Rotation 7: Emergency Medicine

Chief complaint: “I have upper back pain x 2 days”

HPI
A 65 y/o female with PMHx of HTN, HLD, DM, Asthma ,Depression and Osteoarthritis, presents with right upper back pain x 2 days. Patient reports sharp pain with deep breathing and movement, dry cough. Reports taking ibuprofen and gabapentin for pain without relief. Reports use of heat packs without improvement. Denies chest pain, shortness of breath, fever/chills, abdominal pain, nausea/vomiting/diarrhea, dysuria, weakness, numbness, paresthesia, headache, syncope, trauma/falls, rash, recent travel, or sick contacts. NKDA.

Past Medical History
Anxiety
Asthma
Depression
Diabetes mellitus
HLD (hyperlipidemia)
Hypertension
Palpitation

Past Surgical History
Right foot surgery
Mandible cyst removal
Cholecystectomy

Family History
None on file.

Social History
Smoking – 4 cigarettes per day
Illicit drugs - Denis any use of drugs.
Alcohol – Yes, wine once every 2 weeks
Diet – standard diet.
Exercise - Denies regular exercise.

Allergies/Intolerance:
N.K.D.A
Medication:
acetaminophen-codeine (TYLENOL/CODEINE #3)
amLODIPine (NORVASC)
aspirin (BAYER)
atorvastatin (LIPITOR)
budesonide-formoterol (SYMBICORT) inhaler
enalapril (VASOTEC) 2
eszopiclone (LUNESTA)

hydrOXYzine HCl (ATARAX PO)
lidocaine 5% (LIDODERM)
metFORMIN (GLUCOPHAGE)
montelukast (SINGULAIR)
naproxen (NAPROSYN)
omeprazole (PRILOSEC)

Immunization

Up to date with all immunizations

Review of Systems (ROS):

General: denies fatigue, weakness, weight changes, fevers, night sweats, chills, body aches, sleep
• Skin: denies rash, sores, lumps, itching, color changes, hair, nails
• Head: denies headache, trauma, nausea, vomiting, 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 hoarseness, voice change and sore throat, bleeding gums, dentures, cavities, dry mouth, difficult/painful
• Nose/Sinuses: Denies stuffiness, rhinorrhea, sneezing, itching, epistaxis, allergies (perennial, seasonal)
• Neck: denies lumps/masses, goiter, pain, stiffness, swelling
• Respiratory: **Admits cough, upper back chest pain, pleuritic pain.** Denies shortness of breath, wheezing, hemoptysis, snoring
Cardiac: Denies palpitations, DOE, orthopnea, paroxysmal nocturnal dyspnea, syncope, lower extremity edema
• Gl: Denies dysphagia, loss of appetite, nausea, vomiting, regurgitation, indigestion, bowel movement frequency/color/size/caliber, changes in bowel habits, diarrhea, constipation, bleeding (hemorrhoids, melena, hematemesis, hematochezia), abdominal pain, jaundice
• Urinary: denies frequency, polyuria, nocturia, hesitancy, urgency, dysuria, hematuria, incontinence, reduced caliber of stream
• Female: hernias, menarche age, period regularity/frequency/ duration/amount, dysmenorrhea, itching, discharge, sores, lumps, menopause, hot flashes
• Vascular: claudication, edema, varicose veins, past clots
• Musculoskeletal: **Admits upper back muscle pain**. denies others muscles or joints pains, 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: denies heat/cold intolerance, sweating/thirst/hunger
• Psychiatric: denies nervousness, mood, anxiety, depression or suicidal ideation.

