HPI Assignment #4 [Internal Medicine]

Chief Complaint: “I woke up with really severe lower back pain” around 7:30 AM on April 7th

HPI

Ms. S.T. is a 68-year-old female with a history of osteoporosis diagnosed 1 year ago (not controlled on medications) and previous compression fractures in October and November 2024, both treated with kyphoplasty, who presents with severe lower back pain. She states that the pain began abruptly in the morning of April 7th when she woke up around 7:30 AM without any triggers. She reports waking up with “extraordinary” pain in her lower back, severe enough to call an ambulance. She has had similar episodes of pain in the past when she was diagnosed with compression fractures. She describes the pain as “excruciating, in agony, unrelenting, intensely sore, tender, and throbbing”. The pain is constant and is localized to the lower back. She reports that there is associated weakness of both lower extremities, but denies any radiation of pain itself. She took ibuprofen and Tylenol without relief, and movement worsened the pain. On the day of her symptom onset, she rated her pain as 10/10, stating it worsened throughout the day until she received pain medications in the hospital. She was diagnosed with a compression fracture at L2 and is currently awaiting a kyphoplasty. Today, she feels improvement in her pain levels as she has been on pain medications (Morphine & Tramadol) and rates her current pain as a 5/10. She states that the pain still lingers in her lower back without radiation. She reports occasional headaches and ongoing weakness of the lower extremities, which interferes with daily activities such as going to the bathroom. She temporarily uses a walker to ambulate and reports occasional sleep disturbances from the pain. She denies any new or different symptoms today. She denies any trauma, fever, chills, loss of consciousness, nausea, vomiting, numbness, tingling, chest pain, shortness of breath, urinary urgency, incontinence, or dysuria.

PMHx

- Osteoporosis → present for approximately 1 year, not controlled with medications.
- Compression Fractures [2 in Oct & Nov 2024; both treated with Kyphoplasty]
- Scoliosis → present for approximately 50 years, wore a brace as a teenager.
- Sleep Apnea → present for approximately 40 years, controlled with nightly CPAP
- Ductal Carcinoma in Situ → present 8 years ago [2017], treated with a bilateral lumpectomy and radiation therapy
- Depression → present for approximately 10 years, controlled with Pristiq
- Bipolar Disorder → present for approximately 10 years, controlled with Depakote & Abilify
- Immunizations: Up to Date, including influenza & COVID-19 vaccines

PSHx

- Bilateral Lumpectomy in 2017 at NYP/Queens, no complications
- Kypoplasty in Oct & Nov 2024 at NYP/Queens, no complications
- No History of Blood Transfusions

Medications

- Pristiq (Desvenlafaxine) [unknown dose], QD (daily) for Depression
- Depakote (Valproate) [unknown dose], QD (daily) for Bipolar Disorder
- Abilify (Aripiprazole) [unknown dose], QD (daily) for Bipolar Disorder
- Daily Supplements/Vitamins: Vitamin B12, Folic Acid, Vitamin D, Ca2+, Mg2+
- Patient is compliant with daily medications & supplements/vitamins
- Takes no other medications, vitamins, or supplements

Allergies

- Penicillin → pruritus, rashes

- Codeine → pruritus, rashes
- No known food or environmental allergies.

FHx:

- Grandparents → unknown medical history. Passed away in Auschwitz.
- Mother → history of Diabetes Mellitus 2, Breast Cancer, & Colon Cancer. Passed away at 95 years old from natural causes.
- Father → history of Ulcerative Colitis & Pancreatic Cancer. Passed away at 70 years old from a stroke.
- Has No Siblings
- Daughter → 36 years old, alive and well, no known medical history

SHx

- Ms. S. T. is a retired lawyer who now owns a consulting business that focuses on entrepreneurship for women. She currently lives alone as her husband passed away in 2019. She has a home-health aide who helps with her daily activities. She feels safe at home and does not live with any pets. She admits to feeling more depressed and unhappy due to being in the hospital for a prolonged period, and has a history of depression.
- Habits → Admits to having about 3 8-oz bottles of Coke per day. Does not consume caffeine or alcohol. She has never smoked or used illicit drugs.
- Travel → no recent travel
- Diet → "very bad"; typical diet: Breakfast: yogurt, a bottle of soda, snacks; Lunch: fast-food; Dinner: take-out food
- Exercise → minimal to no physical activity
- Sleep → before admission was "good" – about 8hrs a day; currently "not so great" – about 6hrs, and wakes up from time to time from the pain
- Sexual → used to be sexually active with her husband (monogamous) with and without barrier protection. No longer sexually active. Denies any STIs in the past.

ROS

General – Admits to weakness in the lower extremities. Denies weight changes, weakness in the upper extremities, nausea, fever, chills, and night sweats.

Skin, Hair, Nails – Admits to hair thinning and a new rash on the posterior neck with pruritus. Denies other lesions, masses/lumps

Head – Admits to occasional headaches. Denies trauma, dizziness, vertigo

Eyes – Denies recent changes in vision, conjunctivitis, eye pain, pruritus, lacrimation, last eye exam May 2024 (no abnormalities)

Ears – Denies ear pain, hearing loss, discharge

Nose/Sinuses – Denies epistaxis, congestion, discharge

Mouth/Throat – Denies sore throat, dysphagia, bleeding gums, ulcers. Last dental exam September 2024 (no abnormalities)

Neck – Denies neck pain or stiffness, swelling, or decreased ROM

Breast – Admits to bilateral lumpectomy done in 2017 due to diagnosed DCIS. Denies discharge, bleeding, pain, lumps/masses. Last mammogram was in August 2024 (no abnormalities).

