancy is not excluded. Short-term interval follow-up with CT abdomen pelvis with contrast in 2-3 months is advised if there is a explainable underlying etiology for reactive lymphadenopathy. Soft tissue sampling is advised to exclude metastases and/or lymphoma.

Mild periportal edema, nonspecific but possibly related to history of sepsis. Attention on follow-up imaging.

CT Head without IV Contrast
Narrative: HISTORY: Altered mental status.

FINDINGS:
No acute intracranial hemorrhage or extra-axial collection. No midline shift or other significant mass effect.

No acute loss of gray-white differentiation.

EKG
ECG 12 Lead

Ventricular Rate	92	BPM
Atrial Rate	92	BPM
P-R Interval	156	ms
QRS Duration	92	ms
Q-T Interval	382	ms
QTc	472	ms
P Axis	69	degrees
R Axis	65	degrees
T Axis	54	degrees

DIAGNOSIS

Assessment and Plan

Lance Ashford is a 57 year old male with PMHx of IDDM, HTN, osteomyelitis s/p bilateral transmetarsal amputations (Nov 2022), A flutter (previously on digoxin and amiodarone) presents from New Franklin rehabilitation for unresponsiveness, and elevated blood sugar. Per ED note, pt was noted to be unresponsive, NH was concerned about cardiac arrest and 1 round of CPR was done. NO medication was given. Severity of signs and symptoms suggest following diagnosis

Diagnosis:
• acute metabolic encephalopathy likely due to multifocal pneumonia
• sepsis likely due to multifocal pneumonia
• acute hypoxic respiratory failure likely due to multifocal pneumonia
• Incidental lymphadenopathy
• sinus tachycardia possible due to sepsis
• lactic acidosis
- Received vancomycin, cefepime 2g, zofran 4mg x 2, Reglan 10mg.
- f/up blood culture x 2
- f/up ID house – meropenem and vancomycin, f/up Vancomycin trough AM
- f/up pulmonology
- f/up MRSA/ MSSA
- f/up sputum culture
- f/up urine legionella, strep, and mycoplasma
- f/up Cardiology, to restarting digoxin and consult recommended to start pt on metoprolol 50mg BID
- f/up CEA, AFP, Ca19-9, PSA

• **Acute blood anemia**
- H/H 6.9/23.3,
- keep type and screen active
- Give 1 U PRBC, repeat after H/H
- f/up GI
- PPI BID
- patient refused occult, f/up occult with next BM

• **Subclinical hypothyroidism**
- per Nursing Home paperwork, pt previous was on synthroid, but was discontinued 2/8/23
- TSH 19, FT4 7.59
- per PMD continue to monitor for now, hold off endo consult at this time.

• **Diabetes Mellitus Type II with hyperglycemia**
- Glucose 573>370, AG 19>13, Betahydroxybutyrate 0.44,
- Give Humulin 5 U, 5U, 10U
- ICU evaluated the patient
- Check hemoglobin A1C
- Initiate diabetic diet
- Per NH, pt was noncompliant with his medications, Initiate insulin sliding scale
- Monitor fingerstick and adjust accordingly

- Monitor for hypo/hyperglycemia

• **Hyperkalemia**
- K 6.2> 5.4>5.1
- ECG HR 92, PR 156, no peaked T waves noted
- Give calcium gluconate, albuterol and insulin
- Trend BMP

• **AKI likely in setting of ATN due to sepsis**
- BUN: 37.7 Cr 3.29
- CT a/p negative for hydroneuphrosis
- Nephrology consulted: Recommend avoid nephrotoxic medications
- f/up UA, UPC, urine lytes, urine osmolarity, Urine protein, creatinine
- strict I/O
- daily weights
- monitor BMP

• **Hyperphosphotemia**
- Phos 6.7
- Per nephrology: F/Up repeat phos, likely due to AKI

• **Elevated troponin**
- s/p CPR in NH
- trop 113>103
- ECG negative for ST elevations
- monitor on tele
- f/up TTE

• **Elevated d-dimer**
- d-dimer 3K
- CTA neg for DVT
- f/up US Lower extremity, pt noted to have right Lower extremity edema

• **Chronic problem**
- A flutter- will hold Eliquis due to hemoptysis
- HLD- will hold atorvastatin 20mg due to elevated LFTs
- Insomnia- continue with melatonin 5mg
- depression continue with Remeron 15mg at bedtime.

Diet: clear liquids
GI PPX: Protonix IV Q12H for GI Bleed
DVT PPX: Sequential Compression Device SCDs