Date of visit: January 21st, 2026

Location: NYP Queens, Flushing, NY
Source of information: Self
Reliability: Not very reliable (poor historian)
Source of referral: Nursing home
Mode of transport: EMS

Chief complaint: Shortness of breath

HPI: B.R is an 81 YOM with PMHx of HTN, HLD, CAD, prior PE and ischemic stroke with residual left hemiplegia, COPD on 3 L NC at baseline, TIIDM who was sent to the ED from nursing home for SOB, increasing oxygen requirement and cough. He began feeling more short of breath about 4 days ago, requiring up to 6 L NC. He also developed a productive cough at that time, occasionally producing clear sputum. Per nursing home documentation, pt was recently discharged from NYPQ on 12/6/25 after being treated for pneumonia and bacteremia, for which he completed a course of meropenem and doxycycline through 12/12/25. He denies fever, chills, hemoptysis, nausea, vomiting, diarrhea, urinary symptoms, or change in mental status. No sick contacts or recent travel.

On evaluation by the medicine team, pt is AOx2-3 (which is his baseline) but a poor historian. He endorses persistent cough and new bilateral lower abdominal pain, worse in the right lower quadrant, which began earlier today. He states due to the pain, he has decreased appetite in fear of making it worse. Pt is unable to characterize the pain but states he feels like he needs to use the bathroom, but is unable to. Unknown last BM. He reports experiencing chest pain a few days ago but denies current chest pain and is unable to further describe the prior episode. Pt was admitted to the medicine floor for acute hypoxic respiratory failure.

Past Medical History
- Hypertension x present, controlled
- Hyperlipidemia x present, controlled
- Iron deficiency anemia x present, controlled
- Anxiety disorder x present, controlled
- Major depressive disorder x present, controlled
- Benign prostatic hyperplasia x present, controlled
- Coronary artery disease x present, controlled
- COPD x present, controlled
- Type II diabetes mellitus x present, controlled
- GERD x present, controlled
- Other: Ischemic stroke, Hemiplegia, Pulmonary embolism, Pneumonia, Seizures

Immunizations: up to date on all immunizations

Past Surgical History
- No reported past surgeries.

Medications
- Alogliptin benzoate 12.5 mg daily
- Bisacodyl 10 mg daily PRN
- Cholecalciferol 25 mcg tablet, 2 tablets daily
- Clopidogrel 75 mg daily
- Famotidine 20 mg tablet, 1 tablet nightly
- Ferrous sulfate 325 mg daily with breakfast
- Folic acid 1 mg, oral, daily

- Gabapentin 300 mg capsule, 1 capsule 3x a day
- Robitussin 200 mg, oral, every 4 hours PRN
- Hydrocortisone 25 mg, rectal, BID
- Ipratropium-albuterol 3 mL, BID
- Lactulose 30 mL daily
- Keppra 500 mg tablet, 1 tablet every 12 hours
- Metoprolol succinate 25 mg tablet ER, 1 tablet daily
- Paroxetine 10 mg tablet, 1 tablet nightly
- Senna 8.6 mg tablet, 2 tablets nightly
- Sucralfate 1 g, BID
- Tamsulosin 0.4 mg capsule, 1 capsule daily

Allergies
- Penicillins

Family History
- No known significant FHx

Social History
Habits: Denies smoking, alcohol or illicit drug use. No caffeine intake.
Diet: patient reports decreased appetite due to abdominal pain.
Exercise: does not exercise, is bed bound.
Travel: no recent travel.
Sleep habits: unable to specify.
Marital status/living situation: lives in nursing home.

ROS
General: denies weight loss, fatigue, weakness, fever, chills, or night sweats
HEENT: denies headache, 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
Pulmonary: (+) SOB, (+) cough; denies orthopnea, hemoptysis, or wheezing
Cardiovascular: hx of HTN; denies current chest pain, palpitations, or swelling of legs or feet
Gastrointestinal: (+) abdominal pain, (+) decreased appetite; denies nausea, vomiting, diarrhea, heartburn or pain with swallowing
Genitourinary: denies urinary frequency or urgency, nocturia, dysuria, hematuria, incontinence, flank pain or penile discharge
Neurological: denies syncope, weakness, new seizures, 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 anemia, (+) hx of PE
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Psychiatric: (+) depression, (+) anxiety; denies mood changes, new difficulty sleeping, difficulty concentrating or suicidal ideations

Physical Exam
General: 81 year old male on high flow NC; well nourished, well developed and well groomed. Pt appears stated age; found sleeping in bed. Upon awakening, pt is AOx3 to person, place, and time. He continuously complains of lower abdominal pain, otherwise has no complaints.

