Martin Vanegas
09/20/2023
Prof. Seligson
CUNY York PA Program
HPPA 522 – Physical Diagnosis II (Lab)

Hospital Visit H&P – Internal Medicine

CC: "Cough and my pee burns" x 7 days

HPI: 71 y/o M Ex-smoker with a PMH of Afib, COPD, CHF(unknown EF), DMII, HTN and CUR (chronic urinary retention) admitted to internal medicine c/o of fever, cough and dysuria x 7 days. Initially, he reported having a low grade fever (100.7 F) and having a productive cough being worse during the night. Pt states that the cough felt directly over the center of his chest and states that laying up with two pillows makes his cough better and laying down aggravates his cough. Patient states that the cough comes and goes throughout the day. Also he initially started to develop dysuria the night after the cough had started and he currently has a suprapubic transcather in place. Currently the patient reports only mild pain around the area of the cather with no radiation of the pain and a discomfort of 5/10 on pain scale. The patient was placed on a fourth generation cephalosporin (cefepime) IV 6 days ago that minimally helped improve his symptoms of dysuria over days 2-6. He is currently on a new authorized antibiotic (meropenem) and is being kept for continuous monitoring. Pt denies any new onset of fever, chest pain, hemoptysis, fatigue, night sweats, nausea, vomiting, abdominal pain, hematuria and or rectal bleeding.

Past Medical History:
-Afib - controlled with rx.
-Chronic urinary retention -controlled with suprapubic transcather
-Type II DM- controlled with rx.
-HTN -controlled with rx.
-COPD - controlled with Bipap
-CHF - controlled with rx.
-Immunizations: Up to date on all immunizations

Past Surgical History:
-Right knee replacement - Unable to recall year
-Cholecystectomy - Unable to recall year
-Aortic dissection surgery - 05/1998

Medications:

-Atorvastatin 80 mg -QHS
-Bisacodyl 10 mg - QD
-Symbicort 160-4.5 MCG - Q12H
-BusPIRone 5 mg - BID
-Calcitriol 0.25 mg - QD
-Diltiazem 30 mg - Q8H
-Fluticasone - QD
-Gabapentin - 100 mg - Q12H
-Insulin glargine 24 units -QHS
-Insulin Lispro - TID
-Losartan 25 mg - QD
-Meropenem 1 G - Q3H IV
-Metoprolol Tartrate 25 mg -Q12H
-Oxybutynin 5 mg - TID
-Pantoprazole 40 mg - TID
-PARoxetine 10 mg - QHS
-MIRALAX - QD
-Sucralfate -TID

Allergies:
-PNA allergy (Unknown reaction)
-Heparin allergy (Turns red and itchy)
-Denies food allergies
-Denies environmental allergies

Family History:
-Paternal/maternal grandparents, deceased, unsure of age or their medical history
-Father - Deceased, Age 79, Hx of HTN and DMII
-Mother - Deceased, Age 86, Hx of HTN and DMII
-No children

Social History:
Status - Pt is single and lives alone in a nursing home.

Occupation - Retired

Habits - Admits to “caffeine” intake with 1 coffee drink daily.

Smoking - Admits to a 25 year pack history of smoking and occasional use of mairjuana.

Illicit drugs - Admits to cocaine use 15 years ago.

Alcohol - Admits to having 1-2 alcoholic drinks socially.

Diet - Pt reports eating an overall balanced diet that is provided at the nursing home and reports eating a mixture of eggs, chicken/beef, rice and vegetables.

Exercise - Pt has physical therapy 5 times per week lasting 1 hour per session at the nursing home.

Sleep - Pt states he gets a good amount of sleep every night, about 7-8 hrs. No issues noted.

Travel - Denis any recent travel

Sexual - Denis any current sexual activity.

Immunizations
-Up to date with all childhood immunizations
-Up to date COVID-19 Moderna vaccines with boosters.
-Up to date with Influenza vaccine.

Review of systems:
General - Denies fatigue, weight loss, night sweats, fever, chills, weakness.

Skin, Hair and Nails - Denies skin, hair, nail changes, discolorations, pruritus, or new moles.

Head - Denies HA, vertigo, head trauma or lightheadedness.

Eyes - Denies photophobia, dryness, blurry vision or vision changes. Last eye exam - unable to recall

Ears - **Admits to using hearing aid on the right ear**. Denies deafness, tinnitus, pain, discharge.

