Erika Kissick
LTC Rotation 2 Week 1

History

Highlighted was forgotten or couldn't do

Identifying Data:
Full Name: BBK
Address: 123 Avenue D Apt 121 NYC NY 10009
Age: 60 y/o
Date & Time: Feb. 19, 2019 2:16 pm
Location: Gouverneur Skilled Nursing Facility
Religion: Episcopalian
Race: AA
Nationality: American
Marital Status: Single
Source of Information: Self/son/medical records
Source of Referral: Reliable patient

Chief Complaint: "BBK is a 60 year old black female current cigarette smoker 4 cig/day x 20 yr, asthma, chronic, uncontrolled HCV genotype 1b s/p Peg IFN/RIB w/o SVR (2005), HTN, Influenza A+, and PNA x 1 month to Gouverneur Skilled Nurisng Facility for decompensation s/p intubation for ARDS c/b PNA x 1 month"

HCV genotype 1b Peg INF/RIB w/o SVR viral load = 204,431 IU/mL c/b transaminitis

① Note - on a formal document, cannot add in this way - must be appended at the end

HPI:
BBK 60 y/o black female PMHx ~~HVC +~~, asthma, current cigarette smoker 4 cig/day x 20 years, and HTN presented to City MD on 12/23/18 c/o progressively worsening subacute, productive "green" cough, SOB, and malaise. Pt diagnosed with PNA and laryngitis discharged home with Levaquin. Patient never intubated nor hospitalized for asthma before this event. Patient completed course of Levaquin but symptoms worsened and patient presented to Bellevue Hospital ED on 12/31/18 c/o SOB, malaise and subacute, productive cough, afebrile, hypertensive, and found it difficult to finish sentences. Diagnosis of Influenza A + tx with Tamiflu. Additionally, patient had NBNB emesis, nausea, pleuritic chest pain, diffuse arthralgias, and chronic lower back pain. Respiratory infection later c/b asthma exacerbation decompensating to ARDS. Patient intubated for ARDS and later developed PNA +/- COPD. From 1/1/19-1/15/19 patient intubated and was treated with vancomycin and cefepime c/b electrolyte imbalance secondary to ATN resolved with D5W. Patient developed ICU delirium treated with Zyprexa 5 mg BID; patient weaned off Zyprexa after improvement of AMS. NCHCT and brain MRI negative. EKG showed sinus tachycardia with prolonged Qtc (493 ms) without ischemic change. HR WW 100s.Echo normal. CTPE negative. TSH and Cortisol levels are wnl and labs are negative for pheochromocytoma. Patient is not currently treated for Hep C + status. Patient independent in ADL and IADLs and ambulates with cane 2/2 chronic arthralgia. Patient transferred to Gouverneur SAR for PNA s/p intubation deconditioning s/p PEG IFN/RIB 2005 w/o SVR. Patient admitted to Gouverneur SAR 2/19/19 for fall precaution, aspiration precaution, and skin break precaution, SAR/PT for improvement of functional mobility and to decrease fall risk due to patient's frequent SOB requiring rest in between activities. Denies recent traumas/falls, recent exercise/heavy lifting, paresthesia, , fever, head injury,, dizziness, hip pain, abd pain, nausea/vomiting/diarrhea, wheezing, extremity numbness, . hemoptysis, cyanosis, wheezing, orthopnea or PND. Denies palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope. Denies recent weight loss or gain, loss of appetite, fever or chills, or night sweats. Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, change in memory. Denies deformity/swelling, or redness on MSK.

why? SOB? other?

② The type etc. would be better placed in PMH

which jts?

Past Medical History:
Present illnesses –
GERD
HTN - how well controlled
Asthma
- S/P ARDS

Rhinitis

Linear Wounds/ulcerations- Admitted to Gouverneur with partial thickness, linear opening on gluteal cleft secondary to moisture and shearing with pink, non granulation tissue and non/scant sanguineous drainage in addition to slightly erythematous, peeling skin in inner gluteal area.

Hospitalizations (see HPI and sx hx)
Childhood illnesses – Chicken pox at age 6. Denies other illnesses.
Immunizations – PPD +, Patient refused Hep A/B immunizations
Screening tests and results –

Past Surgical History:
D&C x 2 L salpingectomy, tubal ligation 1997
R breast biopsy (benign) 2002
Injuries – Denies past trauma
Transfusions – HCV+ transfusion during childbirth son # 1 ~1975

Medications:
→ Is this proven or the pt.'s theory?

