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Rotation 4: Internal Medicine

MEDICINE ADMISSION HISTORY AND PHYSICAL EXAMINATION

Chief Complaint: “Weakness and Fall 3 days ago with right hip pain, on Eliquis”

History of Present Illness:
A a 77-year-old female with PMHx of atrial fibrillation (s/p loop closure of LAA by Columbia and on Eliquis, GCS 15) , HTN, HLD, hypothyroidism, chronic epistaxis presenting for weakness. Per daughter, patient had episode of epistaxis on Wednesday, with big blood clots. She admits she was also feeling weak, fatigue. She had a mechanical fall on Saturday, while sitting on the toilet she tried to get up, but fell backwards on to the toilet and hit her right side of the back. She admits that her weakness was getting progressively worse, and she was told by her neighbor she looked more pale than usual. Per daughter she had more difficulty to ambulate than usual from her weakness. She uses a wheelchair, prior to the epistaxis and fall she was able to make few more steps. Pt admits to constipation. Per daughter she noticed blood from her hemorrhoid on Wednesday as well. Denies hitting head, fever, chills, abdominal pain, shortness of breath, nausea, vomiting, diarrhea.

ED course, BP 102/48 | Pulse 61 | Temp (Src) 36.8 °C (Oral) | Resp 18 | Ht 5' (1.524 m) | Wt 116 lb (52.6 kg) | SpO2 95% WBC 8.2/28, - CT head showing No evidence for intracranial injury. Stable area of chronic infarction in the right basal ganglia. Mild chronic microvascular ischemic changes in the periventricular/subcortical white matter. - Xray ribs and chest showing There is mild right basilar atelectasis. No pneumothorax is identified. The cardiac silhouette is mildly enlarged and unchanged. There is mild degenerative disc disease in the visualized spine. There is no evidence for right rib fracture or focal rib lesion.

Past Medical History
Acute respiratory failure with hypoxia,
Anemia, Asthma, Atrial fibrillation, Cardiac arrhythmia, Cardiogenic shock, Embolism and thrombosis of arteries of the upper extremities, GERD (gastroesophageal reflux disease), Hypertension,
Nonrheumatic aortic (valve) insufficiency, Nonrheumatic mitral (valve) insufficiency, and Respiratory syncytial virus pneumonia.

Surgical History
LAA: Left Atrial Appendage Closure

Family History
Mother Diabetes Mellitus II.

Social History
Never smoked. She has
Denies smokeless tobacco.
Denies drinking alcohol

Denies use of drugs.

Allergies:
Ibuprofen

Outpatient Medications
• Amiodarone (PACERONE) 200 mg, Oral, Every 12 Hours Scheduled
• Apixaban (ELIQUIS) 2.5 mg, Oral, Every 12 Hours Scheduled
• Digoxin (LANOXIN) 62.5 mcg, Oral, Every Other Day
• Docusate sodium (COLACE) 100 mg, Oral, 2 Times a Day PRN
• Levothyroxine 25 MCG Tablet 1 tablet, Oral, Daily
• Lidocaine 5 % Patch patch 1 Patch, Topical, Every 24 Hours, Remove & Discard Patch within 12 hours or as directed by MD
• Metoprolol succinate 25 MG Tablet ER 24 Hour Every 24 Hours
• Metoprolol tartrate (LOPRESSOR) 12.5 mg, Oral, Every 12 Hours Scheduled
• Omeprazole 40 MG Capsule DR 1 capsule, Oral, Daily
• Pantoprazole (PROTONIX) 40 mg, Oral, Daily
• Simvastatin 10 MG Tablet simvastatin 10 mg tablet
• Sodium chloride 0.65 % Solution nasal spray 1 Spray, Each Nostril, 4 Times a Day PRN
• Sodium chloride 3 % Nebulization Solution nebulizer solution 4 mL, Every 6 Hours PRN
• Spironolactone (ALDACTONE) 12.5 mg, Oral, Daily

Review of Systems
Constitutional: Negative for chills.
Respiratory: Positive for shortness of breath.
Cardiovascular: Negative for chest pain and leg swelling.
Genitourinary: Negative.
Musculoskeletal: Negative.
Neurological: Negative.
Psychiatric/Behavioral: Negative.