Nose/sinus - Denies pain, discharge, epistaxis, difficulty breathing.

Mouth/throat - Denies sore throat, ulcers, bleeding gums, lesions or use of dentures. Last dental exam - (unable to recall)

Neck - Denies any localized swellings, masses, or decreased range of motion.

Breast - Denies any pain, masses, nipple discharge, gynecomastia, or other changes.

Pulmonary system - **Admits to cough.** Denies dyspnea, asthma, wheezing.

Cardiovascular system - **Admits to lower B/L leg edema.** Denies chest pain, chest tightness, palpitations, irregular heart beat, known heart murmurs, syncope.

Gastrointestinal System - Denis abdominal pain, nausea, vomiting, dysphagia, diarrhea, or rectal bleeding.

Genitourinary system - **Admits to dysuria.** Denis urinary frequency, urinary urgency, testicular swelling, flank pain or oliguria.

Menstrual/obstetrical – Not applicable to patient.

Nervous -Denies seizures, peripheral numbness, sensory disturbances or ataxia.

Musculoskeletal system - Denies weakness, swelling, arthritis.

Peripheral vascular system - Denies any known skin changes or ulcers.

Hematologic system - **Admits to hx of blood transfusions (unable to recall total times) and Hx of DVT + PE.** Denies any hx of anemia, abnormal bleeding, easy bruising.

Endocrine system - Denies heat intolerance, goiter or excessive sweating.

Psychiatric - Denies anxiety, sadness, depression, suicidal ideations.

Physical
General: 71 y/o M laying upright at 45 degrees on hospital bed with two pillow support on nasal cannula, A&Ox3 (person, place, time), afebrile, responding to questions with minimal trouble, appears stated age and in no acute distress.

Vital Signs
BP:
Supine: R:140/82 mm/Hg L:136/78 mm/Hg
Seated: R:128/74 mm/Hg (Done on roommate) - L:122/70 mm/Hg (Done on roommate)
RR: 14 breaths/min, unlabored, regular rhythm
Pulse: 86 beats/minute, regular
Temp: 98.1 F, oral

SPO2: 96% room air
Height: 5'8"
Weight:240 lbs
BMI: 36.4

Skin: Skin was pink, warm & moist with good turgor. Non-icteric in nature. Normal body temperature.

Hair: Black hair color, normal texture, distribution, and quantity noted.

Nails: Capillary refill on nails was under 2 seconds. No clubbing, erythema, swelling, lesions were noted.

Head: Normocephalic, atraumatic and nontender on palpation.

Eyes: Symmetrical OU. PERRLA, EOMs intact with no strabismus, exophthalmos, or ptosis. Sclera was white, cornea clear, conjunctiva pink and clear. Visual fields full OU.
Visual acuity uncorrected - 20/20 OS, 20/20 OD, 20/20 OU (Done on roommate)
Fundoscopy - Red reflex intact OU. Cup to disk ratio < 0.5 OU. No AV nicking, papilledema, hemorrhages, exudates, or neovascularization OU (Done on roommate)

Ears: Symmetrical and appropriate in size. No lesions or trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TM's grayish-white, intact, cone of light in normal position AU. Auditory acuity intact to whispered voice AU. Finger rub test demonstrated intact auditory acuity. Weber midline, Rhinne showed AC>BC B/L. (Done on roommate)

Nose: Symmetrical nares. No masses, lesions, trauma, discharge. Nasal mucosa pink. No foreign bodies or nasal septal hematoma noted b/L.

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses (Done on roommate)

Lips: Pink, moist, no cyanosis, cheilitis or lesions. Non-tender to palpation (Done on roommate)

Oral mucosa: Pink and dry. No masses or lesions. No leukoplakia. Non-tender to palpation (Done on roommate)

Palate: Pink and well hydrated. Palate intact with no lesions, masses or scars. Continuity intact.

Teeth: No signs of loose teeth or visible tooth decay.

Gingivae: Pink and moist. No hyperplasia, masses, lesions, erythema or discharge.

Tongue: Pink and well papillated. No masses, lesions or deviation noted.

