Lisette Romo PA-S2

Chief Complaint: Admission to SAR s/p hospitalization for acute respiratory failure and pneumonia
HPI:

A.B is a 78-year-old female with a PMHx COPD, asthma, CKD stage 3, T2DM, and HTN, hgA1C 7.4%, who presented to the ED on 5/27/2026 with two days of fever, nasal congestion, productive cough, and shortness of breath. She was brought in by ambulance, and on arrival, she was tachycardic with a 91% O2Sat on room air. Initial workup in the ED was most notable for positive rhinovirus and bibasilar opacities on chest x-ray, concerning for pneumonia. She was given dexamethasone, as well as ceftriaxone and azithromycin. She was subsequently admitted to the Internal Medicine unit for further workup and management. While hospitalized, the patient received supplemental oxygen, continued on PNA antibiotic therapy, and was started on DuoNebs, budesonide, and Prednisone. The hospital course was then complicated since the patient developed urinary retention, AKI, and steroid-induced hyperglycemia, which had resolved before discharge. She was also assessed by PT and was recommended for subacute rehab (SAR). The patient was seen and evaluated today for admission and reports right-sided low back pain, which is non-radiating and dull/achy. Otherwise, reports feeling better since hospitalization. Denies fever, chills, chest pain, SOB, orthopnea, N/V/D, abdominal pain, dysuria, or hematuria.

Past Medical History:
COPD
Asthma
CKD stage 3a
Heart Failure (HFpEF)
Hypertension
Peripheral Arterial Disease
Hyperlipidemia
Insomnia
Anemia
History of Colon Cancer (remission)
History of Lung Cancer (remission)

Past Surgical History:
Colectomy (2016)
Lung resection (2017)
PAD stent placement (2022)

(No surgical complications)

Medications:
Aspirin 81 mg, 1 tablet by mouth daily for PAD
Atorvastatin 40 mg, 1 tablet by mouth daily for PAD
Irbesartan 75 mg tablet by mouth nightly

Jardiance 10 mg by mouth daily
Insulin lispro 100 units/mL injection, sliding scale
Pregabalin 75 mg capsule by mouth two times a day (max 150mg)
Trazodone 50mg tablet, 1 tablet by mouth at bedtime
Symbicort (budesonide-formoterol) 160/4.5 mcg inhaler
Lasix 40mg by mouth once a day in the morning
Ferrous sulfate 325 mg

Allergies:
NKDA

Family History:
Mother: unknown medical history
Father: unknown medical history

Social History:
Habits: Former smoker with an approximately 15–20 pack-year history; quit over 20 years ago. Denies current tobacco use. Denies alcohol or illicit drug use.
Diet: Consistent carbohydrate (diabetic) diet with Glucerna nutritional supplementation. Thin consistency foods.
Exercise: Limited physical activity due to chronic conditions and impaired mobility.
Baseline Functional status: Ambulates independently with assistive device (walker), lives home alone, requires some assistance with ADLs/IADLs at baseline

ROS:

Constitutional: Denies fever, chills, fatigue, or weight loss.

HEENT: Denies headache, dizziness, vision changes, hearing loss, or sore throat.

Cardiovascular: Positive for bilateral lower extremity swelling. Denies chest pain, palpitations, orthopnea, or syncope.

Respiratory: Reports improving SOB, and cough since hospitalization. Denies hemoptysis or wheezing.

Gastrointestinal: Denies abdominal pain, nausea, vomiting, diarrhea, constipation.

Genitourinary: Denies dysuria, urinary frequency, urgency, hematuria, or urinary retention.

Musculoskeletal: Reports non-radiating right low back. Denies recent falls.

Skin: Denies rash or open wounds.

Neurologic: Denies weakness, numbness, tingling, dizziness, or loss of consciousness.

Psychiatric: Denies anxiety, depression, suicidal ideation, or hallucinations.

Vital Signs:

H: 63 in W: 149.1 lbs BMI: 26.4 kg/m²

BP:120/67 mmHg

HR:74 bpm

RR:16 breaths/min

T: 97.8 F

O2Sat: 98% on room air

Physical Examination:

General: Patient appears her stated age of 78 years old, and was found seated comfortably in a chair watching TV in her room. AOx3 and in NAD.