Vital Signs:
Blood pressure: 127/75 mmHg
Respiratory rate: 27 breaths per minute, unlabored
Pulse: 102 beats/min, regular rate & rhythm, 2+
Temperature: 36.3 degrees C, oral
SpO2: 97% on high flow NC
Height: 173 cm
Weight: 162 lbs
BMI: 24.6

Skin: warm and moist, good turgor. Nonicteric, no lesions or rash.
Nails: no clubbing. Cap refill <2 seconds in upper and lower extremities.
Head: normocephalic, atraumatic.
Eyes: symmetrical OU. No strabismus, nystagmus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink. PERRLA, EOMs intact.
Nose: symmetrical; no masses, lesions, or discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated. Septum midline. No foreign bodies noted.
Throat: lips pink and moist, no cracking or cyanosis. Mucosa pink and well hydrated. Oropharynx with no injection, exudates, masses, lesions, or foreign bodies; tonsils without injection or exudates; uvula pink and midline, no edema.
Pulm: tachypnea noted, decreased breath sounds on right, bilateral crackles. Chest rise symmetrical. *Should have performed: percussion and tactile fremitus.*
CV: slightly tachycardic to 102, otherwise normal rhythm, distinct S1 and S2, with no murmur, S3, or S4 on auscultation. No splitting of S2 or friction rubs appreciated.
Abdomen: distended, tender to palpation in lower abdomen, worse to RLQ; BS normoactive in all 4 quadrants with no bruits. No guarding, rebound, hepatosplenomegaly, or CVA tenderness noted.
Peripheral vascular: Extremities have good color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis, or edema noted bilaterally. No stasis changes or ulcerations noted.
MSK**:** left hemiplegia with LUE and LLE contractures; no swelling, erythema, or ecchymosis in bilateral upper and lower extremities. Non-tender to palpation, no crepitus noted throughout.
Mental status/neuro exam: Patient is alert and oriented to person, place, and time currently. No focal neurological deficits.
Rectal exam: normal tone. Large amount of stool in rectal vault. Manual disimpaction performed with removal of significant stool burden. No gross blood noted.

Labs/Imaging:
Hg 10.9
Hct 34.6
WBC 10.54 with 9% bands
Procal 1.78
Lactate 3.2
BUN 27
Glucose 246
Trop 814
ProBNP 21,950
RPP negative

ABG on 6 L NC: 7.45/43/78/29

EKG sinus tachycardia, rate 102 bmp, STD V2/V3

CXR (compared to prior from 12/05/25): worsening bilateral interstitial and airspace opacities

compatible with pneumonia and/or pulmonary edema. Small pleural effusions are unchanged. No pneumothorax.
CTA chest: negative for PE, suspicious for multifocal pneumonia, small left and moderate to large right pleural effusion with compressive atelectasis.
CTAP with IV contrast: moderate rectal fecal load, no obstruction.

Assessment
Patient is an 81 YOM with PMHx of HTN, HLD, CAD, prior PE and ischemic stroke with residual left hemiplegia, COPD on 3 L NC at baseline, and TIIDM who presented with 4 days of progressive dyspnea, cough, and increased O2 requirement from baseline 3 L to 6 L at NH, now requiring high flow NC in the hospital. Pt also reports lower abdominal pain, likely due to fecal impaction shown on CTAP (supported by rectal exam findings). Workup is notable for tachypnea, tachycardia, bilateral crackles with decreased right sided breath sounds, proBNP of 21,950, troponin 814, lactate 3.2, procal 1.78 with 9% bandemia. Imaging is notable for multifocal pneumonia, bilateral pleural effusions (R>L), and interstitial opacities. Concern for acute hypoxic respiratory failure likely multifactorial, including multifocal pneumonia with superimposed acute decompensated HF, complicated by sepsis.

