**H&P 3 for IM**

**Identifying Data:**

Full Name: W.V.

Date of Birth: xx/xx/1953

Age: 65 y/o

Sex: Male

Date & Time: 05/07/2019, 8:50 am

Location: NYHQ, Flushing, NY

Religion: N/A

Source of Information: Self

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** “epigastric burning sensation and chest tightness” for 3 hours.

**History of Present Illness:**

65 y/o Male with PMHx COPD, Asthma, GERD, Barret esophagus presented to Ed for epigastric burning sensation and chest tightness. Patient reports around 2 PM this afternoon while watching TV he started experiencing acute burning like epigastric discomfort that was associated with burping and gas, 7/10, no radiation, intermittent for 3 hours with each episode 5-10 minutes. He reports epigastric pain and chest tightness on exertion sometimes with only 3-4 blocks and sometimes when he goes up stairs. Pt denies fever, chill, SOB, palpitations, cough, nausea, vomiting, or any focal neurological deficits.

**Past Medical History:** COPD, Asthma, and GERD for 15 years, Barret esophagus for 5 years.

**Past Surgery History:** None

**Past Hospitalization History:** Denied

**Immunizations** – Up to date (Flu 12/2018, Tdap 4/2010, and PPSV 23 1/2019)

**Medications:**

Symbicort 160 mcg-4.5 mcg/inh inhalation aerosol: 2 puffs inhaled 2 times a day -Indication: COPD.

Montelukast 10 mg oral tablet: 1 tab orally once a day -Indication: asthma.

Flomax 0.4 mg oral capsule: 1 cap orally once a day -Indication: BPH.

Nexium 40 mg oral delayed release capsule: 1 cap orally once a day -Indication: GERD.

Ranitidine 300 mg oral tablet: 1 tab orally once a day (at bedtime) -Indication: GERD.

**Allergies:** Denies any drug, environmental or food allergies.

**Family History:** non-contributory.

**Social History:** Married, living with wife. Smoking for 30 pack-years and quit for 10 years. Denies drinking alcohol/caffeine, or illicit drug use. Denies recent travelling. Regular diet. Routine running. Denies sleeping problem. Sexually active, only with wife. Denied STD.

**Review of Systems:**

General –Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever, chill or night sweats.

Skin, hair, nails – Denies excessive sweating, moles or changes in hair distribution.

Head – Denies headaches or head trauma.

Eyes – Denies pain, redness, swelling, visual disturbances, or photophobia. No glasses.

Ears – Admits spinning dizziness. Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or use dentures. No recent dental exam.

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion.

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Admits epigastric burning sensation and chest tightness. Denies palpitation, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system –Admit epigastric burning sensation and chest tightness. Denies change in appetite, intolerance to specific foods, dysphagia, nausea, vomiting, constipation, diarrhea, or jaundice. Last colonoscopy, 2016, normal.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysura, incontinence, awakening at night to urinate or flank pain.

Nervous –Denies seizures, headache, loss of consciousness, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

Musculoskeletal system – Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes.

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

Endocrine system – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric – Denies depression/sadness, anxiety, OCD or ever seeing a mental health professional.

**Physical Exam:**

General: Well developed, well nourished obese male, in no acute distress. Alert and cooperative. Looks just like his age.

Vital signs: BP: R L

Seated 118/76 118/80

Supine 108/74 112/72

R: 18 breaths/min, unlabored

P: 80 beats/min, regular

T: 36.8 degrees C (oral)

O2 Sat: 96% Room air

Height 68 inches Weight 236 lbs. BMI: 35.9

Skin: warm, good turgor. Nonicteric, no tattoos. Dry, raised, red skin lesions covered with silvery scales on left lower leg.

Hair: grey color, average quantity and distribution.

Nails: no clubbing, capillary refill <2 seconds throughout.

Head: normocephalic, atraumatic, non tender to palpation throughout

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity-deferred. Visual fields full OU. PERRLA. EOMs full with no nystagmus. Fundoscopy - refused.

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.

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.

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

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

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

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; foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions

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

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

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

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious sounds.

Heart: JVP is 2.5 cm 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. Regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

Abdomen: Flat/ symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present. No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Soft. No evidence of organomegaly. No masses noted. No evidence of tenderness, guarding or rebound tenderness. No CVAT noted bilaterally.

Rectal: refused.

Peripheral Vascular: Bilateral lower leg edema, non-pitting ++. Skin normal in color and warm to touch upper and lower extremities bilaterally. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No cyanosis, clubbing / noted bilaterally.

Neurological:

Mental Status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted.

Cranial Nerves

II- Visual fields by confrontation full. Fundoscopic refused.

III-IV-VI- PERRLA, EOM intact without nystagmus.

