Ruthie Schreiber

H&P #2

Internal Medicine (Rotation #9)

9/30/20

ID:

Ms. V.C. Queens Hospital Center

Informant: Self, Reliable

Chief Complaint:

"I've been having trouble breathing" x 1 week

HPI:

59 year old female with significant PMH of moderate persistent asthma, history of COVID-19 pneumonia, and varicose veins was sent to the ED from the vascular clinic for wheezing and SOB x 1 week. Patient was at her appointment this morning around 10am where staff noticed her SOB and wheezing and suggested she should visit the emergency department. She states that she has asthma exacerbations every so often which she attributes to her living situation. Patient lives in an attached apartment where her neighbors smoke, which exacerbates her asthma. She denies experiencing any wheezing or SOB when she's at work or away from her home. She has tried to change her living situation but it has become complicated due to the pandemic. She takes Albuterol (inhaler and nebulizer) and Symbicort at home, and admits to needing to use the Albuterol nebulizer up to 5x/day for the past week. She denies any sick contacts, recent travel, cough, chest pain, or fever.

PMH:

Asthma

COVID-19

HTN

PSH:

Nasal Polyp Surgery (2009)

Right knee arthroscopy (1999)

Medications:

Albuterol (Proventil HFA; Ventolin HFA) 108 (90 base) MCG/ACT inhaler, inhale 2 puffs 4x a day

Albuterol (Proventil) 2.5mg/3mL 0.0083% nebulizer solution, take 3mL (2.5mg total) by nebulization 3x a day

Budesonide-formoterol (Symbicort) 160-4.5 MCG/ACT inhaler, inhale 2 puffs 2 times a day

Allergies:

Egg or Egg-derived products (cough/sneeze/chills)

Social History:

Admits to social alcohol drinking (1 glass of wine per week). Denies smoking or illicit drug use

Family History:

Mother- heart disease, HTN, stroke, multiple myeloma

Father- pancreatic cancer

Review of Systems:

General : Admits to generalized weakness/ fatigue. Denies fever, chills, night sweats, loss of appetite, weight loss.

Skin, Hair, Nails : Denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, change in hair distribution

Head : Denies headache, trauma, unconsciousness, coma, fracture, vertigo

Eyes : Denies corrective lenses, visual disturbances, fatigue, photophobia, pruritus, lacrimation

Ears : Denies deafness, pain, discharge, tinnitus, hearing aids

Nose/Sinuses : Denies discharge, epistaxis, obstruction, rhinorrhea

Mouth/Throat : Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures

Neck : Denies lumps, swelling, stiffness, decreased range of motion

Breast : Denies lumps, nipple discharge, pain

Respiratory : Admits to SOB, DOE, wheezing. Denies cough, hemoptysis, cyanosis, paroxysmal nocturnal dyspnea

Cardiovascular : Denies chest pain, palpitations, irregular heartbeat, edema, syncope, known heart murmur

Gastrointestinal : Denies change in appetite, abdominal pain, diarrhea, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, constipation, hemorrhoids, blood in stool

Genitourinary : Denies change in frequency, urgency, hesitancy, dribbling, nocturia, polyuria, oliguria, dysuria, change in urine color, incontinence, flank pain

Musculoskeletal : Denies muscle/joint pain, leg weakness, deformity, swelling, redness

Peripheral Vascular : Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change

Hematologic : Denies anemia, lymph node enlargement, history of DVT/PE, easy bruising/bleeding

Endocrine : Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism

Neurologic : Denies loss of strength, ataxia, seizures, loss of consciousness, sensory disturbances, paresthesia, dysesthesia, hyperesthesia, memory loss, asymmetric weakness

Psychiatric : Denies feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideation, anxiety

<u>Physical Exam:</u>

Vital Signs:

T 97.7 F

BP 111/69

P 87 bpm

RR 16 breaths/min

SpO2 99% on NC (2L), 92% on RA

General Survey : 59 year old female well developed/nourished in no acute distress

Skin : Warm and moist, non-diaphoretic

Head : Normocephalic, atraumatic, non-tender to palpation throughout

Eyes : No conjunctival injection/ pallor or scleral icterus. PERRLA

Nose: No obvious masses, lesions, signs of trauma or discharge noted

Neck : Trachea midline. No masses, lesions, scars. Supple, nontender to palpation. Full range of motion. No palpable lymphadenopathy.

