Jun Ma Hospital Visit

Date: 12/05/2017

Time: 9:00 am

Location: NYP Queens, 56-45 Main Street, Flushing, NY 11355

History

Identification	Name: C.B.	Sex: Male	DOB: 07/13/1951
	Age: 66 y/o	Race: White	Citizenship: U.S.A.
	Marital status: single		Religion: N/A

(6/6)

Informant: Self, reliable

Referral source: Self

Chief complaint: SOB for 3 months, worsening for 2 weeks

(a worsening SOB x 2 wks')

(would be good to mention PP year.)

HPI: Mr. B, a 66 y/o male former smoker with PMH of HTN and DM II and family history of cancer, presented to ED with c/o SOB, which started suddenly 3 months ago, consistent and moderate, not aggravated by physical activity or relieved by rest. He had a primary physician visit and lung CT showed left lung mass. 2 weeks ago, SOB became severe, accompanied by weakness, dry cough, chest discomfort and bilateral leg swelling. Denies fever, chill, sputum, hemoptysis, palpitation or varicose veins. Recent biopsy showed small cell lung cancer.

(24/30)

Explain these some more details.

need more

weight loss?

Sick contacts? Recent travel

What was done in ED? Dx? Findings?
How does pt present currently? feels.

Past Medical History

HTN x 20+ years under control (see medications)
DM Ⅱ x 20+ years under control (see medications)
Immunizations up-to-date
Dental exam 5/2017
Eye exam 7/2017

Past Hospitalization and Surgery History

Denies hospitalization, surgery or blood transfusions

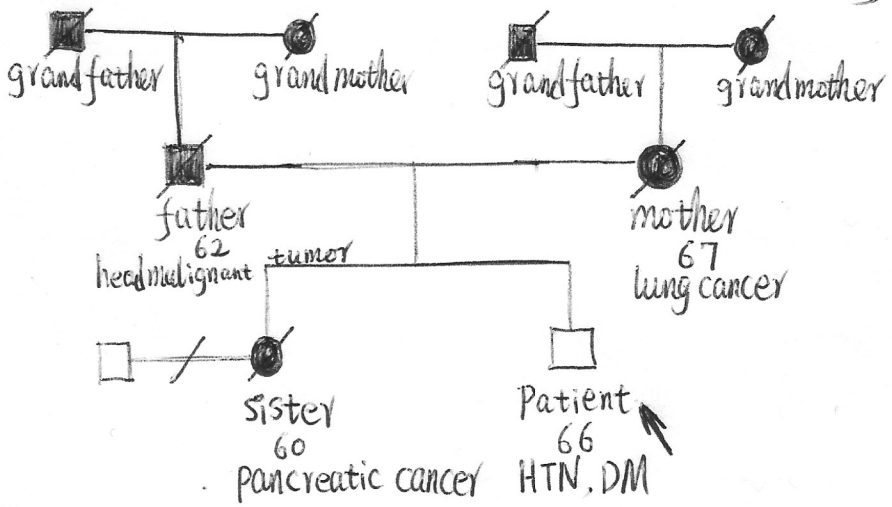
Medications

Glucophage (metformin) 1000 mg, 1 tab, PO twice a day for DM Ⅱ, last dose yesterday
Exforge (amlodipine and valsartan) 10/320 mg, 1 tab, PO qdaily for HTN, last dose yesterday

Allergies

Denies food, drug or environmental allergies.

Family History



20/20

Social History

Smoking x 33 years (cigarettes, 66 package years) and quit x 12 years
Denies alcohol or caffeine drinking
Denies recent traveling
Single, retired, living alone
Denies any specific sleeping disorders
Low-carbohydrate low-salt diet
No exercises
Sexual life inactive and denies STD history

ROS

Should mention in HPI

General: Admits weakness. Denies weight loss or gain, loss of appetite, night sweats, fever or chill.

Skin, hair and nails: Denies dryness, itchiness, discolorations, moles or rashes.

Head: Denies pain, vertigo or trauma.

Eyes: Denies visual disturbance, lacrimation, photophobia or pruritus. Last eye exam 7/2017

Ears: Denies hearing loss, pain, discharge, tinnitus or hearing aids.

Nose/Sinuses: Denies running, itching nose, epistaxis or obstruction.

Mouth and throat: Denies bleeding gums, sore tongue or throat, mouth ulcers, voice changes or dentures.

Neck: Denies localized swelling, lumps or stiffness.

Pulmonary system: Admits SOB, cough and chest discomfort. Denies sputum, wheezing, hemoptysis or cyanosis.