Review of Systems
General: **Positive fatigue, weakness**. Denies weight changes, fevers, night sweats, chills, body aches.
• Skin: + for pale skin. Denies, rash, sores, lumps, itching, hair, nails
• Head: Denies trauma headache, dizziness.
• Eyes: **pale conjunctiva**. 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: **Positive epistaxis,**. Denies stuffiness, rhinorrhea, sneezing, itching, 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: Denies chest pain Denies palpitations, lower extremities edema
• GI: **Positive constipation, bloating, hemorrhoids and hematochezia .** Denies nausea, vomiting decreased appetite, hemoptysis., dysphagia, regurgitation, indigestion, changes in bowel habits, diarrhea, abdominal pain, jaundice.
• 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, paresthesia, fainting, blackouts, burning, tremors
• Hematological: **positive easy bruising/bleeding(epistaxis).** Denies petechiae, purpura, ecchymosis, transfusions.
• Endocrine: Denies heat/cold intolerance, thirst, sweating/hunger.
• Psychiatric:. Negative psychosis, nervousness, mood, anxiety, depression, or suicidal ideation.

Physical Examination:
Vital Signs:
Temp: 36.8 °C, Pulse: 61, Resp: 18 room air, BP: 102/48, left arm, 134/51 right Arm
SpO2: 95 % ;Height: 5'02; Weight: 116 lb ; BMI: 21.2

Physical Exam
Constitutional:
General: Pale skin . She is not in acute distress.
Appearance: Normal appearance. She is normal weight. She is not toxic-appearing.
HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Nose: no epistaxis.
Mouth/Throat:
Mouth: dry mucous membranes.
Pharynx: Oropharynx is clear.
Eyes:
General: No scleral icterus.
Conjunctiva/sclera: Pale Conjunctivae.
Cardiovascular:
Rate and Rhythm: Regular rhythm, S1 and S2 present.
Pulses: Normal pulses.
Pulmonary:
Effort: Mild respiratory effort. No respiratory distress.
Breath sounds: Bilateral
Chest:

Chest wall: No tenderness.
Abdominal:
General: Bowel sounds are normal. No distension.
Palpations: Abdomen is soft.
Tenderness: There is no abdominal tenderness.
Musculoskeletal:
General: Normal range of motion.
Cervical back: Normal range of motion and neck supple.
Right lower leg: No edema.
Left lower leg: No edema.
Skin:
General: Skin is warm.
Capillary Refill: Capillary refill takes less than 2 seconds.
Coloration: Skin is pale.
Findings: Bruising present. Right 3rd and 4th finger gangrene.
Neurological:
General: No focal deficit present.
Mental Status: She is alert and oriented to person, place, and time. Mental status is at baseline.
Psychiatry: No acute psychosis.

Laboratory Studies:
Recent 05/01/24

CBC	**BMP**	**Hepatic Panel**
HGB 8.2*	NA 135	TP 6.4
CRIT 28.9*	K 4.7	ALB 3.8
PLT 218	CL 102	SGOT 31
WBC 5.37	CO2 19*	SGPT 9
NEUTP 82.6*	BUN 17.1	TBILI 0.6
LYMPHP 6.90*	CREATININE 1.35*	DBILI 0.2
EOSP 0.40	GLU 98	ALK 50
	ANOINGAP 14	
	CA 8.5*	
Coags Lab	Cardiac:	**Microbiology Results**
APTT 30.9	PBNP 555*	RESPIRATORY PATHOGEN PCR PANEL
INR 1.18*		Specimen: Nasopharyngeal Swab, for PCR Negative

Imaging Studies:
CT Head without IV Contrast : HISTORY: Fall

Comparison is made with prior CT scan of the brain dated 10/20/2019

Findings:

The ventricles and sulci are normal in size and configuration. There is no intracranial hemorrhage or extra-axial collection. There is a stable area of chronic infarction in the right basal ganglia. Mild low attenuation in the periventricular/subcortical white matter is unchanged and nonspecific, but likely related to chronic microvascular ischemic changes. There is no mass, mass effect or midline shift. Gray-white differentiation is preserved.