Cyclobenzaprine (Flexeril) 10 mg oral tab q 12h @ 1000 and 2200 for chronic lower back pain PRN
Amlodipine 10mg oral tab qd for HTN HOLD if SBP <90
Budesonide / formoterol unknown dose nebulized for COPD/ARDS
Magnesium oxide unknown dose oral supplement for electrolyte imbalance
Fluticasone 1 spray nasally qd PRNfor rhinitis
KCL XR 40 mg tab supplement for electrolyte imbalance
Rizatriptan 10 mg oral tab max dose 30mg/24 hours PRN for migraines
Vitamin B oral tab unknown dose qd for supplementation
Vitamin D3 oral tab unknown dose qd supplementation
Ensure oral supplement unknown dose for electrolyte imbalance — This is a meal replacement. How will it treat electrolyte imbalance?
Lidocaine topical cream q6h PRN for lower back pain
Capsaicin cream (Zostrix) 0.025% to topically to upper back for itching
Miralax (polyethylene glycol) 3350 1 pckt po qd with 8 oz water for constipation
Ipratropium HFA (Atrovent) 2 puff MDI inhalation q6h @ 0400, 1000, 1600, 2200 for COPD/ARDS
Petrolatum white (Vaseline) apply topically to both legs
Heparin 50000 units SQ q 12 h @ 10:00 and 22:00 for DVT ppx
Ranitidine 150 mg oral tab BID for GERD

Allergies:
Drug:
PCN Swelling of hands and feet
No environmental or food allergies

Family History:
Paternal Grandfather – pt doesn't know
Paternal Grandmother – pt doesn't know
Maternal Grandfather – pt doesn't know
Maternal Grandmother – pt doesn't know
Father – pt doesn't know
Mother – 82 y/o alive CAD, stoke
Son – 44, alive and well
Son– 48, alive asthma

Family h/o cirrhosis, CVA, CAD and HTN. Denies family h/o heart arrhythmia, lung disease, cancer, diabetes mellitus, gastrointestinal disease, disease of urinary tract, or psychiatric or nervous disorders.

Social History:
BBK is a single female, living at home alone in an apartment building with an elevator. HHA x 4 days for 4 hours duration.
Habits –Current cigarette smoker 4 cigarette/day x 20 years. Recently attempted to wean herself off of cigarettes before initial hospitalization by also using nicotine gum as replacement. Denies present/past illicit drug use, caffeine or ETOH use.
Education: college
Diet – She claims to follow a healthy diet consisting of many fruits and veggies.
Exercise – PT x 14 min/day x 2 x week due to SOB.
Safety measures – admits to wearing a seat belt.
Sexual hx – Denies current sexual activity or history of STIs

ROS:
General – See HPI

Skin, hair and nails – Positive for ulcerations x 2 b/l LE. denies other change in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, changes in hair distribution.

Head - denies headaches, vertigo, head trauma, visual changes, or glasses/contact use.

Eyes – denies visual disturbance, lacrimation, photophobia, pruritis, or glasses/contact use. Unknown last eye exam.

Ears – denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses – states that she has nasal discharge of clear color without blood; denies deviated septum, epistaxis or obstruction, or congestion.

Mouth and throat –denies bleeding gums, sore tongue, sore throat, mouth ulcers, or voice changes.

Neck - denies localized swelling/lumps, stiffness/decreased range of motion.

Breast - denies lumps or pain.

Pulmonary System – See HPI

Cardiovascular System : See HPI

Gastrointestinal System – She states that she gets constipation at times treated with Miralax (see meds). Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, change in bowel habit, hemorrhoids, or melena.

Genitourinary System –Patient incontinent using foam dressings/pads in place of diaper. denies flank pain, oliguria, polyuria, dysuria,. She states last LMP was in her 50's. Last pap smear was 2016. . G2T2002. Sexual (see hx)

Nervous System See HPI

Musculoskeletal System –See HPI

Peripheral Vascular System - denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change.

Hematologic System - Patient is easily bruised, denies bleeding, lymph node enlargement, or history of DVT/PE.

Endocrine System - denies polyuria/polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating, hirsutism.

Psychiatric - denies depression/sadness, anxiety, obsessive/compulsive disorder, seeing a mental health professional,or taking psychiatric medications.

PERTINENT DIAGNOSTIC STUDIES (laboratory, imaging):
12/28/19
UA negative

12/31/18
CXR
CXR: multifocal pneumonia vs congestive failure vs fluid overload. Comcommitment PNA unlikely due to lack of definitive infiltrate on imaging, lack of abx response, and influenza A positive; possible reactive airway/incited asthma exacerbation

1/29/19
CXR
NGT/Endotracheal tube removed. Airspace and interstitial opacities at R base and more extensive in the L lung shows slight improvement. No definite effusion or pneumothorax. Normal cardiac silhouette, mediastinal contours and pulmonary vascularity.
Portable AP CXR
Single AP view: unchanged b/l airspace and interstitial opacities without pleural effusion or pneumothorax.