Pulmonary – Denies cough, shortness of breath, wheezing, hemoptysis, cyanosis

Cardiovascular – Denies chest pain, palpitations

Gastrointestinal – Admits to changes in bowel movements and constipation (last bowel movement on 4/27). Denies diarrhea, changes in bowel movements, abdominal pain, or blood in stool. Last colonoscopy unknown.

Genitourinary – Denies changes in urination, pain, blood, incontinence, or pruritus

Menstrual & Obstetrical – G2P1011, LMP unknown, Menarcheal Age unknown, Menopausal Age at 50 years old. Denies hot flashes, nausea, vomiting, vaginal discharge, bleeding, or urgency

Nervous – Denies headaches, numbness, problems with balance, loss of consciousness, syncope, memory changes

Musculoskeletal – Denies joint pain, redness, deformities, or swelling.

Peripheral Vascular – Denies extremity coldness, pain walking

Hematological – Denies anemia, abnormal bleeding & bruising

Endocrine – Denies temperature sensitivity, changes in appetite, and thirst

Psychiatric – Admits to feeling more unhappy and depressed due to prolonged stay at the hospital. Admits to a history of depression and anxiety. Denies memory changes/deficits.

Vital Signs [Blue → Done on Classmate]
BP (R/L): Seated 128/80mmHg / 112/76 mmHg

Standing 106/74 mmHg / 108/72 mmHg

P (radial): 88 bpm, regular, 2+ bilaterally

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

T (oral): 98 F

O2 Sat: 99% on room air

Height: 5 feet 4 in | Weight: 240 lbs | BMI: 41.2

Physical Exam [Blue → Done on Classmate]
General: AxO3 (person, place, time). Appears slightly fatigued, but in no apparent acute distress. Dressed appropriately in a hospital gown and comfortable in bed. Appears adequately nourished with no signs of malnutrition such as wasting of the temporals or poor skin turgor. Temporarily requires a walker for ambulation. Appears stated age of 68 years old.

Skin: warm and dry, good skin turgor, no cyanosis/erythema/jaundice, lesions, rashes, contusions

Hair: normal aging hair loss & shedding seen on the bed. No abnormal hair loss/patches, nits, lice, lesions

Nails: capillary refill <2 seconds in upper & lower extremities, no signs of clubbing or pitting

Head: normocephalic, atraumatic, no masses, lesions, lymphadenopathy, or tenderness to palpation

Eyes: Symmetrical and appropriate in size OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink. PERRLA Visual acuity → 20/20 OS, 20/20 OD, 20/20 OU [corrected]. Visual fields are full OU. EOMs are intact & able to converge with no nystagmus or lid lag.

Fundoscopy – red reflex is intact OU on fundoscopy. Cup to Disk Ratio is < 0.5 OU. No AV nicking, copper/silver wiring, cotton wool spots, hemorrhages, exudates, or neovascularization seen OU

Ears: Symmetrical and appropriate in size. No lesions, masses, or trauma on external ears. Cerumen was noted in both external auditory canals. No discharge or foreign bodies in external auditory canals AU. TMs are pearly grey, intact with cone of light AU with no signs of perforation or inflammation/bulging. Auditory acuity is intact to finger rub test AU. Weber Test is midline. Rinne Test is AC > BC AU.

Nose: External nose symmetrical with no masses, lesions, deformities, trauma, or discharge. Nares are patent bilaterally. Nasal mucosa is pink. No septum deviation, deformities, lesions, perforations, discharge, or foreign bodies seen on rhinoscopy.

Sinuses: Nontender to palpation over bilateral frontal and maxillary sinuses.

Lips: Pink & moist. No cyanosis, cracks, ulcers, or lesions.

Mucosa: Pink, well hydrated. No masses or lesions seen. No leukoplakia or white membranes.

Palate: Pink, well hydrated. Hard and soft palate continuously intact with no lesions, masses, or scars.

Teeth: Good dentition. No obvious dental caries.

Gingivae: Pink & moist. No hyperplasia of the interdental papillae, masses, lesions, erythema, or discharge.

Tongue: Pink & well papillated. No masses, lesions, or deviation.

Oropharynx: Well hydrated. No injection, exudate, masses, lesions, or foreign bodies. Tonsils present with no injection or exudate. Uvula pink with no deviation, edema, or lesions.

Neck: Trachea is midline. No masses, lesions, or scars seen. Neck is supple & nontender to palpation posteriorly & anteriorly. No lymphadenopathy.

Thyroid: Nontender, soft, and mobile; no palpable masses; no thyromegaly

Chest: Symmetrical with no deformities or trauma. Non-tender to palpation throughout. Respirations are unlabored, with no use of accessory muscles or paradoxical movements. AP to lateral diameter is approximately 2:1.

Lungs: Clear to auscultation and percussion bilaterally. Vesicular breath sounds present, no adventitious sounds heard. Chest expansion and tactile fremitus are symmetric.

Heart: JVP is 2 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdomen: Soft, protuberant, and symmetric with no scars, bruising, striae, or pulsations noted. Bowel sounds are normoactive in all four quadrants without aortic/renal/iliac or femoral bruits. Tender to palpation in all 4 quadrants, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated.