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H&P 2
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H&P 2 - Internal Medicine

Chief Complaint: "I'm feeling short of breath" x 5 days

History of Present Illness:
Patient S.B. is a 78 year old female with a past medical history of type 2 diabetes, hypertension, hx of endometrial cancer (dx 2013) and asthma presenting to the emergency department as a transfer from Queens Hospital with worsening shortness of breath, chest pain and lower extremity swelling and pain bilaterally. In the emergency room at Queens Hospital, patient was started on BiPAP for increased work of breathing and received duonebs, IV solumedrol 125mg. and magnesium 2 g for possible asthma exacerbation. Imaging revealed extensive bilateral PE involving the main, segmental, and subsegmental branches with CT evidence of R heart strain. EKG showed left axis deviation, and elevated troponins (58->99). Patient was given aspirin 324 mg, started on a heparin drip and was transferred to NSUH for cardiology evaluation vs PERT evaluation. Currently she states she feels much better after being on the oxygen. She denies any chest pain, admits to minimal lower extremity pain, denies abdominal pain, nausea, vomiting. States she has not had any recent travel, and is up to date on other cancer screening. She denies any family history of blood clots.

In the ED, vitals are significant for O2 sat at 94% currently on 4L nasal cannula with RR of 18. Labs were significant for troponin of 77, BNP of 1042, Na 140, K 4.3, BUN 22, and Cr 0.60. VBG revealed pH 7.26, pCO2 65. Duplex of BL lower extremities were negative for DVT. CT angiogram of chest revealed large pulmonary emboli in BL main pulmonary arteries. Patient was admitted to medicine for further management of BL pulmonary embolism

Past Medical History
Hx of endometrial cancer, 2013
Hypertension, unknown year of diagnosis
Type 2 diabetes mellitus, unknown year of diagnosis
Asthma, unknown year of diagnosis

Immunization: Covid and TDaP vaccines up to date

Past Surgical History
Hysterectomy 2013

Medications

Aspirin 81 mg oral capsule, 1 cap(s) orally once a day
hydroCHLOROthiazide 12.5 mg oral capsule, 1 cap(s) orally
Ramipril 10 mg oral capsule, 1 cap(s) orally once a day
Albuterol (Eqv-ProAir HFA) 90-mcg/inh inhalation aerosol, 2 puff(s) inhaled every 6 hours as needed for shortness of breath and/or wheezing
Fluticasone 220 mcg/inh inhalation aerosol, 2 puff(s) inhaled once a day
Gabapentin 100 mg oral capsule, 1 cap(s) orally 2 times a day
metFORMIN 1000 mg oral tablet, 1 tab(s) orally 2 times a day
Rosuvastatin 40 mg oral capsule, 1 cap(s) orally once a day

Allergies:
Lasix - reaction unknown

Family History
No pertinent family history in first degree relatives.

Social History
Habits: Denies smoking, alcohol use, drinking coffee or usage of illicit drugs.
Travel: Denies recent travel outside of the country.
Living situation: Lives with son at home, walks with a walker.
Sexual history: Pt is not currently sexually active. Pt denies hx of past STIs. Denies use of barrier methods or contraceptives.

Review of Systems:
General: Denies fevers, chills, recent weight loss or weight gain, loss of appetite, generalized weakness/fatigue, or night sweats.

Skin, hair, nails: Denies excessive dryness or sweating, changes in skin texture, discoloration, pigmentations, moles/rashes, pruritis, or changes in hair distribution.

Head: Denies headache, vertigo, or head trauma.

Eyes: Denies visual disturbances, lacrimation, photophobia, or pruritus. Admits to wearing reading glasses.

Ears: Denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses: Denies discharge, epistaxis, or obstruction.

Mouth and Throat: Denies sore throat, sore tongue, bleeding gums, mouth ulcers, voice changes, or use of dentures. Last dental exam unknown.

Neck: Denies localized swelling/lumps, decreased range of motion, or stiffness.

Breast: Denies lumps, nipple discharge, or pain.

Pulmonary System: **Admits to dyspnea**. Denies cough, wheezing, hemoptysis, or cyanosis.

Cardiovascular System: **Admits to chest pain.** Denies palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, or known heart murmur.

Gastrointestinal System: Denies abdominal pain, nausea, vomiting, constipation, diarrhea, intolerance to specific foods, dysphagia, pyrosis, flatulence, eructations, jaundice, change in bowel habits, hemorrhoids, rectal bleeding, or blood in stool.

Genitourinary System: Denies frequency, nocturia, urgency, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate, flank pain, dribbling, or hesitancy.

Menstrual/Obstetrical: Menarche age 15. Menopause at age 50. Denies bleeding, spotting, or vaginal discharge.

Nervous System: Denies seizures, headache, loss of consciousness, sensory disturbances (numbness, paresthesias, dysesthesias, hyperesthesias), ataxia, loss of strength, change in cognition/mental status/memory, or weakness.

Musculoskeletal System: Denies muscle/joint pain, deformity, or swelling and redness. Denies arthritis.

Peripheral Vascular System: **Admits to mild BL lower extremity edema.** Denies intermittent claudication, coldness or trophic changes, varicose veins, or color change.

Hematologic System: Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

Endocrine System: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism.

Psychiatric: Denies depression/sadness, feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideations, anxiety, obsessive/compulsive disorder or ever seeing a mental health professional.

Physical Exam

General: 78 y/o female, well groomed, mildly tachypneic. Patient was found lying on hospital bed, A&O x 3.

Vital Signs:

BP:	139/77 mm/Hg	
RR:	18 breaths/min, unlabored	
P:	88 beats/min, regular	
T:	98.2°F, oral	
SpO2	94% on 4L nasal cannula	
Ht: 5'3"	Wt: 115 lbs	BMI: 20.4

Skin: Warm & moist, good turgor. No scars, rashes, or ecchymosis. No jaundice.
HEENT: Noncephalic, sclera non-icteric, PERRLA, oropharynx well hydrated, moist, non-erythematous, neck is supple with no lymphadenopathy, no JVD.
Lungs: Clear to auscultation bilaterally, no wheezing, rhonchi, or rales. **Mildly increased work of breathing.**
Heart: Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, gallops, or friction rubs.
Abdomen: Soft, non-distended. No striae or pulsation noted. Bowel sounds normoactive in all four quadrants. Non-tender to palpation, no palpable masses. No CVA tenderness.
Extremities: No edema, clubbing, or cyanosis, distal pulses 2+ and symmetric.
Neurologic Exam: A&O x3, cooperative, thoughts & speech coherent. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.

Problem List:

- Hypertension
- Type 2 diabetes mellitus
- Asthma
- Shortness of breath
- Bilateral pulmonary embolism

Assessment: 78 year old female with past medical history of type 2 diabetes, hypertension, hx of endometrial cancer (dx 2013) and asthma presents with a 5 day history of shortness of breath, chest pain, and bilateral lower extremity edema. Patient was seen at QHC ED where she was diagnosed with bilateral pulmonary embolism. Vitals revealed O2 sat of 94% on 4L nasal cannula, with RR 18. On physical exam, she was mildly tachypneic with slightly increased work of breathing. Given that CTA confirmed the diagnosis, patient's presentation is due to bilateral pulmonary embolism.

Differential Diagnoses:

