Melinda Chiu
NYPQ - LTC Rotation

H&P

Name: Mr. MA
Age: 67
Address: Queens, NY
Date & Time: Nov 9 2020 @ 10:32 AM
Location: NYPQ
Reliability: Reliable
Source of Information/Referral: patient and daughter
Mode of Transportation: family car
Language: English

CC: chest tightness, sweating, anxiety x starting 2am in the morning
PHI: 67yo Indian male with PMH of HTN, DM2, HLD, Hepatitis B - complicated by Cirrhosis, MI in 2013 s/p 3 stents, CVA in 3/2019 and 4/2019 s/p L side cerebral stent with residual right arm and left leg weakness, presented to the ED c/o of sweating, chest tightness, and anxiety. Symptoms started at 2am in the morning when the patient woke up from sleep sweating (although the fan was on). He reported feeling chest tightness and anxiety (despite denying having any emotional stress recently), which were similar to symptoms he experienced with his past MI. The chest tightness was located in the general area of his chest, with no radiation, 1/10 pain scale, lasting around 20 minutes and resolved spontaneously prior to this visit to the ER. Patient stated that the pain lasted continuously during the 20 minutes, not aggravated nor alleviated by his changing of positions, nor drinking of water. He did not try to take any medication to relieve the pain. Patient's BP taken at home prior to coming to hospital was 210/83, with a pulse of 64 bpm. He stated that he takes his medications regularly, and that the SBP is usually around 125. Patient stated that prior to going to bed at 11pm, he felt normal and did not do anything out of the ordinary. Denies fever, chills, N/V/D, H/A, dizziness, LOC, palpitations, SOB, DOE, PND, orthopnea, history of GERD, back pain, abdominal pain, blurry vision, other sx.
Patient's symptoms resolved by time of arrival in the ED. In the ED, he was given one dose of Aspirin and Nitroglycerin. EKG showed normal sinus rhythm at 65 bpm, flipped T-wave in aVL, and no interval prolongations, similar to previous EKG performed on 04/15/19. CXR showed a cardiac silhouette upper limits of normal for size, mild pulmonary vascular fullness, and no pneumothorax, pulmonary edema, nor pleural effusion.

PMH: HTN x 35 years, DM2 x 30 years, HLD x 30 years, Hepatitis B x unknown length of time - complicated by Cirrhosis x 20 years, MI in 2013 s/p 3 stents, CVA in 3/2019 and 4/2019 s/p L side cerebral stent with residual right arm and left leg weakness
Surgical history: 2013 - 3x cardiac stents; 2019 - left side cerebral stent; unknown year - esophageal banding
Social History: lives with wife in a house with 5 steps leading up to entrance, able to perform ADLs (able to climb stairs to enter house and navigate around it, feeding, dressing/grooming, toileting, transferring), ambulates without assistive devices, able to perform IADLs (manage

medications and use telephone, but wife helps to prepare meals and house clean), denies ever smoking, drinking, nor illicit drug use
Family History: Mother: DM, deceased in 80s from old age; Father: DM, deceased in 60s from throat cancer; Brother: 78, with ACS
Allergies: NKDA, No food allergies

Medications:
Spironolactone 25 mg oral tablet: 1 tab(s) orally once a day x 30 days -Indication: HTN
Propranolol 20 mg oral tablet: 2 tab(s) orally every 12 hours -Indication: HTN
Viread 300 mg oral tablet: 1 tab(s) orally once a day -Indication: Hep B
Lipitor 80 mg oral tablet: 1 tab(s) orally once a day -Indication: HLD
Plavix 75 mg oral tablet: 1 tab(s) orally once a day -Indication: Stroke ppx
Aspirin 81 mg oral tablet: 1 tab(s) orally once a day -Indication: Stroke ppx
NovoLOG 100 units/mL SC solution: 15U SC 3 times a day -Indication: DM (rapid-acting)
Basaglar KwikPen 100 units/mL: 50U SC once a day -Indication: DM (long acting)
Canagliflozin 300 mg oral tablet: 1 tab(s) orally once a day -Indication: DM
Gabapentin 300 mg oral tablet: 1 cap(s) orally once a day -Indication: Diabetic neuropathy