1/30/19
CT PE
No emboli. Diffuse fibrosing lung disease that may reflect either interstitial lung fz like nonspecific interstitial fibrosis or sequala or ARDS given patient's prolonged intubation without parenchymal consolidation or mass. Evidence for previous granulomatous disease. Sub centimeter lung nodes. (+) Hepatic cirrhosis

2/1/19
NCHCT
Unremarkable non contrast CT head

2/9/19
RBC 3.61
Hgb 10.2
Hct 32.7
MCHC 31.2
RDW 16.3
Neutro 37.4%
Lymph 45.4%
Eos 5.5 %

MCV ↑

2/18/19
CO2- 22
Glu- 118
CalcOsmo 273 m/Osm/L

2/19/19

MRI
No evidence of acute infarct, hemorrhage, or abnormal intracranial contrast enhancement

Physical

General: 60 y/o female, AO x3. Patient is very thin, looks older than stated age and is well developed/well groomed without agitation.

Vital Signs:
BP: Seated 132/76 LT 142/78 RT
Supine "/" "/"

RR: 18 breaths/min, labored
HR: 98 beats/min, regular
Temp: 97.6 T (oral)
O2 Sat: 98%, room air
Height: 160 cm
Weight: 75.9 lbs
BMI: 29.6

Skin: partial thickness, linear opening on gluteal cleft secondary to moisture and shearing with pink, non granulation tissue and non/scant sanguineous drainage, slightly erythematous, peeling skin in inner gluteal area
(could not assess wounds protected/covered) otherwise skin warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.
Hair: average quantity and distribution.
Nails: no clubbing, capillary refill <2 seconds throughout.
Head: normocephalic, atraumatic, non-tender to palpation throughout.

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera icteric, conjunctiva & cornea slightly cloudy.
Visual acuity (uncorrected - 20/50 OS, 20/40 OD, 20/40 OU).
Visual fields full OU. PERRL, EOMs full with slight L nystagmus. R eye negative for nystagmus.
Fundoscopy - Red reflex intact OU, Cup:Disk < 0.5 OU/no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.

In which direction?
Can always do this grossly ~ magazine or newspaper (arm's)

Ears: Symmetrical and normal size. No evidence of lesions/masses/trauma on external ears.
Moderate cerumen impaction in external auditory canals AU; no discharge/foreign bodies. TM's pearly white/intact with light reflex in normal position AU.
Auditory acuity intact to whispered voice AU. Weber midline/Rinne reveals AC>BC AU.

Nose: Symmetrical, no obvious masses/lesions/deformities/trauma/discharge. Nares patent bilaterally/Nasal mucosa pink & dry. No discharge noted on anterior rhinoscopy. Slight deviated septum without lesions/deformities/injection/perforation. No evidence of foreign bodies.
Sinuses: Non-tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Lips: Pink, chapped; no evidence of cyanosis or large lesions. Non-tender to palpation.
Mucosa: Pink; well hydrated. No masses; lesions noted. Non-tender to palpation. No evidence of leukoplakia.
Palate: Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation.

what does this mean? How can you capture it more accurately?

Teeth: Moderate dentition, some mild dental caries noted.
Gingivae: Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.
Tongue: Pink; slightly papillated, no masses, lesions or deviation noted. Non-tender to palpation.
Oropharynx: Injected/reddish/inflamed oropharynx; well hydrated; no evidence of exudate; masses; lesions; foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions.

Neck: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no palpable adenopathy noted.
Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted.

Chest – Symmetrical, no deformities, no evidence trauma. Respirations labored without paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. L sternal thoracic tenderness

Lungs –Clear to auscultation and percussion b/l w/o wheezing, rales, or rhonchi.. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout.

Heart: JVP is 2.3 cm above the sternal angle with the head of the bed at 30°. PMI in between 4-5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. S1 and S2 are normal. There is a systolic murmur best heard at the L upper sternal border but no other murmurs or extra heart sounds.