1. Massive/submassive pulmonary embolism
   The patient's initial presentation with acute dyspnea, chest pain, hypoxia, and tachycardia requiring BiPAP fits classic PE physiology. Elevated lactate and VBG showing acidemia also supports system stress from impaired cardiopulmonary circulation. Ultimately, CT imaging showing large BL pulmonary emboli involving the main pulmonary arteries confirmed the diagnosis. The evidence of right heart strain also indicates RV dysfunction and myocardial injury.
2. Right heart failure (secondary to PE)
   While not a separate diagnosis, this diagnosis is supported by her symptoms and lab values. The elevated BNP (1042) and troponin rise reflects RV myocardial ischemia due to pressure overload from occluded pulmonary vasculature. Her improvement with oxygen and anticoagulation supports that symptoms are due to RV strain rather than a primary lung issue.
3. Acute hypoxic respiratory failure
   The need for BiPAP and oxygen supplementation indicates acute hypoxic respiratory failure, most likely driven by the extensive embolic obstruction. Although she was initially treated for asthma exacerbation, her lack of wheezing improvement after steroids and definitive impairment makes PE the dominant cause. Mild improvement on oxygen further supports this diagnosis.
4. Acute coronary syndrome
   Elevated troponins raise concern for myocardial injury. However, the absence of classic ischemic EKG changes and the presence of massive PE with RV strain makes ACS less likely. Still, it remains an important differential in elderly patients with chest pain and troponin elevation.
5. Asthma exacerbation
   The patient has a history of asthma and was initially treated with duonebs, IV steroids, and magnesium, suggesting concern for bronchospasm. However, CTA imaging confirmed BL PE. Additionally, lack of wheezing also argues strongly against an acute asthma exacerbation.

Labs:

CBC

- Hgb: 12.6
- Hct: 41.8
- WBC: 8.35
- Plts: 201

BMP

- Na: 140
- K: 4.3
- Cl: 104
- CO2: 16 ↓
- BUN: 22
- Creatinine: 0.60
- Glucose: 219 ↑
- Ca: 8.7
- Phos: 3.5
- Mg: 2.1
- eGFR: 95
- Troponin: 82 -> 77 ↑
- BNP: 1042 ↑ -> 137

Hepatic Panel

- AST: 32
- ALT: 12
- AlkP: 64
- Alb: 3.7

ABG

- pH: 7.26 ↓
- pCO2: 65 ↑
- HCO3: 30 ↑
- Lactate: 3.2 ↑ -> 1.9

Imaging:

EKG: Left axis deviation, no acute ST-T wave changes

CXR: Prominence of the perihilar region bilaterally with a nodular morphology, may represent lymphadenopathy versus prominent vasculature. Hazy left basilar opacity.

VA Duplex BL Lower Extremities: No acute DVT of the right or left lower extremities.

CTA chest: Large pulmonary emboli in the right and left main pulmonary arteries extending into the middle and lower lobar branches bilaterally and segmental and subsegmental branches on the right. There is right heart strain.
TTE: Severe right ventricular enlargement, reduced right ventricular systolic function, with pulmonary artery systolic pressure of around 27 mmHg

Workup/Plan:

Bilateral pulmonary embolism

- PERT team evaluated - no acute intervention
- Transitioned to Lovenox 1 gm/kg BID for now
- Trend troponins/BNP
- Repeat lactate
- Vascular cardiology consulted
- Pt affirms DNR/DNI status, states she is not interested in revoking for invasive producers. Therefore, not a candidate for endovascular intervention.
- Given cancer history, will get CT head and abdomen/pelvis to assess for malignancy - showed no evidence of malignancy
- MICU consulted
- Doesn't appear to be a tPA candidate at this time as patient has been improving clinically over the past 10 hours with reduced oxygen requirements
- Was transferred to MICU for tPA due to worsening respiratory status, but was not given to due patient's stable blood gas, vitals, and O2 requirements. Was eventually downgraded.

Acute respiratory failure with hypoxia

- Initially on BiPAP but on 4L nasal cannula likely secondary to PE, not due to asthma
- Wean as tolerated - c/w HFNC 40L/40%
- Consulted pulmonology
- Monitor respiratory status
- Monitor hemodynamics, ABG
- Continue wean O2

Asthma

- Not in acute exacerbation
- C/w home inhalers

Type 2 diabetes mellitus

- Hold home metformin, obtain A1C, start insulin sliding scale

Hypertension

- Blood pressure stable, but holding medications due to possible right heart strain and also due to potential nephrotoxic nature or ramipril and hydrochlorothiazide, in a patient who has received multiple CT scans with contrasts and has been NPO.

Diet: Regular, DASH/TLC
DVT ppx: Lovenox therapeutic dosing
Code status: DNR/DNI

/s/ Jeleeta Jolly, PA Student