Cardiovascular system: Admits bilateral leg edema. Denies palpitations, irregular heartbeat, syncope or any known heart murmur

Gastrointestinal system: Denies loss of appetite, intolerance to specific foods, heartburn, nausea, vomiting, dysphagia, flatulence, burping, abdominal pain, diarrhea, constipation, jaundice, hemorrhoids, melena, or change in bowel habits.

Genitourinary system: Denies urinary frequency, pain, urgency, nocturia, oliguria, polyuria, incontience or flank pain. Urine color is light yellow. Denies hesitancy or STDs. Sexually inactive.

Nervous system: Denies dizziness, seizures, loss of conciousness, sensory disturbances, ataxia, or memory loss.

Musculoskeletal system: Admits bilateral leg edema. Denies muscle or joint pain, intermittent claudication, varicose veins, skin temperature changes, or skin color changes.

19/20

ROS (continued)

Hematologic system: Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions or history of PE/DVT.

Endocrine system: Denies polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating or hirtuism.

Psychiatric: Denies anxiety, depression/sadness, OCD, mental health professional visit or any related medications.

Physical Exam

General: 66 y/o male, well-developed, well-nourished, moderated distressed, A/o X3. moderate build and good posture. Looks ~~just~~ like his stated age.

Vital signs:

8/8

BP (mmHg):

	R	L
seated	120/82	118/82
supine	118/80	118/80

R: ~~22~~ breaths/min, unlabored

P: 94 beats/min, regular

T: 98.4°F (oral)

O_2 sat: 92% Room air

Height 69 inches Weight 168 lb BMI 24.8

Skin: Warm & moist, good turgor, nonicteric, no lesions noted, no scars or tattoos.

Hair: Average quantity and distribution, grey and black color

Nails: No clubbing, capillary refill < 2 seconds throughout

Head: Normocephalic, atraumatic, non tender to palpation throughout

Eyes: Symmetrical OU; no evidence of strabismus, ptosis or exophthalmos; sclera white; conjunctiva & cornea clear

10/10

Visual acuity (uncorrected - 20/20 OS, 20/20 OD, 20/20 OU)

Visual fields full OU. PERRLA. EOMs full with no nystagmus

Fundoscopy - Red reflex intact OU. Cup: Disk ≤ 0.5 OU/no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.

Physical Exam (continued) 20/20

Nose: Symmetrical / no obvious masses / lesions / deformities / trauma / discharge. Nares patent bilaterally / Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions / deformities / injection / perforation. No evidence of foreign bodies.

Sinuses: Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Ears: Symmetrical and normal size. No evidence of lesions / masses / trauma on external ears. No discharge / foreign bodies in external auditory canals AU. TM's pearly white / intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC > BC AU.

Lips: Pink, dry; no evidence of cyanosis or lesions. Non-tender to palpation

Mucosa: Pink, well hydrated. No masses or lesions noted. Non-tender to palpation. No evidence of leukoplakia.

Palate: Pink, well hydrated. Palate intact with no lesions, masses or scars. Non-tender to palpation; continuity intact.

Teeth: Good dentition / no obvious dental caries noted.

Gingivae: Pink, moist. No evidence of hyperplasia, masses, lesions, erythema or discharge. Non-tender to palpation.

Tongue: Pink, well papillated; no masses, lesions or deviation noted. Non-tender to palpation

Oropharynx: Well hydrated; no evidence of injection, exudate, masses, lesions, or foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema or lesions.

Neck: Trachea midline. No masses, lesions, scars or pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulse, no thrills or bruits noted bilaterally, no palpable adenopathy noted.

Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.

Physical Exam (continued)

Chest: Symmetrical, no deformities, no evidence of trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1, Non-tender to palpation.

Lungs: Tachypneic, dull to percussion left lower lobe, egophony over left lower lobe, breath sounds diminished in both lungs without any abnormal sounds. Chest expansion and diaphragmatic excursion symmetrical.

8/10

Heart: JVP is 2.5cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. S_1 and S_2 are unremarkable. No murmurs or extra heart sounds.

Assessment:

66 y/o male former smoker with PMH of HTN and DM II and family history of cancer, presented with SOB x 3 months worsening x 2 weeks accompanied by weakness, dry cough, chest discomfort and bilateral leg swelling, tachypneic, dull to percussion and egophony left lower lobe, breath sounds diminished. CT and biopsy showed left lung small cell cancer consistent with left small cell lung cancer with pleural effusion.

Plan:

1. Left small cell lung cancer with pleural effusion.
   - O_2 supplement
   - Albuterol 2.5mg, nebulization prn
   - specialist consultation
   - Abdominal and brain CT to check metastasis.
   - Thoracentesis
2. Hypertension
   - continue exforge (amlodipine and valsartan) 10/320 mg, 1 tab PO Qdaily
3. DM II
   - continue glucophage (metformin) 1000 mg, 1 tab, PO twice a day