Abdomen: Flat, symmetrical, no evidence of scars, striae, caput medusae or abnormal pulsations.
BS present in all 4 quadrants. No bruits noted over aortic/renal/iliac/femoral arteries.
Tympany to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Gynecological- v/v - w/o lesions, masses, bruising, white mucopurulent d/c from introitus, urethral oriface nl, vaginal mucosa pink, no blood in vault, cervix nulliparous, pink, with scant white mucopurulant d/c, Os closed, neg CMT, uterus midline(retroflexed/anteroflexed), smooth ,nontender, w/w/o enlargement, Adnexa w/o tenderness or masses, ovaries palpable/nonpalpable. Rectal good tone w/o masses, lesions, tenderness, heme neg brown stool (Foam dressing in place)

Rectal :brown stool in rectal vault, guiac negative; no masses, hernias, or lesions. (Foam dressing in place)

Breast- symmetric, no dimpling, nipple dx or masses. No palpable nodes

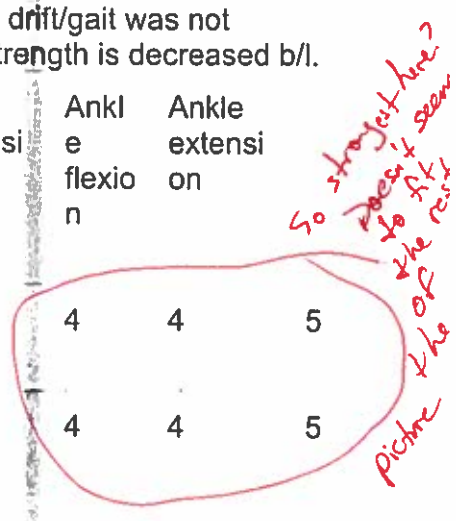
└ where?

Peripheral Vascular-
Skin normal color. Varicose veins noted b/l. Warm/dry to touch LE/UE b/l. No calf tenderness, calves equal in circumference. Negative Homan's sign. No palpable cords. No palpable inguinal/epitrochlear adenopathy. No cyanosis, clubbing, or edema b/l.

Mental Status- Well Dressed, well-groomed cooperative/pleasant. Speech is slow, clear, fluent, adequate volume and intonation in no apparent distress sitting comfortably. Thought process/content logical without rumination. No suicidal ideations or phobias, delusions, or hallucinations. Memory recall 2/3 objects after 5 min. A&OX3 displays good judgement.

Cranial nerves-CN II: Visual fields are full to confrontation. Fundoscopic exam is normal with sharp discs and no vascular changes. Venous pulsations are present bilaterally. Pupils are 4 mm and briskly reactive to light. Visual acuity is 20/20 bilaterally.
CN III, IV, VI: At primary gaze, there is no eye deviation. When the patient is looking to the left, the right eye does not adduct. When the patient is looking up, the right eye does not move up as well as the left. She develops horizontal diplopia in all directions of gaze especially when looking to the left. There is ptosis of the right eye. Convergence is impaired.
CN V: Facial sensation is intact to pinprick in all 3 divisions bilaterally. Corneal responses are intact.
CN VII: Face is symmetric with normal eye closure and smile.
CN VII: Hearing is normal to rubbing fingers
CN IX, X: Palate elevates symmetrically. Phonation is normal.
CN XI: Head turning and shoulder shrug are intact
CN XII: Tongue is midline with normal movements and no atrophy. Pronator drift/gait was not assessed due to fall risk. Patient shows decreased muscle tone and bulk. Strength is decreased b/l.

	Deltoid	Biceps	Triceps	Wrist extension	Finger abduction	Hip flexion	Hip extension	Knee flexion	Knee extension	Ankle flexion	Ankle extension	
L	3	3	3	3	2	2	2	2	4	4	5	
R	3	3	3	3	2	2	2	2	4	4	5	



Reflexes:
Reflexes are 2+ and symmetric at the biceps, triceps, knees, and ankles. Plantar responses are flexor.
Sensory:
Light touch, pinprick, position sense, and vibration sense are intact in fingers and toes.
Coordination:
Rapid alternating movements and fine finger movements are intact. There is no dysmetria on finger-to-nose and heel-knee-shin. There are no abnormal or extraneous movements. Romberg not assessed due to fall risk!
Gait/Stance:
Posture is normal. Gait not assessed due to fall precaution in place. Per PT, patient can ambulate with cane in very slow, shuffled gait. - As discussed, can report these findings - usually as consult after your PE
MSK: No soft tissue swelling, ecchymosis, or deformities b/l x 4. Non-tender without crepitus. Full assited range of motion of muscles with atrophy noted b/l UE and LE.

