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Professor Cunningham
HPPA 522- Physical Diagnosis II
IM Visit Write Up

Date of visit: October 21, 2025

Source of information: Self
Reliability: Reliable
Source of referral: Self
Mode of transport: Ambulance

**Chief complaint**: “I am here because I have COPD and my breathing got really bad.”

**HPI**:
Pt is a 96 year old female, previous smoker, with PMHx of HTN and COPD who presented to the ED 5 days ago due to progressive SOB and productive cough over the prior several days. She reports that her baseline COPD symptoms usually require O2 only at night and PRN Albuterol inhaler, but noticed she was requiring increased O2 and inhaler use with minimal relief of symptoms, along with more frequent “coughing attacks” producing yellow-green sputum. Pt rated the severity a 10/10. She called EMS and was sent to the ED, where she was found to be febrile and tachypneic with increased work of breathing, requiring supplemental O2. In the ED, blood cultures were obtained and found to be E. Coli positive. Pt was started on antibiotics and was admitted to internal medicine for management of COPD exacerbation complicated by bacteremia. There she was found to have common bile duct dilation on imaging. Pt currently reports improvement of her symptoms. Pt denies chest pain, hemoptysis, nausea, vomiting, chills, abdominal pain, urinary symptoms or changes in BMs. No sick contacts, recent travel or hospitalizations.

**Past Medical History**
- COPD x present, controlled
- Hypertension x present, controlled
- Glaucoma in right eye x present, controlled
- Polycythemia Vera x present, controlled
- Vertigo x present, controlled

Immunizations: up to date on all immunizations, except Flu.
Screening tests: mammogram done 2024 and normal; colonoscopy done 2023 and normal; DEXA scan done 2024 and normal.

**Past Surgical History**
- Glaucoma procedure done (right eye) in 2015. Queens, NY. No complications.
- Phlebotomy procedures x2 for Polycythemia Vera in 2015. Queens, NY. No complications.

**Medications**
- Albuterol inhaler for COPD
- O2 via NC at night for COPD
- “BP medication” but unable to recall the name, for hypertension
- OTC Meclizine as needed for vertigo

**Allergies**
Known allergy to codeine, gets facial edema and hives on body.

**Family History**

- Maternal/paternal grandparents: deceased at unknown ages due to unknown causes; uncertain PMHx
- Mother: deceased at 86, PMHx of HTN and COPD.
- Father: deceased at age 88, PMHx of HTN.
- No brothers or sisters.
- No children.

**Social History**

Habits: previous smoker of 1 pack per day for 30 years. Denies alcohol or illicit drug use. No caffeine intake.
Diet: breakfast typically consists of cereal; lunch consists of a salad; dinner consists of meat and vegetables.
Exercise: does not exercise but is able to carry out daily activities by walking without a cane.
Travel: no recent travel.
Occupation: retired x20 years, worked as an accountant.
Safety measures: admits to wearing seatbelts in car.
Sleep habits: endorses healthy sleeping habits; about 8 hours per night.
Marital status/living situation: husband deceased. Lives alone with her Yorkie.
Sexual history: not currently sexually active. No history of STD.

**ROS**

General: endorses generalized fatigue/weakness due to COPD; denies weight loss/gain, loss of appetite, fever, chills, or night sweats
Hair, skin, nails: denies rash, itching, excessive sweating or dry skin, new moles, change in existing moles, hair loss, change in hair texture or nail changes
HEENT: endorses occasional vertigo, hard of hearing; denies headache, lightheadedness, dizziness, head trauma, visual changes, double vision or blurriness, tinnitus, discharge from ears, nose bleed or discharge, congestion, sore throat, mouth ulcers or bleeding gums
Neck: denies localized swelling, lumps, stiffness or decreased ROM
Breast: denies lumps, nipple discharge, or pain
Pulmonary: admits to SOB and occasional cough due to COPD; denies orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: hx of HTN; denies chest pain, palpitations, syncope, heart murmur, or swelling of legs or feet
Gastrointestinal: denies nausea, vomiting, abdominal pain, changes in appetite, change in bowel habits, diarrhea, constipation, heartburn or pain with swallowing
Genitourinary: denies urinary frequency or urgency, nocturia, dysuria, hematuria, incontinence, flank pain or vaginal discharge
Neurological: denies weakness, seizures, LOC, numbness, tingling, memory loss or changes in gait or mental status
Musculoskeletal: denies muscle/joint pain, redness, deformity, or trauma.
Peripheral Vascular: denies claudication, coldness or swelling of extremities or color change in extremities
Hematologic: hx of polycythemia vera; denies anemia, easy bruising, blood transfusions or hx of DVT/PE
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Psychiatric: denies depression, anxiety, mood changes, sleep disturbances, difficulty concentrating or suicidal ideations

