Family Medicine – HPI #1

Chief Complaint: “on and off chest pain, left shoulder and arm pain” for the past 2-3days

HPI

Ms. R.S. is a 65y/o F with a PMHx of breast cancer (s/p total mastectomy, lymph node dissection, and chemotherapy), HLD, and HTN who presents today with intermittent chest pain associated with left shoulder and left arm pain for the past 2–3 days. The patient reports that the chest pain began suddenly when she woke up and describes the pain as a heaviness and “squeezing”, localized to the left upper sternal border, near the site of her old chemotherapy port. She states that she’s always had chronic left shoulder and arm pain for a while, however, the chest pain is new. The pain occurs intermittently and has been progressively worsening over the past 2–3 days with increased discomfort while waiting for today’s appointment. She states that the pain is worse when lying down and partially relieved with acetaminophen 650 mg, but the pain comes back. Patient admits to being a “little” short of breath at rest when the pain comes on, but denies doing any physical activity. She denies any radiation of the pain to the jaw or back and denies feeling this way before.

Denies fever, chills, diaphoresis, nausea, vomiting, dizziness, syncope, palpitations, pleuritic chest pain, abdominal pain, lower extremity edema, history of blood clots, trauma, recent travel, prolonged immobilization.

PMHx

- HR+/HER2- Breast CA (Invasive Lobular Carcinoma) → treated with right total mastectomy, lymph node dissection & adjuvant chemotherapy 3 years ago; currently in remission and maintained on Verzenio
- Essential HTN → controlled with Lisinopril 10mg & Amlodipine 10mg
- Hyperlipidemia → controlled with Atorvastatin 10mg & Fenofibrate 67mg
- GERD → controlled with Ondansetron 4mg
- Osteoarthritis of the Knee → controlled with Diclofenac Sodium 1% Transdermal Patches
- Iron Deficiency Anemia → controlled with Ferrous Sulfate 325mg
- Immunizations: Up to Date, including influenza, COVID-19, Shingrix, and Pneumococcal

PSHx

- Mastectomy of the Right Breast on 02/2023, no known complications.

Medications

- Lisinopril 10mg, QD for HTN
- Amlodipine 10mg, QD for HTN
- Ferrous Sulfate 325mg, QD for Fe-Deficiency Anemia
- Fenofibrate 67mg, QD for HLD
- Verzenio 100mg, BID for Breast CA Remission
- Atorvastatin 10mg, QD for HTN
- Famotidine 20mg, BID for GERD
- Diclofenac Sodium 1% Transdermal Patch, BID for OA of the Knee (R > L)
- Daily Supplements/Vitamins: Daily Multivitamin
- Patient states she is compliant with daily medications & supplements/vitamins

Allergies

- No known drug, food, or environmental allergies.

FHx:

- Paternal/Maternal Grandparents → unknown medical history.
- Mother → alive and well, hx of breast CA & HLD
- Father → deceased at unknown age, hx of HLD & HTN
- 5 Sisters → all alive and well, unknown medical history
- Brother → alive and well, unknown medical history
- Son → alive and well, unknown medical history
- Daughter → alive and well, unknown medical history

SHx

- Ms. R. S. is a retired former cashier who currently lives with one of her sisters.
- Habits → denies tobacco smoking, alcohol consumption, and illicit drug use.
- Travel → no recent travel
- Diet → regular diet described as mainly vegetables, fruits, and rice, does not consume red meat or seafood often
- Exercise → walks around at home & needs to rest often, and is unable to walk outside for about a couple of blocks due to OA of the knee.
- Sexual → no longer sexually active.

Preventive Screenings

Pap Smear: no longer applicable at 65 years old
Mammogram: last done in Feb 2025. Next due Feb 2026.
Colorectal Cancer Screening: FOBT stool kit was done in Dec 2025. Next due Dec 2026.
DEXA Scan: due this year as she is 65 years old

ROS

General – Denies fever, chills, nausea, vomiting, unexplained weight loss, and night sweats.

HEENT – Denies vision changes, eye pain, or sore throat.

Neck – Admits to neck pain and stiffness on the left lateral side.

Chest – Denies lumps, discharge, pain, and swelling.

Cardiovascular – Admits to chest pain and tightness. Denies palpitations.

Pulmonary – Admits to shortness of breath. Denies cough, wheezing, hemoptysis, or history of blood clots..

Gastrointestinal – Denies abdominal pain, diarrhea, or constipation.

Nervous – Denies numbness or tingling of the upper and lower extremities, headaches, dizziness, or loss of consciousness.

Musculoskeletal – Admits to left upper extremity weakness, bilateral knee pain (R > L), and decreased range of motion of the knees. Denies trauma, joint swelling, and erythema.

Peripheral Vascular – Denies swelling in the lower extremities.

Psychiatric – Admits to being more tired recently. Denies depression, anxiety, or memory changes/deficits.

