Kevin Zhang
HPPA 522
H&P #2 – Internal Medicine

Chief Complaint: "My chest was hurting" x3 days

History of Present Illness:

59-year-old male, non-smoker, BMI 48.7, with a past medical history of hypertension and hyperlipidemia, family history of coronary artery disease (brother), was admitted on the night of 10/03 for worsening mid-sternal chest pain that started on 10/01. Pain is described as sharp, initially 3/10 and progressing to 9/10, radiates to the right side of face (jaw, eye, ear, head), and is unlike anything that he's experienced in the past. Previous episodes were intermittent, non-radiating, and relieved with rest. Denies any aggravating factors or medication use to relieve the pain. Admits to sedentary lifestyle since back surgery in 2024. Denies fever, shortness of breath, diaphoresis, dizziness, palpitations, nausea, vomiting, abdominal pain, leg swelling, and fatigue.

Past Medical History:
- Hypertension x unknown years, well controlled on medications
- Hyperlipidemia x unknown years, well controlled on medications
- Immunizations: last influenza vaccine in 2023, COVID vaccines and booster up to date (date unknown)
- Denies any other chronic or childhood illnesses.

Past Surgical History:
- Left inguinal hernia repairment, 20s, done in Florida, no complications
- Neck lipoma removal, 40s, unknown location, no complications
- Varicocelectomy, 50s, at Elmhurst hospital, no complications
- Back surgery, 12/02/2024, at Elmhurst hospital, no complications

Medications:
- Amlodipine 5 mg PO daily, for hypertension
- Chlorthalidone 25 mg PO daily, for hypertension
- Valsartan 320 mg PO daily, for hypertension
- Rosuvastatin 20 mg PO daily, for hyperlipidemia
- Isosorbide mononitrate 30 mg PO daily, for coronary artery disease
- Aspirin 81 mg PO daily, for coronary artery disease

Allergies:
- Denies drug allergies, food allergies or environmental allergies

Family History:
- Father – deceased at around 60 years old, history of throat cancer
- Mother – alive, age 81, history of diabetes, hypertension, hyperlipidemia
- Brother – deceased at age 56 from heart attack, history of hypertension, hyperlipidemia
- Paternal/material grandparents – deceased at unknown age, uncertain of past medical history
- Denies any children

Social History:
Habits: Denies tobacco. Social drinker. Denies past and present substance or illicit drug use.

Travel: Denies any recent travels out of state or country.

Marital History/Home Situation: Single. Living situation unspecified.

Occupational History: Retired. Used to work at a church

Diet: well-balanced → breakfast – 3 eggs; lunch – chicken, broccoli; dinner – potato with rice

Sleep patterns: Reports 2-3 hours of sleep daily. Had a sleep study done recently. Will be going back soon for another.

Exercise: Used to be at the gym multiple times per week for many years but has been mostly sedentary since back surgery. Now starting to get back into routine. Admits to weight bearing exercise 3-4 times per week.

Safety Measures: Admits to wearing a seatbelt.

Sexual History: Patient declines answering any questions related to sexual history

Review of Systems:

General: Denies fever, fatigue, weight loss/gain, loss of appetite, diaphoresis, chills, or night sweats.

Skin, Hair, Nails: Admits to skin dryness. Denies changes in hair texture/distribution, new moles/rashes, excessive sweating, discolorations, pigmentations, or nail changes.

Head: Admits to right-sided headache. Denies lightheadedness, vertigo, or head trauma.

Eyes: Admits to right-sided eye pain. Denies lacrimation, photophobia, pruritus, or glasses/contact use. Last eye exam unspecified.

Ears: Admits to right-sided ear pain. Denies changes in hearing, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses: Admits to congestion. Denies discharge or epistaxis.

Mouth and Throat: Admits to right-sided jaw pain. Denies bleeding gums, sore throat, mouth ulcers, loose teeth, or voice changes. Last dental exam unspecified.

Neck: Denies localized swelling, lumps, or stiffness.

Pulmonary System: Denies cough, shortness of breath at rest/exertion, wheezing, or hemoptysis.

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

Gastrointestinal System: Admits to constipation. Denies abdominal pain, nausea, vomiting, diarrhea, dysphagia, flatulence, eructation, jaundice, change in bowel habits, rectal bleeding, or blood in stool.

Genitourinary System: Denies urinary frequency, urgency, incontinence, nocturia, oliguria, polyuria, dysuria, or flank pain. Urine is yellow.