Physical Exam

Vital Signs
BP 118/84
Pulse 98

Temp 98.2 °F (36.8 °C)
Resp 18
LMP (LMP Unknown)
SpO2 95%
OB Status Postmenopausal

Constitutional:
General: shee is not in acute distress. AOx3
Appearance: She is well-developed. Not toxic-appearing or diaphoretic.
HENT:
Head: Normocephalic and atraumatic.
Eyes:
Conjunctiva/sclera: Conjunctivae normal.
Pupils: Pupils are equal, round, and reactive to light. EOM Intact
Cardiovascular:
Rate and Rhythm: Regular rate and rhythm.
Heart sounds: S1 and S2 heart sounds appreciated. No murmur heard.
No friction rub. No gallop.
Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress.
Breath sounds: Bilateral breath sounds. No wheezing or rales.
Abdominal:
General: Bowel sounds are normal. There is no distension.
Palpations: Abdomen is soft. Not distended
Tenderness: There is no abdominal tenderness. There is no right CVA tenderness or left CVA tenderness.
Musculoskeletal:
Cervical back: Normal range of motion and neck supple.
Thoracic back: Spasms (R sided) and tenderness present. No deformity, lacerations or bony tenderness. Normal range of motion.
Comments: Radial and dorsalis pedis pulses equal bilaterally, steady independent gait
Skin:
General: Skin is warm and dry.
Capillary Refill: Capillary refill takes less than 2 seconds.
Coloration: Skin is not pale.
Findings: No erythema or rash.
Neurological:
Mental Status: She is alert and oriented to person, place, and time.

Test/lab/Imaging
CBC and differential:
Hemoglobin: 14.8, Hematocrit: 45.1 RBC: 4.76 WBC:12.76, Indices (Normal range) Platelet: 214
BMP:
Na:136, K:4.3, Cl:104, CO2:20, BUN:21, Creattine:0.6, Glucose: 167, Calcium:8.7, Anion Gap:12.

Protime-11.5, INR-1.0
aPTT: 28.7
Pro BNP: 66
Troponin T HS: 8. Reference 0-14ng/L
D-dimer: 308
EKG and Trop repeated without signs of acute ischemia

Chest X-ray
Bilateral lung base atelectasis versus scarring.. The heart size is normal. The mediastinum and hila are unremarkable. Degenerative and senescent changes.

Assessment
A 65-year-old female with a significant medical history of hypertension, hyperlipidemia, diabetes mellitus, asthma, depression, and osteoarthritis, who presents with a 2-day history of right upper back pain. Report pleuritic pain and dry cough. She denies fever, chills, shortness of breath. Vital sign within normal limit. On physical exam, there is tenderness and muscle spasm in the right thoracic back region, and her chest X-ray reveals bilateral lung base atelectasis versus scarring. Blood work is mostly unremarkable, except for an elevated glucose level. Given her presentation, her symptoms could be related to musculoskeletal, pulmonary, or cardiac etiologies.

Differential Diagnoses
Muscle Strain: The presence of tenderness, muscle spasms in the thoracic back, and pain exacerbated by movement make muscle strain a likely diagnosis. This could be attributed to her osteoarthritis or overuse, especially since there's no history of trauma.

Pleuritis: The sharp pain worsened by deep breathing and a dry cough could indicate pleuritis. Her recent history of cough and the findings of atelectasis/scarring on the chest X-ray further support this possibility. However, she denies fever or respiratory distress, which makes infectious causes less likely.

Pneumonia: Although she denies fever, the presence of a dry cough and right upper back pain raises the possibility of pneumonia, especially with bilateral lung base changes seen on the chest X-ray. The absence of systemic symptoms and normal CBC, however, makes it less probable.

Pulmonary Embolism (PE): Given her pleuritic pain and mildly elevated D-dimer, PE should be considered. However, the absence of shortness of breath, normal respiratory examination, and normal vital signs make it less probable.

Plan
Pain Management: Discharge with ibuprofen, Tylenol prn, lidocaine patch, and Zanaflex (Tizanidine) for pain relief,
Follow up with PCP for optimal control of chronic conditions.
Encouraged incentive spirometry to reduce atelectasis.
PT referrals
Discussed strategies and support options to quit smoking.