Jaspreet Kaur Sra
Rotation #2 Internal Medicine

History

Identifying Data:
Full Name: Ms. M
Address: Smithtown, NY
Date of Birth: Feb 23, 1960
Date & Time: May 27, 2022 (2:10 pm)
Location: NSUH Queens, NY
Religion: Christian
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Self

Chief Complaint: " I am having chest pain and palpitations"

History of Present Illness:
62 year old female with a PMHx of C3-C5 cervical radiculopathy, anxiety, depression, HTN, asthma, PE on apixaban, atrial tachycardia and atrial fibrillation on diltiazem. presents with chest pain and palpitations while at the urology office today. Once she was finished with her endometrial biopsy, she felt chest pain and palpitations. She states the pain was non radiating and rates it 6/10. Denies alleviating or exacerbating factors. Reports the provider checked her heart rate which was 180 and called the ambulance. Patient states she held her eliquis for the past two days in anticipation for an endometrial biopsy today. She states she had a PE a few years ago but was given an oral medication and discharged. Reports she was not taking her diltiazem as her blood pressure was measuring to be low at home. Denies SOB, DOE, orthopnea, lightheadedness, syncope, recent travel, sick contact, abdominal pain, dizziness, recent travel, headache, vision changes, nausea and vomiting.

Here at NSUH patient reported left sided weakness for which a stroke code was activated, but symptoms self resolved.

Past Medical History:
Asthma
Atrial fibrillation
C3-C5 cervical radiculopathy
Tricuspid valve regurgitation
Mitral valve regurgitation
Pulmonary embolism

Past Surgical History No past surgeries

Medications:
apixaban 5 mg oral tablet: 1 tab orally every 12 hours

Jaspreet Kaur Sra
Rotation #2 Internal Medicine
aspirin 81 mg oral delayed release tablet: 1 tab PO QD
dilTIAZem 120 mg/24 hours oral capsule, extended release: 1 tab PO QD
enalapril 5 mg oral tablet: 2.5 tab 2 tablets BID
fluticasone 50 mcg/inh nasal spray: 1 spray nasal 2 times a day
guaiFENesin 1200 mg oral tablet, extended release: 1 tab(s) orally every 12 hours, swallow whole do not crush
ipratropium-albuterol 0.5 mg-2.5 mg/3 mL inhalation solution: 3 milliliter(s) by nebulizer every 6 hours
levalbuterol 45 mcg/inh inhalation aerosol: 1 puff(s) inhaled every 6 hours
polyethylene glycol 3350 oral powder for reconstitution: 17 gram(s) orally once a day (at bedtime)
predniSONE 20 mg oral tablet: 2 tab(s) orally once a day
Protonix 40 mg oral delayed release tablet: 1 tab(s) orally once a day AM
senna oral tablet: 2 tab(s) orally once a day (at bedtime)
Singulair 10 mg oral tablet: 1 tab(s) orally once a day (at bedtime)
Symbicort 160 mcg-4.5 mcg/inh inhalation aerosol: 2 puff(s) inhaled 2 times a day
ZyrTEC 10 mg oral tablet: 1 tab(s) orally once a day (at bedtime)

Allergies
contrast media (iodine-based) (Short breath)
erythromycin (Anaphylaxis)
kiwi (Short breath)
Peaches (Rash)
peanuts (Angioedema)
penicillin (Anaphylaxis; Rash)
Tomatoes (Short breath; Rash)
Tree Nuts (Swelling)
Zithromax (Short breath; Rash)

Family History
Asthma - mother, siblings, aunts, uncles
Myocardial infarction- Mother with MI at 62. Brother with MI at 37
Ovarian cancer- mother
Pulmonary embolism- mother

Social History
Ms. M is a single female who lives alone. She is retired but used to work at a grocery store. She denies any **history of substance abuse and history of illicit drug use. D**enies **recent** travels. She states she eats mostly outside food as she does not have energy to cook daily and does not exercise. She has a daughter that lives close by who helps her if needed.

Review of Systems
General – Denies fever, weight gain/loss, loss of appetite, generalized weakness/fatigue, or night sweats.
Skin, hair, nails – Denies changes in texture of legs, discolorations, pigmentations, and changes in hair distribution in the extremities. Denies excessive dryness or sweating, moles/rashes, or pruritus.