Chest : Symmetrical, no deformities. No paradoxical respirations or accessory muscle use. Respirations are unlabored

Lungs : Diffuse wheezes heard throughout both lung fields bilaterally

Cardiovascular : S1 and S2 normal. Regular rate and rhythm. No S3, S4, splitting of heart sounds, murmurs, rubs.

Abdomen : Soft and non-distended abdomen. Non-tender to palpation throughout. BS present in all four quadrants. No bruits over aortic/renal/iliac/femoral arteries. No guarding, rebound tenderness. No hepatosplenomegaly appreciated

Extremities/Peripheral Vascular: Varicose veins noted bilaterally. Extremities are normal in size and temperature. No clubbing/cyanosis/edema noted. Full ROM.

Neurologic :

<u>Mental Status:</u>

Awake, alert and oriented to person, time, place, situation. Appears as stated age, well groomed, eye contact good. No dysarthria, dysphonia, aphasia noted.

<u>Cranial Nerves:</u>

II-XII grossly intact.

Labs/Imaging:

140 | 103 | 10

----------< 133 CO2: 28 Anion Gap: 11

4.7 | 24 | 0.62

WBC: 11.52 Hb: 13.3 (MCV 95.67)/ Hct 41.7/ Plt: 262 Diff: N: 87.7% L: 9% Mo: 2.5%

E: 0% B: 0.1%

Venous Blood gas: pH= 7.308/ pCO2= 65/ pO2= 41.6/ HCO3= 31.6

Peak flow: 150 (Personal peak flow best= 250)

Portable Chest X-ray (9/29): No radiographic evidence of acute pulmonary abnormality. Cardiac silhouette is not enlarged, no pneumothorax, no focal consolidation, no pleural effusion

Bilateral lower extremity venous duplex (9/29): No evidence of lower extremity deep vein thrombosis

EKG (9/29): sinus rhythm at 86bpm

Differential Diagnosis:

-Acute asthma exacerbation

-COPD

-Bronchitis

-Bronchiectasis

-Pneumonia

-Aspiration

Assessment:

V.C. is a 59 year old female with significant PMH of asthma, COVID-19 pneumonia, and varicose veins % wheezing and SOB x 1 week. Findings most consistent with acute asthma exacerbation.

Plan:

-Ipratropium-Albuterol (Duoneb) 0.5-2.5mg/ 3mL nebulizer solution, 3mL every 4 hours
-Resume Symbicort 2 puffs BID
-Start Solumedrol 40mg IV q8h
-Oxygen supplementation via nasal cannula to keep O2 saturation > 94% prn
-Monitor BMP, VBG, CBC, vitals

Patient Education:

The main goal in treating your asthma is to reduce your number of exacerbations and prevent future emergency department visits and subsequent asthma-related hospital stays.Take the following measures to reduce your risk of developing future exacerbations and complications

1) Home environment: Try to change your living conditions as soon as possible, despite the pandemic. Second-hand smoke can exacerbate your asthma and increase your risk. Avoid other public places where cigarette smoking occurs
2) Medication reconciliation: before discharge we will review your current medications and determine the most appropriate regimen for you
3) Peak flow meter: This device will be used to check how well your asthma is controlled. Move the marker to the bottom of the numbered scale, take a deep breath and fill your lungs all the way. Hold your breath while you place the mouthpiece in your mouth between your teeth. Close your lips around it, blow as hard and as fast as you can in a single blow. Write down the number you get. Move the marker back to the bottom and repeat all steps 2 more times. The highest of the 3 numbers is your peak flow number and should be documented.