History **Student: Anannya Dey**

Chief Complaint: “Heart was pounding” x 2 weeks.

History of Present Illness:

81 y/o female with PMX of hypothyroidism, HTN, hyperlipidemia, A-fib, anemia, COPD, and a pacemaker presenting with palpitations and dyspnea on exertion for 2 weeks. Pt noted that the SOB started the day after she started experiencing palpitations. Pt was sitting on her sofa and watching television when the palpitations abruptly started. Describes the palpation as “fast and pounding.” Palpitations stay constant throughout the day and do not become better or worse. Rates the intensity at 5/10. Pt noticed she was short of breath along with the palpitations when she went for her morning walk the next morning. She was able to walk only about 8 blocks before she had to take a break due to feeling short of breath. Previously she could walk for 30 mins. Taking a break from her walk and sitting down for about 5 minutes helps her breath better. No SOB with resting or talking. Did not take any medications to relieve palpitations or SOB. States she uses her inhalers as prescribed and they have not been helping. Pt visited her PCP and was instructed to go to the ER. Denies chest pain, cough, nausea, vomiting, pressure or orthopnea.

Past Medical History:

Present illnesses – Hypothyroidism, HTN, Hyperlipidemia, A-fib, Anemia and COPD
Past medical illnesses – GI bleed 4 years ago
Childhood illnesses – unable to recall
Immunizations – Up to date; flu vaccine yearly.
Screening tests and results:

- Last mammogram 6 months ago, no complications
- Pap smear done, unable to recall date, no complications

Past Surgical History:

Main coronary artery surgical clipping for aneurysm, 4 years ago, no complications
Pacemaker placed 6 years ago
Received 3 units of blood transfusion 4 years ago due to bleeding peptic ulcer
Denies past injuries

Medications:

Budesonide-formoterol 80-4.5 MCG/ACT Aerosol inhaler, inhaler 2 puffs every 12 hours, for COPD

Ipratropium albuterol 2-100 MCG/ACT aerosol solution inhaler, inhale 1 puff every 6 hours as needed for wheezing, for asthma
Cyanocobalamin 100 MCG lozenges for anemia
Pantoprazole 40 MG tablet, 1 tablet every 12 hours for gastric hyperactivity
Ferrous sulfate 325 MG tablet, 1 tablet by mouth with breakfast, for vitamin deficiency
Folic acid 1 MG tablet, 1 tablet by mouth daily, for vitamin deficiency
Levothyroxine Sodium 112 MCG tablet, 1 tablet by mouth daily for hypothyroidism
Pravastatin 40 MG tablet, 1 tablet at night for hyperlipidemia

Allergies: Denies allergies to medications or foods.

Family History:
Mother – no medical history known
Father – no medical history known
2 children, one daughter and one son, no significant medical history
Denies family history of cancer.

Social History:

Pt is retired, married and lives with her husband. States her children come to visit her once every 2 weeks. No history of smoking, drinking or use of drugs. Exercises by walking about an hour everyday around the park and doing chores in the house. Pt sleeps about 10 hours a night. Her diet usually consists of bagel and coffee for breakfast, a sandwich for lunch and pasta for dinner. Pt is currently not sexually active. No history of recent travel. Uses seat belts and other safety measures.

Review of Systems:
General: Denies fatigue, loss of appetite, recent weight loss or gain, generalized weakness, fever or chills, or night sweats.

Skin, hair, nails: Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head – Denies vertigo, headache or head trauma.

Eyes – Denies lacrimation, pruritus, visual disturbances, or photophobia. She wears glasses but not with her. Last eye exam 1 year ago – does not know her visual acuity; normal pressure.

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

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – (+) Has dentures. Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes. Last dental exam 2 years ago, no complications.

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

Breast – Denies lumps, nipple discharge, or pain.

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

Cardiovascular system – (+) Palpitation, HTN. Denies chest pain, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur

Gastrointestinal system – Denies nausea and change in appetite. Has regular bowel movements daily, intolerance to specific foods, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

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

Menstrual/Obstetrical – G(2)P(2) (NSVD x 2), no complications. Menarche age at 55. Currently in menopause – denies hot flashes or associated menopausal symptoms. Denies breakthrough bleeding/spotting or vaginal discharge.

Nervous – Denies headache, seizures, loss of consciousness, sensory disturbances, 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 – (+) Anemia, Easy bruising. Denies 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

General: Pt appears her age, alert and oriented. Maintains eye contact and not in respiratory distress or using accessory muscles. Nasal cannula inserted.

