Lisette Romo PA-S2

Chief Complaint: “I have shortness of breath and cough” x1 day

HPI:

An 86-year-old male with a past medical history significant for chronic obstructive pulmonary disease (COPD), anxiety, and benign prostatic hyperplasia (BPH) presents with an acute onset of shortness of breath and productive cough since this morning. The patient reports that the cough has been persistent throughout the morning and has now worsened since it was initially dry and has now developed green sputum. As per RN report, the patient appears anxious regarding his symptoms and is requesting antibiotic therapy since he has a concern for a possible respiratory infection given his history. The patient states that he received one DuoNeb treatment at approximately 8:00 AM without any relief. The patient denies fever, chills, chest pain, palpitations, wheezing, hemoptysis, lower extremity edema, nausea, vomiting, or other systemic symptoms.

Past Medical History:
Chronic Obstructive Pulmonary Disease (COPD)
Generalized Anxiety Disorder
Benign Prostatic Hyperplasia (BPH)
Vitamin D deficiency

Surgical History:
None

Medications:
Trelegy Ellipta (fluticasone furoate/umeclidinium/vilanterol) 100/62.5/25 mcg 1 inhalation daily
Tamsulosin (Flomax) 0.4 mg once daily at bedtime
Risperidone 0.25 mg once daily at bedtime
Docusate sodium (Colace) 100 mg daily
Vitamin D3 2000 IU daily
Patient is compliant with his daily medications as per RN

Allergies:
No known drug, environmental, or food allergies

Family History:
Mother: History of diabetes and hypertension, deceased.
Father: History of hyperlipidemia, deceased at 70 years old.

Social History:
C.G is an 86-year-old male residing in the LTC unit
Habits: Former smoker with an approximately 20 pack-year history. Denies current tobacco use. Denies alcohol or illicit drug use
Diet: Patient is currently being managed by a registered dietician for a weight gain regimen; he

intakes Ensure drinks x2-3 daily, and has a consistent carbohydrate diet (ex: applesauce, bread). Exercise: Patient does not exercise and has limited mobility since he uses a wheelchair for ambulation, and spends the majority of his time in bed. Requires one-person assistance for transfers.

ROS:

General: Denies fever, chills, and night sweats

Skin: Denies any rashes, lesions, or any other skin changes.

HEENT: Denies headaches, changes in vision, or sore throat

Neck: Denies any neck pain/ stiffness

Cardiovascular: Denies chest pain, palpitations, or lower extremity edema

Pulmonary: **Reports shortness of breath and productive cough with green sputum.** Denies wheezing or hemoptysis

Gastrointestinal: Denies nausea, vomiting, diarrhea

Genitourinary: Denies dysuria, hematuria, or urinary frequency.

Neurologic: Denies numbness or tingling sensations, dizziness

Musculoskeletal: Denies joint pain.

Peripheral Vascular: Denies lower extremity swelling, leg cramping, or color changes to the extremities.

Endocrine: Denies excessive thirst, frequent urination, or unintentional weight loss

Hematologic: Denies any easy bruising or prolonged bleeding

Psychiatric: **Reports feeling anxious regarding his current symptoms**

Vital Signs:
H: 64in. W: 127lbs BMI: 21.8
BP: 105/62 mmHg
HR: 52bpm
RR: 20 breaths/ min
T: 97.9F
SpO2: 95% on 3L/min nasal cannula receiving supplemental oxygen

Physical Examination:

General: Patient appears stated age of 86 years old, appears thin and frail. Patient found lying comfortably in bed watching TV and eating a meal, with a nasal cannula in place, and in no acute distress. AOX3 (to person, place, and time)

HEENT: Patient wears eyeglasses. Normocephalic, atraumatic.

Neck: Supple.

Skin: Dry and intact without visible lesions or rashes.

Cardiovascular: S1S2, bradycardic with irregular rhythm.

Respiratory: On appearance, ribs are visibly prominent bilaterally, and has slight hyperexpanded chest appearance. Distant breath sounds bilaterally with mild expiratory wheezing. No accessory muscle use noted. Patient is able to speak in full sentences. No rales/ rhonchi, crackles. *(Exam performed anteriorly for lung auscultation as the patient was unable to sit upright or lean forward for posterior auscultation.)*

Abdomen: Soft, non-tender, and non-distended. Normoactive bowel sounds present.