**Physical Exam**

General: 96 year old female, well nourished, well developed and well groomed. Pt appears younger than stated age, found sitting up in bed and AOx3 to person, place and time. Pt is on supplemental O2 via NC and is occasionally taking deep breaths while speaking.

| Vital Signs: | Right: | Left: |
|---|---|---|
| Blood pressure | | |
| *Seated:* | 140/100 mmHg | 140/100 mmHg |
| *Supine:* | 120/90 mmHg | 120/90 mmHg |
| *Standing:* | 120/80 mmHg | 120/80 mmHg |
| Respiratory rate: | 18 breaths/min, regular rate & rhythm, unlabored | |
| Pulse: | 60 beats/min, regular, 2+ | |
| Temperature: | 98.6 degrees F, orally | |
| SpO2: | 97% on RA | |
| Height: | 60 inches | |
| Weight: | 160 pounds | |
| BMI: | 35.2 | |

**Skin & Head:**

Skin: warm and moist, good turgor. Nonicteric, no lesions, tattoos or scars
Hair: average quantity and distribution. No alopecia, seborrhea or lice.
Nails: no clubbing. Unable to assess capillary refill due to red nail polish. Cap refill <2 seconds in lower extremities.
Head: normocephalic, atraumatic; no tenderness; no ecchymosis, hematomas or lacerations
**Eyes**: symmetrical OU. No strabismus, nystagmus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity (uncorrected) – 20/30 OD, 20/200 OS and OU.
Visual fields full OU. PERRLA, EOMs full, with no nystagmus
Fundoscopy: red reflex present OU/OD. Cup to disk ratio <0.5 OU/OD. No AV nicking, hemorrhages, exudates, or neovascularization OU/OD
**Ears**: Symmetrical and appropriate in size. No lesions, masses, trauma on external ears. No discharge or foreign bodies in external auditory canals bilaterally. TM's pearly grey and intact with light reflex in good position bilaterally. Auditory acuity not intact to whisper test bilaterally. Weber midline; Rinne reveals AC>BC bilaterally.

**Nose/Sinuses:**

Nose: symmetrical; no masses, lesions, deformities, trauma, bleeding or discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated. No discharge or bleeding on rhinoscopy. Septum midline with no lesions, deformities, injection or perforation. No foreign bodies noted.
Sinuses: non tender to palpation over bilateral frontal and maxillary sinuses.

**Mouth/Pharynx:**

Lips: pink and moist, no cracking. No cyanosis or lesions.
Mucosa: pink and well hydrated. No masses, lesions or ulcers. No leukoplakia.
Palate: pink and well hydrated. Intact with no lesions, masses or scars.
Teeth: good dentition, no carries noted.
Gingivae: pink and moist. No hyperplasia, masses, lesions, erythema or discharge.
Tongue: pink, well palpillated. No lesions, masses or deviation.
Oropharynx: no injection, exudates, masses, lesions, or foreign bodies. Tonsils without injection or exudate. Uvula pink and midline, no edema.

**Neck, Trachea & Thyroid:**

Neck: trachea midline. No masses, lesions, scars or pulsations. Supple and non tender to palpation. No enlargement of parotid or submandibular glands. No visible lymph nodes.
Thyroid: non tender, no palpable masses. Thyroid noted to move upward upon swallowing. Isthmus noted upon lateral displacement of thyroid.

**Thorax and Lungs:**
Chest - Symmetrical, no deformities, no trauma. Chest wall with no lesions or masses. Respirations unlabored, no paradoxical respirations or use of accessory muscles noted. Lateral to AP diameter 2:1. Non-tender to palpation throughout. Occasional deep breaths during speech.
Lungs - Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.
**Heart**: JVP is 2 cm above the sternal angle with the head of the bed inclined at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits or thrills. Regular rate and rhythm, distinct S1 and S2, with no murmur, S3, or S4 on auscultation. No splitting of S2 or friction rubs appreciated.
**Abdomen**: Abdomen round and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all 4 quadrants with no aortic/renal/iliac or femoral bruits. No tenderness to palpation. No guarding, rebound, hepatosplenomegaly, or CVA tenderness noted.
**Female genitalia**: No inguinal adenopathy. External genitalia without erythema, lesions, or masses. Vaginal mucosa pink. Cervix parous, pink, and without discharge. Uterus anterior, midline, smooth, and not enlarged. No adnexal tenderness.
**Rectal/Anus exam:** No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Rectovaginal wall intact. Stool brown and hemoccult negative (Note: would only report hemoccult if it was performed).
**Breast and axillae:** Breasts were symmetric with no evidence of dimpling. No masses to palpation. Nipples were symmetric. No lesions, no discharge. Axillary nodes were non-palpable.
**Neuro Exam**:
Cranial nerves:
I – Correctly identifies coffee & lavender oil odors bilaterally
II – Visual fields full by confrontation, visual acuity 20/30 OD and 20/200 OS/OU corrected, red reflex present, cream colored discs with sharp borders, no hemorrhages, exudates or crossing phenomena.
III, IV & VI – Extraocular movements intact, pupils 3 mm OU and reactive to direct & consensual light & accommodation, no ptosis.
V – Face sensation in tact bilaterally, corneal reflex intact jaw muscles strong without atrophy
VII – Facial expressions intact, clearly enunciates words.
VIII – Unable to repeat whispered sounds, Weber midline, Rinne AC>BC bilaterally.
IX & X– No hoarseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing
XI – Full range of motion at neck with 5/5 strength and strong shoulder shrug
XII – Tongue midline without fasciculation, good tongue strength