Vital Signs:	BP:	R	L
	Seated	114/64	118/68
	Supine	112/62	114/60

R: 16/min unlabored P: 60, regular rate and rhythm

T: 97.6 degrees F (oral) O2 Sat: 100% Room air

Height 65 inches. Weight 145 lbs. BMI: 24.1

Skin and head:
Skin - (+) mild dryness. Good temperature, good turgor. Nonicteric, no lesions, scars, or tattoos noted.
Hair - (+) Mild alopecia. Good quantity and distribution. No seborrhea or lice on exam.
Nails - No cyanosis, clubbing, or lesions noted. Capillary refill <2 seconds in upper and lower extremities.
Head - Normocephalic, atraumatic with no evidence of contusions, ecchymoses, hematomas, or lacerations. Nontender to palpation throughout.

Eyes - Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity: 20/25 OS, 20/30 OD, 20/20 OU
Visual fields full OU. PERRLA, EOMs intact with no nystagmus
Fundoscopy - Red reflex intact OU. Cup to disk ratio< 0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.

Ears: Symmetrical and appropriate in size. No lesions, masses, or trauma on external ears. No discharge/foreign bodies noted in external auditory canals AU. TMs pearly white/gray and intact with light reflex in good position AU. Auditory acuity intact to whispered voice AU. Weber midline/Rinne reveals AC > BC AU.

Nose - Symmetrical with no masses, lesions, deformities, trauma. Nares patent bilaterally. Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, or perforation. No foreign bodies.
Sinuses - Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Mouth and pharynx:
Lips: pink, moist. No cyanosis or lesions. Non-tender to palpation.
Oral mucosa: pink, well-hydrated. No masses, discharge, or lesions noted.
Palate: pink, well-hydrated. Palate architecture intact with no lesions, masses, or scars.
Teeth: Good dentition. No obvious dental caries
Gingivae: pink, moist. No masses, lesions, or hyperplasia. No swelling, discharge, or bleeding.
Tongue: Pink, well-papillated. No masses, lesions, or erythema. No leukoplakia.
Oropharynx: Well hydrated. No blood, masses, lesions, foreign bodies, or post-nasal drip. Tonsils present with no exudates or deviation. Uvula pink and midline, without edema or lesions.

Neck: Trachea midline. No masses, lesions, or scars. Supple and non-tender to palpation. No cervical lymphadenopathy noted.

Thyroid: Non-tender, rubbery, and mobile. No palpable masses or thyromegaly.

Chest: Symmetrical. Respirations unlabored and no accessory muscle use noted. No deformities or trauma. Lateral to AP diameter 2:1. Non-tender to palpation throughout.

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout.

Heart: Auscultations show regular rate and rhythm. JVP is 2.5 cm above the sternal angle with the head of the bed inclined at 30 degrees. PMI in 5th intercostal space in the mid-clavicular line. Carotid pulses are 2+ b/l without bruits of thrills. Distinct S1 and S2 with no S3 or S4 sounds and no murmur. No friction rub noted.

Abdomen: Soft, nontender and non distended. No lesions, masses, swelling, or discoloration noted on inspection. Bowel sounds normoactive in all four quadrants on auscultation, with no aortic/renal/iliac/femoral bruits. No rigidity, guarding, or rebound noted on palpation. No hepatosplenomegaly appreciated on palpation. No CVA tenderness or flank tenderness noted. No fluid wave noted.

Female GENITALIA:
External genitalia without erythema or lesions. Vaginal mucosa pink without inflammation, erythema or discharge. Cervix parous (or multiparous), pink, and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. Pap smear obtained. No inguinal adenopathy.

RECTAL
Rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative.

BREAST: Symmetric, no dimpling, no masses to palpation, nipples symmetric without discharge or lesions. No axillary nodes palpable

NEUROLOGIC EXAM:
Mental status: Alert and oriented to person, place, and time. Recent and remote memory, attention, abstract thinking, and new learning ability are intact. Cranial nerves: I - XII intact.
Motor: Good muscle bulk and tone with 5/5 strength on bilateral upper and lower extremities. No fasciculations.
Cerebellar: Rapid alternating movements, finger to nose intact. Stable gait. Negative Romberg and pronator drift.
Sensory: Pinprick, light touch, vibratory sense, and position sense intact bilaterally.
Reflexes: biceps 2+ b/l, triceps 2+ b/l, brachioradialis 2+ b/l, patellar 2+ b/l, ankle/achilles 2+ b/l, Babinski absent b/l.