Jaspreet Kaur Sra
Rotation #2 Internal Medicine
ENMT- Denies deafness, pain, discharge, tinnitus, use of hearing aids, discharge, obstruction, or epistaxis, bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes
Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).
Cardiovascular system – **Reports chest pain and palpitations, swelling of ankles/edema.** Denies syncope or known heart murmur.
Gastrointestinal system – Has regular bowel movements daily. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, diarrhea, constipation or blood in stool.
Genitourinary system – Denies nocturia, polyuria, oliguria, dysuria, flank pain, urinary hesitancy, dribbling.
Nervous – Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.
Musculoskeletal system – Denies arthralgia, arthritis, joint swelling
Peripheral vascular system – Denies peripheral edema, color changes, intermittent claudication, coldness or trophic changes or varicose veins.
Hematological system – Denies bruising, blood transfusion, anemia, bleeding, and lymph node enlargement.
Psychiatric – **Reports depression and sees a mental health professional.** Denies sadness, anxiety, OCD.

Physical

General: Obese female, Neatly groomed, well nourished, well oriented, not in respiratory distress

Vital Signs:

BP: Seated, Left arm 142/90

RR: 16/min unlabored HR: 82, regular

T: 98.6 degrees F (oral) O2 Sat: 98% Room air

Height: 5 Feet 5 inches Weight: 1215 lbs. BMI: 35.8

Skin: Warm & moist, good turgor, no pigmentation, no lesions, no bruises, no tattoos, no rash, no papules, and no moles noted.

Nails: Capillary refill <2 seconds throughout upper and lower extremity.

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

Eyes: Symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink; Visual fields full OU. PERRLA, EOMs intact with no nystagmus.

Ears: Symmetrical and appropriate in size. No lesions, masses, or trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TM's pearly white.

Jaspreet Kaur Sra
Rotation #2 Internal Medicine
Nose: Symmetrical, no masses, lesions, deformities, trauma, or discharge. Nares patent bilaterally with nasal mucosa pink & well hydrated.

Oropharynx: Well hydrated; no exudate; masses; lesions; foreign bodies.

Neck: Trachea midline. No masses; lesions

Thyroid: Non-tender; no palpable masses; no thyromegaly noted.

Thorax & Lungs:

Chest - **Left chest wall tenderness. No edema was noted in bilateral extremities.** **Sy**mmetrical, no deformities, no trauma. Respirations unlabored/no paradoxical respirations or use of accessory muscles noted.

Lungs - No consolidations to auscultation bilaterally. No adventitious sounds.

Heart: Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmur. No friction rubs

Abdominal: Abdomen is flat and symmetric with no striae, scars or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted.

Mental status exam:
Intact judgment, insight, and cognitive function. Oriented to time, place, and person. Intact memory and attention for recent/remote events. Intact language and speech. No depression, anxiety, or agitation.

Cranial Nerve exam:

CN I: Nares patency is intact bilaterally.

CN II: Visual fields full OU by confrontation, PERRLA. EOMS intact with no nystagmus

CN III, IV, VI: EOMS intact with no nystagmus. Pupils reactive to direct light, consensual light, and accommodation. No ptosis.

CN V: Face sensation intact bilaterally to light touch and pain.

CN VII: Facial expressions are symmetric and intact. No difficulty with BMP speech sounds.

CN VIII: Auditory acuity intact

CN IX and X: Uvula midline with elevation of soft palate, gag reflex intact. No difficulty swallowing. No hoarseness.

CN XI: Full ROM at neck. Strong shoulder shrug against resistance bilaterally.

Jaspreet Kaur Sra
Rotation #2 Internal Medicine
CN XII: Tongue midline without fasciculations. Strong and symmetric tongue. No difficulty with LTND speech sounds.

Peripheral Nerve Exam:

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Symmetric muscle bulk with good tone. No atrophy, tics, tremors, or fasciculation. Strength 5/5 throughout.

Sensory: Intact to light touch throughout upper and lower extremities.

Peripheral Vascular Exam: Pulses are 2+ bilaterally in upper extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally. No ulcerations, calf tenderness, palpable cords, and varicose veins bilaterally. Both arms and legs are equal in circumference.

Musculoskeletal: No soft tissue swelling/ erythema/ ecchymosis/ atrophy or deformities in bilateral upper and lower extremities. FROM (Full Range of Motion) of all upper and lower extremities bilaterally.

