Melinda Chiu
NYPQ - IM Rotation

H&P 1

Name: WC
Age: 73
Address: Queens, NY
Date & Time: Sept 26 2020 @ 10:32 AM
Location: NYPQ
Reliability: Reliable
Source of Information/Referral: patient
Mode of Transportation: ambulance

CC: chest pain x 3 days ago
PHI: 73yo M with PMH of HTN, HLD, MI (2017 s/p 5 stent placement), CAD (2000s s/p b/l carotid endarterectomies and 1 R carotid stent), and moderate AS (followed by cardiologist Dr. M, with scheduled consult 10/9 for valve replacement), BIBA to the ER 3 days ago CC of midsternal C/P. The patient described the pain to have started spontaneously that morning , "squeezing-like", constant, not exacerbated by exertion, and alleviated with Nitroglycerin administered on the field. There was associated SOB and dry cough during episode. Pt stated he had another C/P episode the day prior (4 days ago) that did not feel as painful, and only lasted for a minute. C/P experienced in both episodes were similar, but less in severity, than MI in 2017. Currently denies N/V/D, chest pain, syncope, palpitations, SOB, DOE, fever, chills, abdominal pain, nor urinary symptoms.

PMH: HTN, HLD, MI (2017 s/p 5 stent placement), CAD (2000s s/p b/l carotid endarterectomy and 1 R carotid stent), moderate AS (diagnosed 3/2020)
Surgical history: 6 stent placements (5 in heart, 1 in right carotid), R hip, L ankle
Social History: denies smoking, drinking, nor illicit drug use
Family History: no known CAD
Allergies: Plavix - anaphylaxis, No food allergies

Medications:
*Amlodipine Tab 10 mg Oral Daily
*Valsartan Oral 320 mg Oral Daily
*Metoprolol XL Sustained Release Oral 50 mg Oral Daily
*Aspirin Chewable Tab 81 mg Oral Daily
*Ticagrelor Tab 90 mg Oral bid
Enoxaparin Inj 40 mg Subcutaneous Daily
Atorvastatin Tab 40 mg Oral bedtime [Rosuvastatin 90mg QD outpatient]
Pantoprazole Delayed Release Tab +R+ 40 mg Oral Daily [Zantac 150mg BID outpatient]

ROS
General: denies fever, chills, fatigue
Skin/Hair/Nails: no complaints
Head: denies H/A, dizziness, trauma

Eyes: no complaints
Ears: denies blurry vision, diplopia, visual disturbances
Nose: no complaints
Mouth: no complaints
Neck : no complaints
Heart: refer to HPI
Lungs: denies SOB, cough, PND, orthopnea, sputum production
GI: denies abdominal pain, change in appetite, hemoptysis, stool changes
Vascular: denies LE swelling, pain, edema
Urinary: no urinary sx.
MSK: no complaints
Neuro: denies H/A, dizziness
Psychiatric: denies anxiety, depression, panic attacks

PE:
VS: BP 124/57, Pulse 75, RR 18, Temp 97.8 F, O2 98% on room air
General: A&Ox3, no apparent distress, well appearing, laying comfortably in bed
Head: atraumatic, non tender
Eye: PERRA, EOM intact
Nose: --
Mouth: --
Ears: --
Neck: no JVD nor lymphadenopathy, ROM intact
Chest: harsh systolic murmur appreciated (grade II/VI)
Lungs: no use of accessory muscles, CTA, no adventitious sounds
Abdomen: non distended, bowel sounds present in all 4 quadrants, soft and nontender to palpation
MSK: full ROM
Neuro: CN 2-7, 9-12 intact; normal gait
Vascular: no edema noted on LE

Differential diagnosis

- *Myocardial infarction* - most important to rule out first, highly suspicious due to patient history of MI, comorbidities, and similar type of pain
- *Complication of Valvular heart disease* - due to patient's known moderate AS, possible severity of AS had worsened
- *Stable angina* - possible due to pain description and ability to resolve, however it occurred spontaneously - not from exertion, and was not predictable
- *Aortic dissection* - must be ruled out, possible due to patient's comorbidities, however unlikely since pain was able to resolve with use of NTG and pain would have been more severe and "ripping" type of pain
- *Anxiety/Panic attack* - possible due to spontaneous episode of "squeezing" chest pain, however, not likely since patient denied any psychiatric issues in ROS

Melinda Chiu
NYPQ - IM Rotation

H&P 2

Name: HW
Age, Gender: 69 F
Address: Queens, NY
Date & Time: Oct 8 2020 @ 2:30 PM
Location: NYPQ
Reliability: Reliable
Source of Information: patient
Source of Referral: self
Mode of Transportation: Ambulance