Differential Diagnoses
1. Acute hypoxic respiratory failure secondary to multifocal pneumonia
    A. Pt presents with 4 days of progressive dyspnea and cough, which required increased O2 requirements from 3 L at baseline, to 6 L at NH, to high flow NC in the hospital. His labs and imaging obtained in the ED were notable for elevated procal and bandemia with CXR showing bilateral interstitial and airspace opacities and CTA suspicious for multifocal pneumonia, which support the diagnosis. Further, his lactate was 3.2, suggesting a systemic response. Pt is a nursing home resident, with a high risk for recurrent or resistant infection (note recent admission for PNA last month).
2. Acute decompensated heart failure
    A. Pt was found to have interstitial opacities and bilateral pleural effusions (R>L) on CXR, as well as bilateral crackles on pulmonary exam. He is tachypneic and has a proBNP of 21,950, further supporting this diagnosis. Infection (in this case, pneumonia), often precipitates CHF exacerbations in elderly patients.
3. NSTEMI
    A. Pt has an elevated troponin of 814 with ST depressions on EKG in the setting of hypoxia, tachycardia, sepsis physiology, and acute cardiopulmonary stress. Given his history of CAD and a reported episode of chest pain several days ago, myocardial injury must be considered.
4. Chronic constipation
    A. Pt reports new bilateral lower abdominal pain, worse in the RLQ, with decreased appetite and sensation of needing to defecate without success. CTAP was notable for moderate rectal fecal impaction without obstruction, and rectal exam revealed significant stool burden requiring manual disimpaction. Pt's bedbound status, chronic bowel regimen use (lactulose, senna, bisacodyl), and unknown last BM increases his risk for constipation.
5. COPD exacerbation
    A. Pt has known COPD on 3 L NC, with increased O2 requirements and a cough. Although his lack of wheezing, lack of increased sputum purulence, and imaging findings are more consistent with pneumonia and pulmonary edema, COPD exacerbation is less likely as the primary driver, but it could be contributing to his respiratory failure.

Plan/Workup
- Place on tele monitor
- Placed on carbohydrate controlled diet, GI prophylaxis with famotidine PO, and DVT prophylaxis

Meds
- Pt is sp Vancomycin, Aztreonam, and 500cc LR bolus in the ED. Will start on Merrem per discussion

with ID
- Duonebs Q6H ATC and continue on Pulmicort due to respiratory distress in COPD patient
- Pt is sp Lasix 20 IV x2 in the ED
- Will give Aspirin 325 mg, and then start on Aspirin 81 mg; Plavix held per cardiology recommendations
    - Will also start on Heparin drip per ACS protocol
- Due to glucose of 246 on admission, will hold PO meds and start on ISS
    - Will get fingerstick Q6H
- Continue on folic acid and iron tabs due to Hg of 10.9 and no signs of active bleed
- Continue lactulose, senna, and PRN dulcolax due to fecal impaction. Will attempt enema when respiratory status improves.
- Continue: Metoprolol for HTN, Keppra for seizure hx, Gabapentin for peripheral neuropathy hx, Paxil for depression hx, and Flomax for BPH hx

Labs
- Will follow up urine legionella/strep antigen, mycoplasma, respiratory cultures, and MRSA/MSSA screen to guide further treatment
- Will follow up lipid profile and HbA1c for cardiovascular risk stratification and TSH to evaluate for thyroid dysfunction
- Active T&S, follow up anemia panel and trend CBC due to Hg of 10.9

Imaging
- TTE on 12/2/25 showed LVEF of 55-50%, will repeat TTE

Consults
- Infectious disease (ID)
- Pulmonary
- Cardiology

Patient education:
Pt and family were educated on his multifactorial respiratory failure due to pneumonia and heart failure exacerbation. We stressed the importance of completing his antibiotics and adherence to medications, including diuretics, inhalers, and bowel regimen. Further information will be provided upon discharge to nursing home staff.