ROS
General: denies fever, chills, fatigue, confusion
Skin/Hair/Nails: prior episode of diaphoresis, but not present during interview
Head: denies H/A, dizziness, trauma
Eyes: denies blurry vision, diplopia, visual disturbances, glasses use
Ears: no complaints, no hearing aids
Nose: denies recent URI, no complaints
Mouth: no complaints, no dentures
Neck: no complaints
Heart: refer to HPI
Lungs: denies recent URI, SOB, cough, PND, DOE, orthopnea
GI: denies history of GERD, N/V/D, abdominal pain, change in appetite, hemoptysis, stool changes
Vascular: denies lower extremity swelling, claudication, ulcerations, nor edema
Urinary: no urinary sx.
MSK: denies obvious upper and lower extremity weakness despite history of strokes, having joint pain/stiffness/swelling, back pain, history of fractures.
Neuro: denies H/A, dizziness, LOC, sensory/motor disturbances
Psychiatric: denies history of anxiety, depression, panic attacks

PE:
Vitals: BP 142/76, Pulse 58, RR 22, Temp 97.8 F, O2 98% on room air, Height 5', Weight 151lb, BMI 29.5
General: A&Ox3, no apparent distress, well appearing, laying comfortably in bed
Skin - warm and moist but not diaphoretic, no scars/lesions noted
Head: normocephalic, atraumatic, non tender
Eye: PERRA, EOM intact, Visual acuity 20/30 OU, conjunctive pink and moist
Nose: no discharge nor erythema of nasal mucosa noted

Mouth: unremarkable dentition, no oral lesions nor erythema of throat
Ears: nontender to palpation, EAC and TM wnl bilaterally
Neck: supple, ROM intact, no JVD nor lymphadenopathy
Chest: clear S1 & S2, RRR, no murmurs, rubs, gallops
Lungs: no use of accessory muscles, CTA, no adventitious sounds
Abdomen: non distended, BS present in all 4 quadrants, soft, non-tender, no abdominal bruits noted
MSK: no atrophy of muscles noted, strength of RUE 4/5, LUE 5/5, bilateral LE 5/5, full ROM on flexion, extension and rotation
Neuro: CN 2-12 intact, mildly slow non-ataxic gait, no focal or sensory deficits, unremarkable speech, patient is able to name simple objections
Vascular: radial and DP pulses 2+, no edema nor signs of vascular insufficiency noted on LE

Lab Results:
142 | 107 | 11.0
----------< 86 Anion Gap: 12 / Creatinine clearance: 57mL/min
4.0 | 23 | 1.02

Prot: 7.3 / Alb: 4.2 / Bili: 1.3 / AST: 41 / AlkPhos: 124
WBC: 7.43 / Platelets: 110
Hb: 13.9 / Hct: 43.4
Troponin: <0.010

EKG:
NSR at 65 bpm, flipped T-wave in aVL, inferior axis, no interval prolongations, similar to previous EKG on 04/15/19.

Assessment:
67yo Indian male with PMH of HTN, DM2, HLD, Hepatitis B - complicated by Cirrhosis, MI in 2013, CVA in 3/2019 and 4/2019, presents c/o of sweating, chest tightness, and anxiety. Patient is being admitted to medicine service for further work up of chest tightness r/o ACS.

Problem List/Plan:
- Chest tightness - need to r/o ACS, admit to medicine, perform repeat EKG in the AM, start telemetry monitoring, first troponin was negative (<0.010) - trend two more sets, test TSH levels, order TTE, get cardiology consult
- HTN, HLD, CAD, history of MI: continue with Spironolactone, Lipitor, Aspirin and Plavix; hold Propranolol due to lowered HR; monitor BP and HR
- History of CVA x 2: continue on Aspirin and Plavix
- Diabetes with neuropathy: continue on Gabapentin; discontinue NovoLOG, Basaglar and Canagliflozin; start in ISS; monitor FS daily and prior to meals
- Hepatitis B complicated by Cirrhosis: continue on Viread, check hepatitis panel