CC: dizziness x 1 day

PHI: 69yo F with PMH of HTN, HLD, stroke x 2 (2018 and 2016) and vertigo, BIBA to ED complaining of dizziness that began at 5am. Dizziness was first noted when patient attempted to get out of her bed, is constant, feels as if the room was spinning, and lessens when she lays down, but exacerbated when attempting to sit up. She was last known well at 11pm last night. She had a similar dizzy episode a month ago, however, it had resolved spontaneously after 10 minutes. She also had associated chest pressure, that was midsternal and non-radiating; worsened balancing when walking, weakness, nausea and diaphoresis. Denies vomiting, fever, chills, headache, tinnitus, vision changes, LOC, SOB, changes in motor/sensory function. At baseline patient uses a cane at home, and walker outside.

PMH:
HTN, HLD, stroke x 2 (2018 and 2016), vertigo

Surgical history:
None

Social History:
Denies smoking, drinking, nor illicit drug use.
At baseline patient uses a cane at home, and walker outside.

Family History:
Mother had stroke at 87, and HTN; Father had HTN

Allergies:
NKDA, No food allergies

Medications:
Amlodipine 5mg, 1 tablet QD
Plavix 75mg, 1 tablet QD
Atorvastatin 10mg, 1 tablet QD
Lovaza (Omega 3) 1000mg capsule, 2 capsules PO BID

ROS
General: denies fever, chills, fatigue, weight loss
Skin/Hair/Nails: no complaints
Head: admits to dizziness, denies H/A and trauma
Eyes: denies blurry vision, diplopia, visual disturbances
Ears: no complaints
Nose: no complaints
Mouth: no complaints
Neck : no complaints
Heart: admits to chest pressure, denies palpitations, syncope, DOE
Lungs: denies SOB, cough, PND, orthopnea, sputum production
GI: admits to nausea, denies vomiting, abdominal pain, appetite/stool changes, hemoptysis
Vascular: history of stroke x 2
Urinary: no urinary sx.
MSK: admits to generalized weakness
Neuro: admits to dizziness and worsened balancing when walking
Psychiatric: denies anxiety, depression, panic attacks

PE:
VS: BP 143/86, Pulse 84, RR 18, Temp 98.4 F, O2 94% on room air
General: A&Ox3, no apparent distress, appears stated age, laying in bed
Head: atraumatic, non tender
Eye: PERRA, EOM intact, visual fields intact
Ears: passed whisper test
Nose/Mouth: symmetric nasal labial fold
Neck: no JVD nor lymphadenopathy, ROM intact
Chest: S1, S2, no murmurs appreciated
Lungs: no use of accessory muscles, CTA, no adventitious sounds
Abdomen: non distended, bowel sounds present, soft and nontender to palpation
MSK: full ROM, 5/5 strength in upper and lower extremities
Neuro: A&Ox3, CN 2-12 intact; unable to assess gait due to patient's dizziness
Vascular: no edema noted on LE

NIHSS:
1. LOC = alert (0), answered both questions correctly (0), performs tasks correctly (0)
2. Best gaze = normal (0)
3. Visual = no visual lost (0)
4. Facial palsy = normal symmetric movements (0)
5. Motor arm = no drift b/l (0,0)
6. Motor leg = no drift b/l (0,0)
7. Limb ataxia = absent (0)
8. Sensory = no sensory loss (0)
9. Best language = normal, no aphasia (0)
10. Dysarthria = normal (0)
11. Extinction and inattention = no abnormality (0)
    Total score = 0

Differential diagnosis

- Benign paroxysmal positional vertigo - high on differential: sudden onset of vertigo, exacerbated by positional changes, associated nausea, with non hearing loss/tinnitus
- Vestibular neuritis - vertigo with nausea, less likely differential due to ability of vertigo to lessen when laying down and no associated hearing loss
- Myocardial infarction - patient has cardiac risk factors and chest discomfort, is a older woman who may present atypically, must r/o this differential
- Elevated BP - dizziness may be due to elevated blood pressures, was 148/84 at admission
- Meniere's disease - due to dizziness, but less likely since patient does not complain of hearing loss, tinnitus nor ear fullness
- Hypoglycemia - must r/o, possible in elderly woman with rice and tea diet
- Stroke - less likely due to negative NIHSS, however must rule out due to patient's risk factors and symptoms of vertigo, unsteady gait and weakness