Labs and results

LABS
Type + Screen
ABO Interpretation: O
Rh Interpretation: Positive
Antibody Screen: Negative
Blood Gas:
Blood Gas Calcium, Ionized - Venous: 1.27, [1.15 - 1.33 mmol/L]
pH, Venous: 7.42, [7.32 - 7.43]
Base Excess, Venous: 6.2, [-2.0 - 2.0 mmol/L]
Total CO2, Venous: 33, [22 - 26 mmol/L]
pCO2, Venous: 49, [39 - 42 mmHg]
pO2, Venous: 43, [25 - 45 mmHg]
HCO3, Venous: 32, [22 - 29 mmol/L]
Oxygen Saturation, Venous: 75.2, [67.0 - 88.0 %]

Blood Gas Profile w/Lytes - Venous: Performed In Lab
Blood Gas Venous - Chloride: 102, [96 - 108 mmol/L]
Blood Gas Venous - Glucose: 108, [70 - 99 mg/dL]
Total Hemoglobin, Calculated: 12.3, [11.7 - 16.1 g/dL]
Hematocrit, Calculated: 37.0, [34.5 - 46.5 %]
Blood Gas Venous - Lactate: 1.6, [0.7 - 2.0 mmol/L]
Blood Gas Venous - Potassium: 4.4, [3.5 - 5.1 mmol/L]
Blood Gas Venous - Sodium: 139, [136 - 145 mmol/L]

Jaspreet Kaur Sra
Rotation #2 Internal Medicine

General Chemistry:
Comprehensive Metabolic Panel
Sodium, Serum: 140, [135 - 145 mmol/L]
Potassium, Serum: 4.3, [3.5 - 5.3 mmol/L]
Chloride, Serum: 105, [96 - 108 mmol/L]
Carbon Dioxide, Serum: 27, [22 - 31 mmol/L]
Anion Gap, Serum: 8, [5 - 17 mmol/L]
Blood Urea Nitrogen, Serum: 13, [7 - 23 mg/dL]
Creatinine, Serum: 0.75, [0.50 - 1.30 mg/dL]
Glucose, Serum: 103, [70 - 99 mg/dL]
Calcium, Total Serum: 9.4, [8.4 - 10.5 mg/dL]
Protein Total, Serum: 6.2, [6.0 - 8.3 g/dL]
Albumin, Serum: 4.3, [3.3 - 5.0 g/dL]
Bilirubin Total, Serum: 0.4, [0.2 - 1.2 mg/dL]
Alkaline Phosphatase, Serum: 72, [40 - 120 U/L]
Aspartate Aminotransferase (AST/SGOT): 15, [10 - 40 U/L]
Alanine Aminotransferase (ALT/SGPT): 15, [10 - 45 U/L]
eGFR: 90, [>=60 mL/min/1.73m2
Magnesium, Serum: 2.3, [1.6 - 2.6 mg/dL]
Phosphorus Level, Serum: 2.9, [2.5 - 4.5 mg/dL]
Serum Pro-Brain Natriuretic Peptide: 72, [0 - 300 pg/mL]

A1C with Estimated Average Glucose Result: 5.9, [4.0 - 5.6 %]
Estimated Average Glucose: 123, [68 - 114 mg/dL]

Cholesterol, Serum: 207, [- <=199 mg/dL]
Triglycerides, Serum: 55, [- <=149 mg/dL]
HDL Cholesterol, Serum: 107, [>=51 mg/dL]
Non HDL Cholesterol: 100, [- <=129 mg/dL],
LDL Cholesterol Calculated: 89, [- <=99 mg/dL]

Coagulation:
Activated Partial Thromboplastin Time: 28.8, [27.5 - 35.5 sec],
Prothrombin Time, Plasma: 12.4, [10.5 - 13.4 sec],
INR: 1.08, [0.88 - 1.16 ratio],

Hematology:
Complete Blood Count + Automated Diff
WBC Count: 5.52, [3.80 - 10.50 K/uL]

Jaspreet Kaur Sra
Rotation #2 Internal Medicine
RBC Count: 4.41, [3.80 - 5.20 M/uL]
Hemoglobin: 11.6, [11.5 - 15.5 g/dL]
Hematocrit: 37.1, [34.5 - 45.0 %]
Mean Cell Volume: 84.1, [80.0 - 100.0 fl]
Mean Cell Hemoglobin: 26.3, [27.0 - 34.0 pg]
Mean Cell Hemoglobin Conc: 31.3, [32.0 - 36.0 gm/dL]
Red Cell Distrib Width: 16.0, [10.3 - 14.5 %]
Platelet Count - Automated: 366, [150 - 400 K/uL]
Auto Neutrophil #: 4.71, [1.80 - 7.40 K/uL]
Auto Lymphocyte #: 0.60, [1.00 - 3.30 K/uL]
Auto Monocyte #: 0.16, [0.00 - 0.90 K/uL]
Auto Eosinophil #: 0.01, [0.00 - 0.50 K/uL]
Auto Basophil #: 0.01, [0.00 - 0.20 K/uL]
Auto Neutrophil %: 85.3, [43.0 - 77.0 %],
Auto Lymphocyte %: 10.9, [13.0 - 44.0 %]
Auto Monocyte %: 2.9, [2.0 - 14.0 %]
Auto Eosinophil %: 0.2, [0.0 - 6.0 %]
Auto Basophil %: 0.2, [0.0 - 2.0 %]
Auto Immature Granulocyte %: 0.5, [0.0 - 1.5 %]
Nucleated RBC: 0, [0 - 0 /100 WBCs]