Vital Signs
BP (L): Seated 138/82 mmHg

Manual BP (L): Seated 140/88 mmHg

P (radial): 62 bpm, regular, 2+ bilaterally

RR: 16 breaths/min, unlabored breathing with no accessory muscle use

T (temporal): 97.3 °F

O2 Sat: 99% on room air

Height: 5 feet 2 in | **Weight:** 141 lbs | **BMI:** 25.7

Physical Exam

General: AxO3. Sitting upright, looks mildly distressed and anxious. Appears stated age of 65 years old.

Skin: No signs of diaphoresis, cyanosis, or pallor.

Cardiac: Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4 gallops. No pericardial friction rub heard on auscultation.

Lungs: Able to speak in full sentences without effort. Respirations are unlabored with a symmetrical rise of the chest, with no use of accessory muscles. Clear to auscultation bilaterally. Vesicular breath sounds are present bilaterally with no crackles or wheezing.

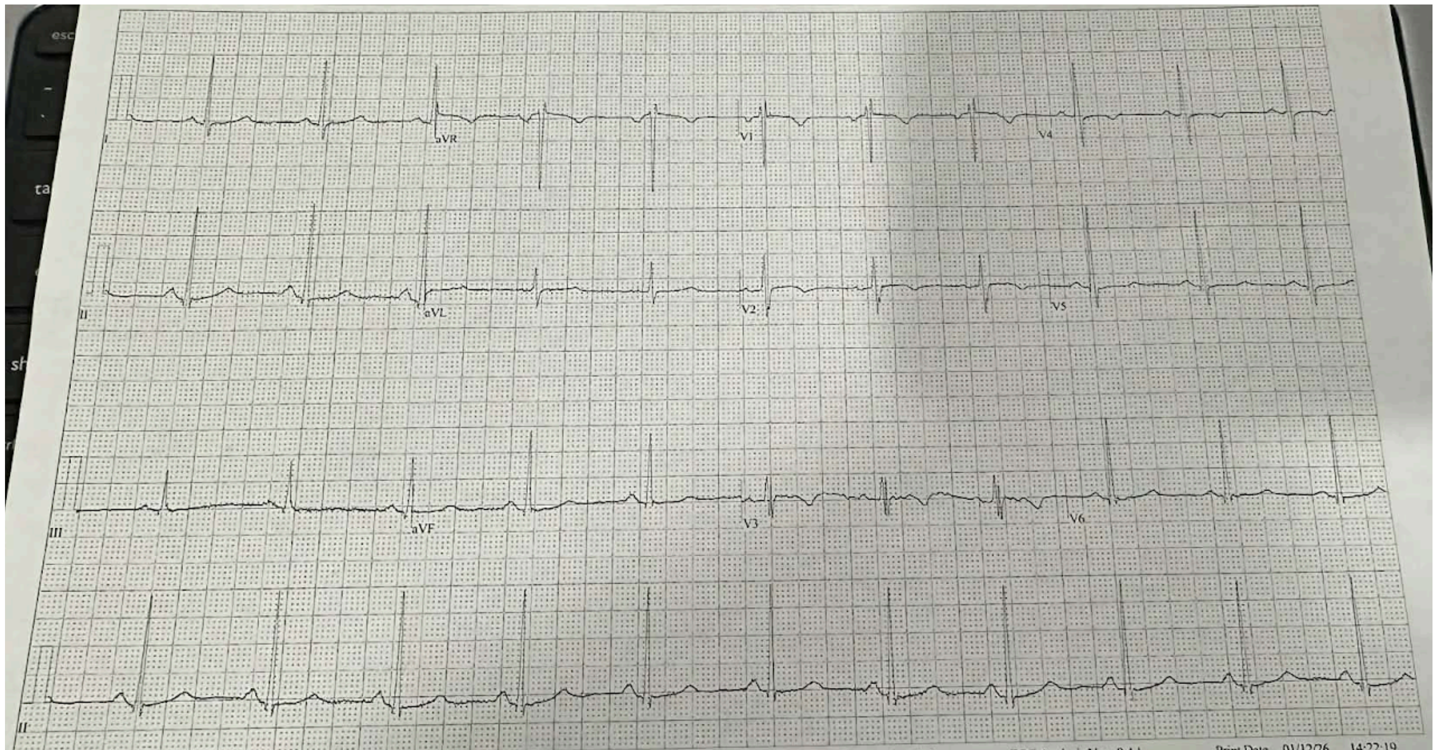
Abdomen: Soft, protuberant, and symmetric with no scars, bruising, or pulsations noted. Bowel sounds are normoactive in all four quadrants. Non-tender to light and deep palpation throughout. Tympanic throughout, no CVA tenderness appreciated.

MSK: Chest wall and sternum is non-tender to palpation. Prior chemotherapy port site is tender on deep palpation. The left clavicle and sternum is non-tender to palpation. Reduced ROM of the left shoulder.