V- Decreased sensation of the right side of face, strength good. Corneal reflex intact bilaterally.

VII- Facial movements symmetrical and without weakness.

VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.

IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No Pronator Drift. Gait normal with no ataxia. Coordination by RAM and point to point intact bilaterally. Romberg negative.

Sensory: Decreased sensation of the right arm to light touch. Intact to sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally.

Reflexes R L R L

Brachioradialis 2+ 2+ Patellar 2+ 2+

Triceps 2+ 2+ Achilles 2+ 2+

Biceps 2+ 2+ Babinski neg neg

Abdominal 2+/2+ 2+/2+ Clonus negative

Meningeal Signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative.

Musculoskeletal: Bilateral lower leg edema, non-pitting ++. No soft tissue erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Non-tender to palpation / no crepitus noted throughout. FROM (Full Range of Motion) of all upper and lower extremities bilaterally. No evidence of spinal deformities.

Lab tests:

142 | 104 | 12.6

--------------------< 96 Ca: 9.2 Anion Gap: 15

4.5 | 23 | 0.85

WBC: 6.52 / Hb: 13.9 (MCV: 84.1) / Hct: 43.3 / Plt: 203

-- Diff: N:61.6% L:26.80% Mo:7.8%

Troponin: <0.010

Prot: 6.9 / Alb: 4.2 / Bili: 0.2 / AST: 15 / AlkPhos: 72

CXR: There is no evidence of pneumonia or pulmonary edema. No pleural effusion or pneumothorax. The cardiac silhouette is within normal limits. No acute osseous abnormality.

EKG: normal sinus at 82bpm, no signs of ischemia.

US VENOUS DOPPLER: No evidence of deep venous thrombosis or venous reflux in either leg from groin to knee.

**Assessment:** 65 y/o Male with PMHx COPD, Asthma, GERD, Barret esophagus presented to Ed for epigastric burning sensation and chest tightness, along with PE findings, compatible with GERD, but ACS and PE need to be ruled out.

**Plan:**

#Epigastric and chest discomfort likely 2/2 GERD r/o ACS

-tele, TTE

-check CE x 3. Hemoglobin A1C, lipid panel

-check US LE

-cont aspirin (81 mg, PO qdaily), Protonix (40 mg, PO bid)

-cardiology called by ED

#Asthma, COPD- Budesonide-Formoterol (2 puffs, inhalation bid), Montelukast (10 mg, PO qdaily)

#GERD- will cont Protonix (40 mg, PO bid)

#BPH- Flomax (0.4 mg, PO qdaily)

#GI/DVT pphx. Enoxaparin (40 mg, subcuntaneously qdaily)

#Obesity- Weight loss recommended

Differential diagnosis based on the chief complaint: GERD, ACS, PE, pneumonia, costochondritis, muscle strain, Dissecting aortic aneurysm, hepatitis, acute abdomen (Acute cholecystitis, Cholangitis, Pancreatitis, Perforated PUD, Appendicitis, Mesenteric ischemia, and Intestinal obstruction)

Differential diagnosis after H&P: GERD, ACS, PE, costochondritis, muscle strain.

Work up: TTE and US LE are unremarkable. Treat as GERD.

Patient education:

Gastroesophageal reflux disease (GERD), also known as acid reflux, is a long-term condition in which stomach contents rise up into the esophagus, resulting in either symptoms or complications. Symptoms include the taste of acid in the back of the mouth, heartburn, bad breath, chest pain, vomiting, breathing problems, and wearing away of the teeth. Complications include esophagitis, esophageal stricture, and Barrett's esophagus. Risk factors include obesity, pregnancy, smoking, hiatal hernia, and taking certain medicines. Medications involved may include antihistamines, calcium channel blockers, antidepressants and sleeping pills. Diagnosis among those who do not improve with simpler measures may involve gastroscopy, upper GI series, esophageal pH monitoring, or esophageal manometry. Treatment options include lifestyle changes; medications; and sometimes surgery for those who do not improve with the first two measures. Lifestyle changes include not lying down for three hours after eating, raising the head of the bed, losing weight, avoiding foods which result in symptoms, and stopping smoking. Medications include antacids, H2 receptor blockers, proton pump inhibitors, and prokinetics. Call your doctor or go to ER if your heartburn symptoms have become more severe or frequent, having difficulty swallowing or pain when swallowing, especially with solid foods or pills, your heartburn is causing you to have nausea or vomiting (especially if you are vomiting blood or black material), you've experienced a drastic or unexplained weight loss accompanied by heartburn, you have a chronic cough, choking sensation or sense of a lump in your throat, or you are having chest pain accompanied by pain in the neck, jaw, arms, or legs; shortness of breath, weakness, irregular pulse, or sweating.