Urine:
Urinalysis + Microscopic Examination
Red Blood Cell - Urine: 1, [0 - 4 /hpf]
White Blood Cell - Urine: 0, [0 - 5 /HPF]
Epithelial Cells: 0, [- <=5 /hpf]
Bacteria: Negative, [Negative]
pH Urine: 7.5, [5.0 - 8.0]
Urine Appearance: Clear
Color: Colorles
Specific Gravity: 1.008, [1.010 - 1.025]
Protein, Urine: Negative, [Negative]
Ketone - Urine: Negative, [Negative]
Blood, Urine: Negative, [Negative]
Bilirubin: Negative, [Negative]
Urobilinogen: Negative, [Negative]
Leukocyte Esterase Concentration: Negative, [Negative]
Nitrite: Negative, [Negative]
Glucose Qualitative, Urine: Negative, [Negative]

Jaspreet Kaur Sra
Rotation #2 Internal Medicine
Infectious Disease:
SARS-CoV-2 Result: NotDetec, [NotDetec]
Influenza A Result: NotDetec, [NotDetec]
Influenza B Result: NotDetec, [NotDetec]
Resp Syn Virus Result: NotDetec, [NotDetec]

Imaging
CT Head Non Contrast
TECHNIQUE : Axial CT scanning of the brain was obtained from the skull base to the vertex without the administration of intravenous contrast. Sagittal and coronal reformats were provided. COMPARISON: CT brain 4/9/2022
FINDINGS:
No hydrocephalus, mass effect, midline shift, acute intracranial hemorrhage, or brain edema. Visualized paranasal sinuses and mastoid air cells are clear.

IMPRESSION: No hydrocephalus, acute intracranial hemorrhage, mass effect, or brain edema.

ECG: Afib with RVR

Echo 12/21/21 TTE
CONCLUSIONS:
1. Mitral annular calcification, otherwise normal mitral valve. **Mild-moderate mitral regurgitation.**
2. Normal trileaflet aortic valve.
3. **Increased relative wall thickness with normal left ventricular mass index, consistent with concentric left ventricular remodeling.**
4. Normal left ventricular systolic function. No segmental wall motion abnormalities.
5. Normal right ventricular size and function.
6. E**stimated pulmonary artery systolic pressure equals 46 mm Hg, assuming right atrial pressure equals 10 mm Hg, consistent with mild pulmonary hypertension.**

Assessment and Plan
62yo woman with anxiety, depression, HTN, asthma, PE on apixaban, atrial tachycardia and atrial fibrillation on diltiazem who presents to NSUH ED from outpatient gynecology after endometrial biopsy with atrial fibrillation with RVR. Afib with RVR likely in the setting of patient not taking her home diltiazem.

Stroke
Neurology was consulted. CT Head was within normal limits, Neuro exam nonfocal. Transient LUE weakness likely secondary to known cervical radiculopathy C3-5 vs. cardiac etiology given chest pain/pressure From neurovascular perspective, CHADsVASC 2, recommend restarting home eliquis if cleared by urology and cardiac workup required. For cervical radiculopathy, outpatient neurology follow up.

Jaspreet Kaur Sra
Rotation #2 Internal Medicine

Chronic atrial fibrillation
Plan: Rate 90-120's on telemetry
Resumed Diltiazem ER 120 mg- if rate still not adequately controlled will increase to 180 mg
Continue Apixaban 5 mg PO BID
Continue telemetry monitoring
Cardiology following

Asthma
Continue Symbicort, Singulair, albuterol
Prednisone 20 mg PO daily 5/28-5/30 then 10 mg PO daily 5/31-6/2 then OFF.

Pulmonary embolism
Continue Eliquis

Constipation
Miralax, senna.

Her Eliquis and Diltiazem were restarted and she was observed overnight but her rate remained poorly controlled and she was admitted. Patient currently feels well, and denies SOB or CP. Has intermittent palpitations

Admit Diagnosis: Uncontrolled heart rate, Atrial fibrillation with RVR