Nervous System: Denies seizures, loss of consciousness, sensory disturbances (numbness, paresthesia, tingling), memory loss, or ataxia.

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

Peripheral Vascular System: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes.

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

Endocrine System: Denies thyroid gland enlargement, polyuria, polydipsia, polyphagia, hot or cold intolerance, excessive sweating, or hirsutism.

Psychiatric: Denies stress, anxiety depression, mood changes, suicidal ideations, binge eating habits or ever seeing a mental health professional.

Physical Exam:

General: African American male in Fowler's position. Well-nourished, neatly groomed, and appears his stated age. Alert and oriented x3. No signs of acute distress.

Vital signs:

Blood pressure:	R	L
Seated	116/66 mmHg (done on friend)	132/80 mmHg
Supine	110/72 mmHg (done on friend)	112/76 mmHg (done on friend)

Respiration: 16 breathes/min, unlabored

Pulse: 84 beats/min, regular rate and rhythm

Temperature: 98.6 °F (oral)

O2 saturation: 99% room air

Height: 173 centimeters Weight: 320 pounds BMI: 48.7

Skin: Warm and moist with good turgor. Scaliness noted on elbows. Vertical linear scar of approximately 2.5 inches in length noted along the lower spine. Non-icteric. No rashes, lesions, or bruising noted. No tattoos present.

Hair: Gray. Average quantity and distribution. No seborrhea, or lice on exam.

Nails: No clubbing or cyanosis. Capillary refill <2 seconds in upper extremities and lower extremities.

Head: Normocephalic, atraumatic, non-tender to palpitation throughout.

Eyes:
Symmetrical OU. No evidence of strabismus, exophthalmos or ptosis
Sclera white, cornea and conjunctiva clear
Visual acuity: not corrected – 20/50 OS, 20/50 OD, 20/50 OU
Visual field: full OU. PERRLA. Extraocular movements intact with no nystagmus. Pupil size 4.0 mm.
Fundoscopy: red reflex intact OU. Cup to disk ratio <0.5 OU. No AV nicking, hemorrhages, exudates, cotton wool spots, or neovascularization OU. (done on friend)

Ears:
Symmetrical and appropriate in size. No masses, lesions, trauma, or tenderness to palpation on external ears. Cerumen noted in external auditory canals AU, no evidence of infection or impaction. Tympanic membrane pearly grey and intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline. Rinne reveals AC > BC AU. (done on friend)

Nose:
Symmetrical. No masses, lesions, trauma, deformities, discharge, or tenderness to palpation noted. Nares patent bilaterally.
Rhinoscopy: Nasal mucosa pink and well hydrated with some mucus present. Septum midline without deviation, injection, or perforation. No evidence of foreign bodies or nasal polyps.

Sinuses:
Non-tender to palpation and translucency noted over bilateral frontal and maxillary sinuses. (done on friend)

Mouth/Pharynx:
Lips – pink, moist. No cyanosis or lesions.
Mucosa – pink, well hydrated. No masses or lesions noted. No leukoplakia or candida.
Palate – pink, well hydrated. Palate intact with no lesions, masses, or scars. Continuity intact.
Teeth – good dentition. No obvious dental caries noted.
Gingivae – pink, moist. No hyperplasia, masses, lesions, erythema, or discharge.
Tongue – pink, well hydrated. No masses, lesions, or deviation.
Oropharynx – well hydrated. No injection, exudates, masses, lesions or foreign bodies. Grade 2 tonsils, present with no injection or exudate. Uvula pink with no edema or deviation.

Neck:
Trachea midline. No masses, visible pulsations, or palpable adenopathy noted. Supple and nontender to palpitation. (done on friend)

Thyroid:
Non-tender to palpation. No palpable nodules, thyromegaly, or bruits noted. (done on friend)

Chest:
Symmetrical, no deformities, no evidence of trauma. Respirations unlabored, no paradoxical respirations or use of accessory muscles noted. Lateral to AP diameter 2:1. Non-tender to palpation throughout.

Lungs:
Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds or drooling noted.

Heart:
JVP is 2 cm above the sternal angle with head of the bed at 30°. Point of maximum impulse in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdomen:
Flat and symmetric with no scars, striae, or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic, renal, iliac, or femoral bruits. Nontender to palpation and tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation, no costovertebral angle tenderness appreciated. (done on friend)

Male Genitalia:
Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias noted.