Peripheral Vascular: capillary refill <2 seconds in upper & lower extremity nailbeds. No lower extremity edema, erythema, or calf tenderness. Radial pulses 2+, pedal dorsalis pulses 2+, unable to palpate posterior tibialis pulses bilaterally.

Labs/Imaging
EKG: RBBB (RSR’) seen on V1, V3 with T-wave inversions, possible for anteroseptal ischemia. Regular rate and rhythm at 67bpm. Normal QT, QRS, and PR intervals. No STEMI and reciprocal changes are seen. No prior EKG in the chart to

compare findings.



<u>Assessment</u>

Ms. R.S. is a 65y/o F with a PMHx of breast cancer (s/p total mastectomy, lymph node dissection, and chemotherapy), HLD, and HTN who presents with new-onset intermittent substernal chest pain described as heaviness/squeezing, associated with left arm pain and intermittent shortness of breath at rest for 2–3 days. Symptoms are progressive, worse when supine, and some alleviation with Tylenol. Vital signs are stable, but the EKG shows RBBB with T-wave inversions in V1–V3, concerning for possible anteroseptal ischemia. Given her risk factors, symptoms, and EKG findings, ACS is concerning and needs to be ruled out.

<u>D/Dx [5] – Ranked from Most Important to Least</u>

1. ACS (Unstable Angina/NSTEMI)
    a. <u>Rationale:</u> Most likely and most concerning diagnosis given her age, history of HTN and hyperlipidemia, and new-onset chest pain described as heaviness and squeezing with potentially associated left arm pain and shortness of breath at rest with EKG abnormalities (RBBB with T-wave inversions in V1–V3). All of this raises concern for myocardial ischemia despite stable vital signs, making this a priority to rule out.
2. PE
    a. <u>Rationale:</u> She has intermittent shortness of breath with chest pain. She does not have any tachycardia, hypoxia, pleuritic chest pain, or unilateral leg swelling, but this is still important to rule out. Wells' Criteria scores a 4.
3. Pericarditis
    a. <u>Rationale:</u> She has chest pain that worsens when lying down. On exam, she has no pericardial friction rub and no diffuse ST elevations on EKG, making this less likely, but still potentially possible.
4. Cardiotoxicity from Breast CA Tx
    a. <u>Rationale:</u> Can be considered due to her history of breast cancer treated with chemotherapy 3 years ago that may have cardiotoxic effects, but she does not currently show signs of HF.

5. Costochronditis
    a. Rationale: Can be considered due to chest wall discomfort and localized tenderness near the prior chemotherapy port site. However, the lack of reproducible tenderness over the sternal area and chest wall, and the presence of a cardiac etiology makes this diagnosis less likely.

Problem Lists & Plan – ACS (Unstable Angina/NSTEMI)

ACS
- Immediate transfer to ED via EMS for urgent evaluation with serial troponins, repeat 12-lead EKG, CXR, Echo
- Administer in ED/EMS: ASA 324mg, Nitroglycerin

HTN
- Continue Lisinopril 10mg and Amlodipine 10mg QD.
- Continue to monitor BP at home and record findings, if possible. Recheck BP manually during future visits.

HLD
- Continue Atorvastatin 10mg and Fenofibrate 67mg QD. Recheck lipid panels in 6-12 months.

Prediabetes
- Last A1C was checked in November 2025, and it was 6.0%. Recheck A1C around February 2026 (3 months after)

Osteoarthritis of the Knees
- Continue Diclofenac Sodium 1% Transdermal Patch as needed

GERD
- Continue Famotidine 20mg as needed.

Iron Deficiency Anemia
- Continue Ferrous Sulfate 325mg QD. Recheck CBC & Iron Panel in 3 months.

Breast Cancer s/p Mastectomy, Lymph Node Dissection, Chemotherapy
- Continue Verzenio 100mg BID. Maintain regular follow-up with her oncologist/breast surgeon.

Preventative Health
- DEXA Scan due this year as she is 65 years old to evaluate her bone health. Will discuss this in future visit.

Patient Education
- Emphasized and advised the patient on the need for urgent evaluation in the ED due to red flag symptoms. Explained that her chest pain and shortness of breath could indicate life-threatening conditions such as a heart attack, and time is crucial in these cases. Reviewed what to expect in the ED, including blood work, EKGs, and continuous vital sign monitoring. Patient is adamant about going to the ED due to previous experiences and fears at the hospital. Reinforced the patient’s right to refuse care, but discussed the benefits of prompt evaluation. If she chooses not to go immediately and symptoms worsen, she is highly advised to call 911 and seek care immediately. Otherwise, follow-up with her PCP via telehealth or an in-office visit as soon as possible was recommended.
- Also reviewed lifestyle management, including a heart-healthy diet, low sodium, limiting processed foods, and physical activity as tolerated. Discussed the importance of medication adherence for blood pressure and cholesterol control to prevent complications such as heart attacks and strokes.