PERIPHERAL VASCULAR: The extremities have good color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis, or edema noted bilaterally. No stasis changes or ulcerations noted.

MUSCULAR EXAM: Upper extremities - no swelling, erythema, atrophy, ecchymosis, or deformities bilaterally. Nontender to palpation with no crepitus noted throughout. Full active range of motion bilaterally.
Lower extremities - no swelling, erythema, atrophy, ecchymosis, or deformities bilaterally. Nontender to palpation with no crepitus noted throughout. Full active range of motion bilaterally.

ASSESSMENT

81 y/o female PMX of hypothyroidism, HTN, hyperlipidemia, A-fib, anemia, COPD, and a pacemaker presents with palpitations and dyspnea on exertion for 2 weeks. Pt reports needing to rest after walking about 8 blocks due to palpitations and SOB. Pt does not appear to be in

acute respiratory distress and no accessory muscle use. Pt is receiving oxygen via nasal cannula. Vitals and PE are unremarkable.
Preliminary workup: EKG, chest x-ray, CBC, CMP, BNP, troponin and ABG.
Would administer oxygen via nasal cannula, confirm medications list, ask about inhaler use. Because the patient is older, I would also involve the family member in the decision making process as well .

DIFFERENTIAL AND PLAN:

Arrhythmia: Afib with RVR

Palpitation and irregular heartbeat are a symptom of Afib. Pt has a history of Afib and a pacemaker. It may be that the pacemaker is not working as well and she is experiencing Afib again. Because the heart is beating too fast, the body might not be receiving enough blood which is causing her shortness of breath on exertion.

Plan: In the ekg, we would see no visible p waves and irregularly irregular QRS complex. For treatment since she is stable we would administer rate control medications, CCB or B-blockade. I would refer her to a cardiologist if there are no other immediate concerns.

Heart failure: Pt is experiencing dyspnea on exertion which is a symptom of HF and has a history of hypertension. The SOB could be a cardiac issue that is causing the lungs to not work as well. It can also cause palpitations and lead to cardiac arrhythmias such as atrial fibrillation with rapid ventricular response, which we know our patient has a history of. But she has no complaints of chest pain, orthopnea, or cough. And on exam there are no rales, pulmonary edema and JVD.

Plan: CXR to check for cardiomegaly, pleural effusion, cephalization. EKG to r/o irregular heart rhythm. Echocardiogram to assess ejection fraction. Troponin and BNP to see if it's elevated. CBC to check for anemia, CMP to assess any complications. I would do airway management with supplemental O2 and check pulse oximetry. If the patient was hypertensive I will administer lasix.

COPD Exacerbation: The pt has a hx of COPD, thus putting her at risk for exacerbation. Besides doing a general survey on the patient I would ask a few questions about her prescribed albuterol use. I will ask the patient if she is using her inhalers correctly. Then a followup question would be is she using it as prescribed and also if she finds herself needing it more often than prescribed. Lastly, I would ask if the inhaler has been helping her symptoms.

Plan: ABG, continued oxygen administration. CBC to check for leukocytosis. CMP to assess for any complications. If the patient is having an exacerbation upon arrival, I would start a Duoneb treatment and oral steroids if needed.

Stable Angina: Pt is an elderly and that increases the chance of stable angina. Angina can occur differently in elderly patients and females so they might not complain of all the typical

symptoms of angina. Symptomatically, the patient experiences SOB on exertion and becomes better with rest. Pt also has a history of coronary artery problems.

Plan: I would do an ekg to make sure there's no ST elevations and troponin to check if it's elevated, which in this case it should not be elevated. I would administer aspirin and plavix. Because the patient is older I would probably have her on an ekg monitor and observe her. Cardiologist consult if required, due to pt's age.

Dyspnea Secondary to Anemia:

Pt has a history of anemia that could be leading to SOB on exertion. Because of lack of iron, the red blood cells have a hard time carrying oxygen. But, the patient is on cyanocobalamin and several vitamin deficiency medications which should be helping increase her iron. Pt does not complain of the typical anemia symptoms such as fatigue which would also steer me away from this differential.

Plan: I would do a CBC and check the hemoglobin, hematocrit, mean corpuscular volume, mean corpuscular hemoglobin and mean corpuscular hemoglobin concentration level. We can do blood transfusion if these levels are severely low. I will also check her medications for anemia and see if anything needs to be changed and then consult her PCP.