Assessment/ Plan: BBK, a 60 y/o female, current smoker 4 cig/day x 20 year and PMHx of HCV genotype 1b s/p peg INF/RIN w/o SVP, asthma, HTN, chronic lower back pain, migraines, sinus tachycardia with prolonged Qtc (493 ms), GERD, rhinitis, Patient admitted to Gouverneur SAR 2/19/19. 12/31/18 CXR: multifocal pneumonia vs congestive failure vs fluid overload. Comcommitment PNA unlikely due to lack of definitive infiltrate on imaging, lack of abx response, and influenza A positive; possible reactive airway/incited asthma exacerbation. . Admitted for fall precaution, aspiration precaution, and skin break precaution, SAR/PT for improvement of functional mobility and to decrease fall risk due to patient's frequent SOB requiring rest in between activities.

1. Fall and Safety precaution in place
   --Bed exit and personal arm in place
2. Continue daily multidisciplinary rehabilitation
   --Monitor VS, pt, assist with ambulation and ADLS → ADL's or just ADL
   --Pressure ulcer prevention: pressure reducing device for chair and bed; turning/repositioning
   --fall precaution
   --DVT PPX- continue Heparin as above
   --Aspiration precaution- HOB elevated at least 30 degrees
   --'Use Bell for safety and help
   PT/OT therapy
   Pain control- Continue Tylenol, cyclobenzaprine PRN, Lidocaine as above for pain

1. PNA- Continue to monitor for s/s of infection including fevers, productive cough, (etc). Continue Aspiration precaution. F/U with PMD in 4-6 weeks after discharge to repeat CXR for resolution. Monitor VS periodically.
2. ARDS/COPD- Obtain spirometry reading to r/o COPD. Continue to monitor patient for respiratory decompensation via VS. Aspiration precaution in place. FU CXR in 4-6 weeks. Continue to monitor O2sat likely due to b/l opacity → The opacity is a result of some other process
3. Wounds- Turn PT every 2 hours. Use disposable white pad in lieu of diaper and apply Z guard incontinence barrier cream to groin and buttocks, reapply after cleaning. Apply foam dressing to vulnerable areas for pressure ulcer prevention change every 3 days. RN assessment of covered skin each shift. Offload heels with pillow under lower legs.
   a. Linear opening on gluteal cleft (partial thickness) secondary to moisture and shearing, with pink non-granulation tissue TX- Wash gently with cleaner. Pat dry apply No-sting Skin Prep barrier and Triad Hydrophilic Wound Dressing Cream. Reapply as needed and after each cleaning.
   a. Slightly erythematous, peeling skin in inner gluteal area- after cleaning apply antifungal ointment 2 x/day x 2 weeks
4. ICU Delirium Improvement with AMS as health improves Encourage ambulation. If necessary, add Zyprexa to regimen as above (HPI). → From what you said, this is already resolved & should be reported as such
5. HCV genotype 1b s/p Peg INF/RIN w/o SVP (2005)
   a. Referral to nephrologist for treatment + HCV Serology
6. HTN → vs. hepatologist?
   a. Continue Amlodipine 10mg oral tab qd for HTN HOLD if SBP <90
   b. Ambulation as tolerated
7. Sinus tachycardia with prolonged Qtc (493 ms Consider diltiazem for HTN to treat tachycardia (contraindicated ∵ prolonged Q-T)

8. Chronic Lower Back Pain
   a. PT/OT with ambulation
   b. Continue Cyclobenzaprine (Flexeril) 10 mg oral tab q 12h @ 1000 and 2200 for chronic lower back pain PRN and Lidocaine topical cream q6h PRN for lower back pain
9. Migraines
   a. Continue Rizatriptan 10 mg oral tab max dose 30mg/24 hours PRN
   b. Stress education
10. Current Smoker
    a. Offer smoking cessation education
11. Rhinitis
    a. Continue Fluticasone as above

12. GERD
    Continue Ranitidine as above

Resolved:

1. Influenza A+
    a. Monitor WBC count (CBC with dif) ✓
    b. Monitor for s/s of infection/increased respiratory s/s. If abx necessary, avoid azithromycin for Qt prolongation.
2. Electrolyte imbalance
    A. Monitor K+, Na+, (BMP, LFT)
    B. Monitor AMS/CV VS periodically
    C. Encourage healthy, wholesome eating style
    D. Continue Ensure oral supplement, Magnesium oxide supplement, Vitamin D3 supplement, KCL XR 40 mg tab supplement

E - I think we've already discussed most of the issues. Key points - ① Summarize a bit more in delivery. Details of issues other than CC-related belong in PMH
② HCV Tx/response/management now unclear
③ D/C considerations need to be clearer
④ Need clearer understanding of lung status

- SM