Genitourinary: Wearing an incontinence brief.

Extremities: No clubbing, cyanosis, or pitting edema.Capillary refill <3 seconds. No lower extremity edema noted. Peripheral pulses are intact in B/L upper and lower extremities.

Neurological: No focal deficits observed.

Labs/Imaging:
CBC/ CMP obtained, pending
Respiratory panel obtained, pending

Assessment:

C.G. is an 86-year-old male with a past medical history significant for COPD, generalized anxiety disorder, BPH, and vitamin D deficiency who presents with an acute onset of shortness of breath and a productive cough with green sputum for one day. Physical examination was notable for distant breath sounds bilaterally and mild expiratory wheezing. Given his history of COPD, with a former smoking history, increased purulent sputum production, and respiratory findings on exam, his presentation is most concerning for an acute exacerbation of COPD.

Differential Diagnosis:

1. COPD exacerbation
   a. Rationale: The patient has a history of COPD and has classic findings of the condition, as he is a thin-appearing male with a hyperinflated-appearing visible chest and low oxygen saturation that patients typically have. He has SOB, purulent sputum, and an expiratory wheeze, which can indicate poorly controlled COPD.

2. Acute Bronchitis
   a. Rationale: This condition should be highly considered, especially since the patient's symptoms started one day ago, and acute bronchitis is a respiratory virus that typically occurs in the time frame of usually 1-5 days, starting with a cough and sputum.
3. Pneumonia
   a. Rationale: The patient presents with a productive cough and purulent sputum, which are seen in pneumonia. This should also be considered given his advanced age, COPD, and residing in a long-term care facility, which increases his risk for respiratory infections. However, the absence of fever, crackles, rhonchi, or other focal pulmonary findings makes pneumonia less likely.
4. Viral Upper Respiratory Infection
   a. Rationale: Given his risk factors, age, COPD, and exposure to other residents, the patient has a high chance of being exposed to a viral infection. A respiratory panel is pending to rule out RSV, COVID-19, and other respiratory viruses.
5. Pulmonary Embolism
   a. Rationale: This is a must-not-miss diagnosis in any patient presenting with a sudden onset of SOB. Certain factors for this patient must be taken into consideration; he is wheelchair-dependent with limited mobility and also spends most of his time in bed, which increases the risk for developing a thromboembolism. The absence of unilateral lower extremity swelling, chest pain, hemoptysis, and tachycardia makes this less likely.

<u>Problem list/ Plan</u>:

#COPD exacerbation

- Continue Trelegy Ellipta 100/62.5/25 mcg, 1 inhalation daily, and reinforce inhaler technique.
- Continue DuoNeb treatments PRN for SOB/wheezing.
- Continue supplemental oxygen via nasal cannula and monitor O_2 saturation.
- Start prednisone 40mg once a day for 5 days.
- Start azithromycin 500 mg PO on day 1, then 250 mg PO daily on days 2-5
- Monitor symptoms for worsening shortness of breath, increased oxygen requirement, wheezing, or respiratory distress.

#R/O Pneumonia / Respiratory Infection

- CBC and CMP obtained; results pending.
- Respiratory viral panel obtained; results pending.
- Consider chest X-ray if symptoms worsen or fail to improve.
- Continue monitoring vital signs

#Bradycardia

- HR 52 bpm noted on vital signs → Consider EKG for further eval
- Monitor HR and BP.
- Monitor for dizziness, syncope, chest pain, or worsening symptoms.

#Generalized Anxiety Disorder

- Continue risperidone 0.25 mg PO QHS.
- Provide the patient with reassurance regarding the treatment plan.
- Encourage participation in daily activities to reduce stress and anxiety

#BPH

- Continue tamsulosin 0.4 mg PO QHS.
- Change incontinence briefs daily

#Vitamin D Deficiency / Nutritional Support

- Continue Vitamin D3 2000 IU daily.
- Continue Ensure supplementation as recommended by dietician.

#Constipation

- Continue docusate sodium 100 mg PO daily.
- Encourage PO hydration as tolerated.

#Patient Education
-Advised pt to report if any sxs of worsening shortness of breath, cough, chest pain, fever

Code Status: Full Code/CPR