**Mental status exam**: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to name, date, time and location. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.
**Motor**: Good muscle bulk and tone. Strength 3/5 throughout.
**Cerebellar**: RAMs and point-to-point movements intact. Stable gait. Negative Romberg & pronator drift.
**Sensory**: Pinprick, light touch, position sense, temperature and vibratory sense intact bilaterally.

**Reflexes**:

| | Biceps | Triceps | Brachioradialis | Patellar | Ankle/Achilles | Babinksi |
|---|---|---|---|---|---|---|
| Right | 2+ | 2+ | 2+ | 2+ | 2+ | Absent |
| Left | 2+ | 2+ | 2+ | 2+ | 2+ | Absent |

**Assessment**

96 year old female, previous smoker, with HTN and COPD who was admitted to internal medicine for COPD exacerbation in the setting of infection with E. Coli, now improving with steroids, antibiotics and supplemental O2. Pt was found to have dilation of the CBD on imaging, raising concern for possible biliary cause of bacteremia. No RUQ tenderness or jaundice on exam. Will continue with hepatobiliary evaluation to determine source of infection.

**Differential Diagnosis**

1. Acute COPD exacerbation in setting of bacteremia
    - Patient was requiring increased, continuous supplemental O2, after admitting that she normally only requires it at nighttime. She was experiencing an increase in dyspnea that was unrelieved with her Albuterol inhaler, and a cough with increased yellow-green sputum. These findings are classic for COPD exacerbation, which is most commonly due to an underlying infection.
    - Plan: broad spectrum antibiotics, systemic steroids, bronchodilators, supplemental O2; continuous pulse ox monitoring.

2. Cholangitis
    - Evidence of common bile duct dilation on imaging indicates biliary obstruction. Further, the patient was found to have an E. Coli infection, which is the most common pathogen in acute cholangitis. Although patient does not present with the typical signs and symptoms of cholangitis (RUQ pain, fever, jaundice), it is important to consider atypical findings in the elderly population.
    - Plan: Labs including CBC, bilirubin, alk phos, LFTs, lipase, RUQ US initially, CTA to improve imaging of biliary tree, ERCP for diagnosis, GI consult

3. Choledocolithiasis
    - The most common cause of common bile duct dilation (which was found on imaging) is common bile duct stones. Patient did not present with any GI complaints, including RUQ pain, jaundice or vomiting, but it is not uncommon that patients are asymptomatic with choledocolithiasis.
    - Plan: Labs including CBC, bilirubin, alk phos, LFTs, and GGT (gamma-glutamyltransferase). ERCP for diagnosis, GI consult

4. Bacterial pneumonia
    - Patient presented with increased dyspnea and productive cough with purulent sputum, indicative of pneumonia. Given the blood cultures being positive for E. Coli, this would be a bacterial cause. Bacterial pneumonia is a common cause of COPD exacerbations.
    - Plan: CXR and CBC to assess for leukocytosis

5. Biliary obstruction from malignancy
    - Because of the common bile duct dilation found on imaging, there is evidence of obstruction, which could be due to malignancies such as cholangiocarcinoma or pancreatic head carcinoma. Tumors could compress the bile duct and cause bile stasis and dilation. A result of this is infection, which the patient was found to have. The patient's age of 96 should also be considered, given that malignancy becomes concerning and more likely in elderly populations.
    - Plan: MRCP to assess for mass lesions; possible ERCP and GI consult

**Plan/Workup: COPD exacerbation in setting of E.coli infection, likely from cholangitis**

- Continue IV antibiotics, systemic steroids and supplemental O2
- Repeat blood cultures to confirm clearance of E. Coli (in about 24-48 hours)
- Trend LFTs
- ERCP
- GI consult