The brainstem and posterior fossa are unremarkable. The visualized paranasal sinuses and mastoid air cells are clear. The orbits are unremarkable. The calvarium and skull base are intact.
Impression: No evidence for intracranial injury.

Stable area of chronic infarction in the right basal ganglia.

Mild chronic microvascular ischemic changes in the periventricular/subcortical white matter.

XR Ribs Right with Chest : Reason for exam: Fall with rib pain.

TECHNIQUE: PA view of the chest and 6 views of the right ribs.

COMPARISON: Prior view of the chest dated 2/8/2024.

FINDINGS:
The examination is limited by patient motion.
There is mild right basilar atelectasis. No pneumothorax is identified. The cardiac silhouette is mildly enlarged and unchanged.
There is mild degenerative disc disease in the visualized spine.
There is no evidence for right rib fracture or focal rib lesion.
Impression: No evidence for right rib fracture or focal rib lesion.

ECG 12 Lead

Ventricular Rate	61	BPM
Atrial Rate		
P-R Interval		
QRS Duration	96	ms
Q-T Interval	428	ms
QTc	430	ms
P Axis		
R Axis	-11	degrees
T Axis	180	degrees

DIAGNOSIS

Assessment and Plan
A 77 year old female with past medical history of atrial fibrillation (s/p loop closure of LAA on Eliquis , HTN, HLD, chronic epistaxis, hypothyroidism presenting s/p for mechanical fall and right hip pain. Patient has been having worsening weakness past few weeks. Severity of signs and symptoms suggest.

• **Mechanical fall likely due to symptomatic anemia**
- monitor on telemetry
- Last TTE 15-20%, severely hypokinetic, left atrial is markedly enlarged, systolic function moderately reduced, severe aortic regurgitation, severe Mitral regurgitation.
- Fall precautions (Stay physically active, Fall-proof your home, sleep hygiene, Stand up slowly, Avoid or limit alcohol, Med reconciliation)
- ECG HR 61, QTC 430, monitor on tele
- Orthostatic monitoring
- f/up A1c, TSH, Lipid

• **Epistaxis**
• **Occult positive anemia**
• **Symptomatic anemia**
- H/H 8.2/28.9 (prior H/H 10.4/21.8), per daughter there is a bright red blood on the pamper
- occult positive
- STAT type and screen active,
- Give 1U pRBC
- patient consented for blood
- follow/up anemia panel
- monitor CBC
- Consider ENT for epistaxis if starts to bleed, at this time no epistaxis noted.
- Patient refused CTA of abdomen, and refusing aggressive therapy such as colonoscopy, endoscopy at this time, f/up with GI

• **Right 3rd and 4th finger gangrene**
- Follow up wound care
-Previous vascular consult: No acute surgical intervention at this time.

• **CKD Stage 3b**
- Cr 1.35 (at baseline)
- Avoid nephrotoxic medications
- monitor BMP

• **A. Fib** : Hold Eliquis; continue with amiodarone and digoxin.
• **HTN-** hold metoprolol 12.5mg BID
• **HLD**- per daughter not on any HLD medications, f/up Lipid panel
• **Hypothyroidism**- continue with Synthroid 25mcg

Diet: Clear Liquid Diet

GI ppx: Protonix IV Q12H for GI Bleed
DVT PPX: Sequential Compression Device SCDs.