Skin: Warm and dry. Scattered ecchymosis noted in B/L upper extremities, reported likely secondary to recent venipuncture/IV placements. B/L lower extremities with visible brown hyperpigmentation consistent with stasis dermatitis.

HEENT: Normocephalic, atraumatic. PERRLA. Wears corrective eyeglasses. Oral mucosa moist.

Cardiovascular: Regular rate and rhythm. S1/S2. No murmurs, rubs, or gallops.

Respiratory: Able to speak in full, clear sentences. No accessory muscle use noted; in no respiratory distress. Faint bibasilar crackles noted.

Abdomen: Soft, non-distended, non-tender. Normoactive bowel sounds present in all four quadrants. No CVAT.

Genitourinary: No suprapubic tenderness.

Musculoskeletal: Active ROM in B/L upper and lower extremities. Mild right lumbar paraspinal tenderness to palpation.

Peripheral Vascular: <2 sec capillary refill in B/L upper and lower extremities. 2+ pitting edema in B/L lower extremities with tenderness to palpation bilaterally. Pedal pulses are difficult to appreciate secondary to edema.

Neurological: Alert and oriented. No focal neurologic deficits noted.

Psychiatric: Normal mood and affect.

Assessment:

78-year-old female with a PMHx of COPD, asthma, HFpEF, CKD, T2DM, HTN, and PAD admitted to SAR s/p hospitalization for acute respiratory failure secondary to rhinovirus infection with superimposed community-acquired pneumonia and COPD exacerbation. Pt was treated with ceftriaxone, azithromycin, corticosteroids, supplemental oxygen, and bronchodilators, which improved her symptoms. Her hospital course was complicated by AKI, urinary retention, and steroid-induced hyperglycemia, which was resolved before discharge. Exam notable for faint bibasilar crackles, B/L LE edema, stasis dermatitis, and right lumbar paraspinal tenderness. Vital signs stable. Admitted to SAR for continued medical and rehabilitation management.

Problem Lists/ Plan:

Acute Respiratory Failure secondary to Rhinovirus Infection with Superimposed Community-Acquired Pneumonia (Improving)
- Completed ceftriaxone and azithromycin during hospitalization.
-Schedule In-house consult with Pulmonology given hospitalization and chronic respiratory conditions
- Cont. supplemental oxygen PRN
- Consider f/u CXR to eval resolution
- Ensure pneumococcal and flu vaccines are UTD
- Complete prednisone taper per discharge instructions (40 mg PO daily × 3 days, then 20 mg PO daily × 3 days, then stop).
- Obtain CBC to assess for resolution of infection

#Asthma/COPD
- Continue Symbicort
- Continue DuoNeb PRN

##Right low back pain
- Start Aspercreme with lidocaine
- Start Acetaminophen PRN 650 mg PO Q6H PRN
-Cont. pregabalin 75 mg PO BID

#HFpEF
- Continue Lasix 40 mg PO daily.
- Monitor daily weight
- Monitor intake and output

CKD Stage 3a / Recent AKI
- AKI resolved
- Obtain CMP to monitor renal function

#T2DM
- Cont. Jardiance 10mg PO daily
- Cont. Insulin lispro sliding scale

- Cont. diabetic diet
-Monitor fingerstick blood glucose
- Recent HbA1c 7.4%

#HTN
- Continue irbesartan 75 mg nightly.
- Monitor blood pressure daily.

#PAD (s/p Stent Placement 2022)
-Cont. aspirin 81 mg daily
-Cont. atorvastatin 40 mg daily

#Anemia
-Continue ferrous sulfate 325 mg daily.

#Insomnia
- Continue trazodone 50 mg PO at bedtime.

#History of Colon Cancer (s/p Colectomy 2016)
#Lung Cancer (s/p Lung Resection 2017)
- Monitor clinically

#Urinary retention
-Resolved before discharge
- Monitor for urinary sxs/recurrence

#Patient Education
-Fall prevention strategies (asking for assistance before ambulation/transfers)
-Encourage elevating legs and using compression socks for B/L LE edema

Code Status: Full Code/ CPR