Anus, Rectum, and Prostate:
No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate smooth and non-tender with palpable median sulcus.

Neurologic Exam:
Mental status: Alert and oriented x3 to name, date, and location. Patient is cooperative. Speech and language ability intact with quantity, fluency, and articulation. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.

CN I-XII are intact
I – correctly identifies apple juice and alcohol wipe odors bilaterally
II, III, IV, VI – visual field full OU. Visual acuity 20/50 OS, OD, OU not corrected. Red light reflex present. PERRLA. EOMs intact without ptosis.
V – facial sensation intact bilaterally to dull and sharp stimuli. Corneal reflex intact. Jaw muscles strong without atrophy
VII – correctly identifies sweet, salty and sour tastes. Facial expression intact, clearly enunciates words.
VIII – repeats whispered words bilaterally. 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

Motor
Good muscle bulk and tone. Strength 5/5 throughout

Cerebellar
Rapid alternating movements and point-to-point movements intact. Stable gait. Negative Romberg and pronator drift.

Sensory
Pinprick, light touch, position sense, temperature and vibratory sense intact bilaterally.

Reflexes

	Biceps	Triceps	Brachioradialis	Patellar	Ankle/Achilles	Babinski
Right	2+	2+	2+	2+	2+	Absent
Left	2+	2+	2+	2+	2+	Absent

Assessment:

59-year-old male, non-smoker, BMI 48.7, with past medical history of hypertension and hyperlipidemia, and family history of coronary artery disease, presents with progressively worsening mid-sternal chest pain that radiates to the right side of face. Unlike previous episodes, which are typically relieved with rest. Mostly sedentary since 2024. Concern for acute coronary syndrome.

Differential Diagnosis:
1. **ACS (NSTEMI, STEMI, unstable angina)**
    - Rationale: Patient is experiencing severe, progressive chest pain radiating to jaw/face that is not relieved by rest, which is characteristic of ACS. Patient also has multiple cardiac risk factors like hypertension, hyperlipidemia, obesity, and a strong family history.
    - Plan:
        - 12 lead EKG
        - Serial troponin
        - Continuous cardiac telemetry
        - CBC, CMP, PT/INR, aPTT, type and screen
        - Aspirin 325 mg PO, nitroglycerin SL for chest pain, metoprolol if tachycardic
        - Cardiology consult pending

2. **Gastroesophageal Reflux disease (GERD)**
   - Rationale: Can mimic cardiac pain. Possible given the patient's sedentary lifestyle and obese weight. Less likely because pain is often worse with meals or lying down, none of which the patient is admitted to. Pain also typically doesn't progress and radiate.
   - Plan:
     - Avoid late night meals, spicy food, caffeine, and alcohol
     - Avoid lying down 2-3 hours after eating
     - Elevate head about 15 cm with wedge pillow while sleeping
     - Omeprazole 20 mg PO once daily before breakfast for 2 weeks

3. **Aortic Dissection**
   - Rationale: Can present as sharp chest pain radiating to the face (not often though). Less likely because patient describes pain as progressive rather than sudden and tearing.
   - Plan:
     - Stat CT angiography of chest/abdomen/pelvis
     - IV morphine for pain control
     - IV esmolol and surgical consult pending imaging
     - Emergent surgical consult once diagnosis confirmed

4. **Costochondritis**
   - Rationale: Can present as sharp chest pain in anterior chest wall. Less likely because no signs of trauma or tenderness over anterior chest noted on physical exam and pain is not worsened/reproducible by movement.
   - Plan:
     - Ibuprofen 600 mg PO every 6-8 hours as needed
     - Apply ice to the affected area for 15-20 minutes, 2-3 times daily
     - Avoid lifting, pushing, and pulling activities until pain improves

5. **Pulmonary embolism**
   - Rationale: Can present with acute chest pain that radiates. Patient has some risk factors like obesity (which increases venous stasis) and a sedentary lifestyle since 2024. Less likely because the patient does not complain of pleuritic chest pain, shortness of breath, or hemoptysis.
   - Plan:
     - D-dimer
     - CT angiogram (if D-dimer positive)
     - EKG, CXR
     - Initiate heparin infusion once diagnosis confirmed

Note: After presenting, the PA informed me that the patient had an NSTEMI. PCI was performed a couple of days after diagnosis.