Oropharynx: Well hydrated. No injection, exudate, masses, lesions, foreign bodies of any kind noted. Uvula is absent. Tonsils are absent

Neck: Trachea midline. No masses, lesions, scars; pulsations noted. Supple; non-tender to palpation. No carotid artery bruit. No cervical adenopathy noted.(Done on roommate)

Thyroid: Non-tender, no palpable masses, no thyromegaly. (Done on roommate)

Chest - Anterior/posterior chest appears symmetrical in nature. No deformities or trauma noted. Respirations unlabored with no signs of paradoxical respirations or use of accessory muscles noted. Lats to AP diameter 2:1. Non-tender to palpation throughout (Done on roommate)

Lungs – No Adventitious sounds noted. Regular rate, rhythm, depth and effort of breathing. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. Negative bronchophony, egophony, or whispered pectoriloquy. (Done on roommate)

Heart: Regular, rate, rhythm (RRR). S1 and S2 are distinct with no murmurs, no S3 or S4. No splitting of S2 or friction rubs appreciated. Carotid pulses are brisk 2+ bilaterally without bruits. JVP is 3 cm above the sternal angle with the head of the bed at 30°.The PMI is tapping, 1 cm lateral to the midclavicular line in the 5th intercostal space.(Done on roommate)

Abdomen: Abdomen is flat and symmetric with no pulsations noted. Bowel sounds hypoactive in all four quadrants with no aortic/renal/iliac or femoral bruits.No hepato-splenomegaly to palpation, no CVA tenderness appreciated. Percussion in all four quadrants are tympani in nature. Light and deep palpation over all four quadrants with negative TTP, guarding or rebound tenderness. Negative tenderness to palpation at McBurney's point. Neg Rovsing sign, no guarding, no rebound tenderness. Negative Murphy's sign.(Done on roommate)

Breast: Not applicable

Female genitalia: Not applicable

Male Genitalia & Hernias: Uncircumcised male. No penile lesions, discharge, discolorations. No scrotal swelling, masses, or discolorations. Testes are smooth and without masses. Nontender epididymis. No inguinal or femoral hernias.

Anus, rectum, & prostate: No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate smooth and nontender with palpable median sulcus. Stool brown; no fecal blood.

Differential Diagnosis

1. **Sepsis due to urinary tract Infection (UTI):** Patient initially had a fever, cough and dysuria. which is being treated with antibiotics. He is still currently having mild dysuria

and discomfort around the suprapubic catheter site which may suggest a urinary tract infection. He has a history of chronic urinary retention and has a Suprapubic catheter in place, which can increase the risk of infection or even sepsis.

2. **Community acquired pneumonia**: Patient presents with a productive cough and fever, which may be common symptoms of pneumonia. Also, his chronic health conditions including COPD and CHF which can make it likely that he is susceptible to respiratory infections like pneumonia.

3. **Congestive Heart Failure (CHF) Exacerbation:** Patient has lower bilateral leg edema and a history of CHF which can give rise to the possibility of a CHF exacerbation. CHF exacerbations may be present with symptoms like that of dyspnea and cough and is consistent with the patient's cough worsening when lying down.

4. **Exacerbation of COPD:** Patient has a history of COPD and reports a cough that's worse at night. This could be indicative of an exacerbation of his COPD, especially considering he is an ex smoker with a 25 year pack history.

5. **Pyelonephritis:** Lastly, the patient's fever and dysuria can indicate a kidney infection, for his age and due to his overlying medical conditions.The presence of a suprapubic catheter may be the potential source of infection.

Assessment:
71 y/o M Ex-smoker with a PMH of Afib, COPD, CHF, DMII, HTN and CUR (chronic urinary retention) presents to internal medicine c/o of fever, productive cough and dysuria that started 1 week ago. Currently, the patient is only exhibiting a productive cough and dysuria with minimal pain around the suprapubic catheter in place. Pt denies any other symptoms at this time. This is pointing to a patient that developed a UTI from his suprapubic catheter that led to sepsis with a superimposed case of community acquired pneumonia.

Plan:
Continue current medical management with treatment with IV meropenem infusion to control current infection. Reassess with labs (CBC with diff, lactate, CMP) and thorough physical exam as treatment progresses. Follow up with blood/urine cultures with sensitivity. Also monitor for any fluid overload due to hx of CHF with an unknown EF.

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History and Physical Verification Form

Class: Physical Diagnosis II (HPPA 522)

Student Expectation:

- Obtain medical history and perform physical exam up to the point covered in class.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

Student: Martin Vanegas

Clinical Site: NYPq-H

Date of Visit: 09/19/23

Activity performed: H and P

Supervisor:

Name and Credentials: Heidi Chen PA-C

Supervisor Signature:

Supervisor Comments: