Aisef Ahmed
02/23/2026
Long- term care rotation

H&P #2

Chief Complaint: "Constipation for two days."

History of Present Illness: Mrs. M.B, an 80-year-old female with a past medical history of Atrial fibrillation, severe tricuspid regurgitation, CVA with right internal carotid artery occlusion, Primary essential hypertension, Type 2 diabetes, cardiac amyloidosis, Chronic systolic heart failure, Internal pacemaker and defibrillator, hyperlipidemia, and GERD without Esphagitis. Patient was admitted to Sub acute rehabilitaion center due to Congestive Heart Failure exacerbation at The Brooklyn Hospital Center. Patient presents with a two-day history of constipation, having not had a bowel movement for two days. She reports discomfort but is awake, alert, and verbally responsive. She denies nausea, vomiting, or diarrhea. On examination, the abdomen was distended and non-tender with positive bowel sounds and tympanic percussion. The patient appears comfortable in bed with her left leg elevated. Vital signs are stable, and the blood pressure is borderline hypotensive at 96/66.

Past Medical History:

- Atrial fibrillation
- Severe tricuspid regurgitation (TR)
- CVA with Right internal carotid artery occlusion
- Primary essential Hypertension
- Diabetes Mellitus (A1c 5.9% on 2/18/2026)
- Amyloidosis
- Chronic systolic heart failure EF 25%
- Hyperlipdemia
- GERD without esophagitis

Past Surgical History:

- pacemaker insertion
- Internal defibrillator

Medications:

- Eliquis 2.5 mg BID
- Amiodarone 200 mg daily
- Lipitor 40 mg daily
- Tylenol 975 mg PRN for pain
- Furosemide 40 mg BID
- Entresto 25-26 mg
- Pantoprazole 40 mg daily
- Aspirin 81 mg daily

Allergies: No known allergies.

Immunizations: Up to date with immunizations.

Family History:
Mother- deceased at an unknown age and unknown cause
Father- deceased at an unknown age and unknown cause
Maternal/paternal grandparents- deceased at unknown age and unknown reasons, no pmh.
No siblings or children

Social history

Ms. B.M., an 80-year-old female long-term care resident at the facility, who wheelchair bound due to right internal carotid artery occlusion. She is retired and previously worked as a teacher. She denies tobacco, alcohol, or illicit drug use. She does not consume caffeine. She reports eating regular meals provided by the facility and describes his appetite as good. She states that he usually sleeps 7-8 hours per night. She has been using a walker for ambulation due to an unsteady gait and is encouraged to continue its use for safety and fall prevention. She is currently participating in physical and occupational therapy to improve strength, balance, and overall functional mobility. She denies any recent travel. She is not currently sexually active.

Geriatric assessment

Cognitive status: fully intact cognition. Alert to person, place, time AOX3

Ambulation: requires an assistive device

Transferfrom position: requires one person for physical assistance to the position.

Feeding ability: Requires meals to be prepped and set up

Catheter: none

Review of Systems:

General: Denies fever, chills, weight loss, fatigue, or night sweats. Reports fair appetite and occasional difficulty falling asleep**.**

Skin: No rashes, itching, or wounds

Cardiovascular: No chest pain, palpitations, or shortness of breath.

Respiratory: complains of a productive cough with clear sputum, denies any shortness of breath, Dyspnea, orthopnea,

Gastrointestinal: reported Constipation, no nausea, vomiting, or diarrhea.

Musculoskeletal: Edema in the left lower extremity (LLE) and Left upper extremity (LUE), no significant pain.

Neurological: patient is awake, alert, verbally responsive, and oriented to person, place, and time AoX3**.** Denies dizziness, weakness, numbness, tremors, or loss of consciousness.

Endocrine: Denies polydipsia, polyuria, polyphagia, or temperature intolerance.

Hematologic: Denies easy bruising, bleeding, or lymphadenopathy.

Psychiatric: denies anxiety, depression, mood swings, hallucinations, or suicidal ideation.

Physical Exam:

General: 80-year-old female, well-groomed, awake, alert, and oriented. Patient was found in a wheelchair in a long-term care facility, awake, alert, and oriented, and is verbally responsive with no acute distress.

Vitals:

BP: 96/66
Temperature: 98.6°F (oral)
O2 sat: 97% on room air
Pulse: 80 bpm, regular
Respiratory rate: 20 breaths/min

Cardiovascular: Regular rhythm rate, diastolic murmurs appreciated, no rubs or thrills,

Respiratory: Clear to auscultation bilaterally with mild cough and expiratory rhonchi.

Gastrointestinal: Abdomen distended on all 4 quadrants, non-tender, bowel sounds present, tympanic on percussion.

Rectal: External inspection without fissures, hemorrhoids, lesions, or erythema. Digital rectal examination is performed with a lubricated gloved finger. Normal anal sphincter tone. A large amount of firm, formed stool was palpated in the rectal vault. No gross blood noted on the glove. Patient tolerated the procedure well. Exam performed with chaperone present (nursing Staff).

Extremities: Left lower extremity edema +2 below the knee. No pain, hard nodule noted, no cyanosis, or clubbing

Skin: No rashes, wounds, intact with appropriate capillary refill > 2 seconds, +2 pitting edema to left extremities.

Head: Normocephalic and atraumatic. No scalp tenderness or lesions. Upper lip with vesicular crusted lesions

Eyes: EOMI, PERRLA, bilateral conjunctivitia, and watery discharge

Neck: Supple with a full range of motion. No lymphadenopathy, thyromegaly, or JVD. Trachea midline. No carotid bruits appreciated.

ENMT: Hearing normal bilateral. External auditory canals are clear. No pain or drainage. Nares patent. Positive watery nasal discharge, no obstruction, or tenderness over the sinuses. Oral mucosa with moist mucous membrane

Neurological: Mental Status: A&O x 3, cooperative, thoughts & speech coherent. Cranial Nerves: II-XII intact.

Motor: poor muscle bulk and tone on the left extremities, strength 3/5 in the left extremities, 5/5 in the right extremities. Weakness was noted in the left upper and lower extremities.

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

Musculoskeletal System:
No ecchymosis/ erythema/ atrophy/or deformities in bilateral upper and lower extremities. Limited ROM of the left extremities requires assistance with passive and active ROM. No crepitus in all upper and lower extremities bilaterally.

Imaging & Labs Ordered:

CXR: Cardiomegaly noted. Pacemaker identified with the distal electrode in a good position. No pneumothorax, pleural effusion, or pneumonia.

Viral Panel:

SARS-CoV-2: Not detected
Influenza A/B: Not detected
Respiratory Syncytial Virus (RSV): Not detected

Labs

BNP : NT-proBNP: 2918 pg/mL

Hgb A1c : 6.1 reported on 2/20/2026

Assessment:
Mrs. M.B. is an 80-year-old female with a significant medical history of atrial fibrillation, severe tricuspid regurgitation, chronic systolic heart failure with an ejection fraction of 25%, amyloidosis, type 2 diabetes mellitus, and primary essential hypertension. She presents with a two-day history of constipation. Her vital signs are stable, and she is alert and oriented. Physical exam reveals a distended, non-tender abdomen with positive bowel sounds, with tympany on percussion, mild left lower extremity edema with +2 pitting below the knee present, and no signs of acute distress. Recent lab results show elevated

NT-proBNP and a stable HbA1c of 6.1 %. Her imaging findings indicate cardiomegaly, but she is currently in no acute respiratory distress, with no presence of infiltrates or consolidations on XR.

My primary concerns for this patient current comorbidites heart failure with reduced ejection fraction (HFref), amyloidosis, atrial fibrillation, and CVA with RICA occlusion. The patient is also presenting with mild edema of the left lower extremity (LLE) due to poor muscle tone from CVA in the past. Currently, patient is complaining of a productive cough and 2 day of constipation with trouble having a bowel movement. Given her age and multiple health issues, her treatment plan prioritizes symptom management and stabilization, with attention to medication adjustments due to her currently low blood pressure while preventing a CHF exacerbation.

Differential Diagnosis:

Fecal Impaction:
Fecal impaction is the most likely diagnosis given the patient's distended abdomen and findings on digital rectal examination, which reveal a large amount of firm stool in the rectal vault. Elderly, immobile long-term care residents are at high risk due to decreased gastrointestinal motility, neurogenic bowel dysfunction from prior CVA, and limited physical activity. Distal stool accumulation can lead to proximal abdominal distention and discomfort. The presence of stool on rectal exam strongly supports this diagnosis.

Medication-Induced Constipation:
Medication-induced constipation remains an important contributing factor. Chronic diuretic therapy may cause dehydration and electrolyte abnormalities, while amiodarone can slow gastrointestinal motility. Advanced age, polypharmacy, and decreased mobility further contribute to functional constipation that may progress to impaction.

Mechanical Bowel Obstruction:
Mechanical bowel obstruction must be strongly considered given the abdominal distention. Although the patient currently denies nausea, vomiting, and severe abdominal pain, early bowel obstruction in elderly patients can present subtly. Obstruction remains possible if there is proximal stool buildup or impaired bowel passage. Abdominal imaging is appropriate to help differentiate obstruction from severe fecal impaction.

Paralytic Ileus:
Paralytic ileus is less likely but should remain in the differential given her complex cardiac history and potential for metabolic disturbances. Ileus typically presents with decreased bowel motility, abdominal distention, and possible absence of bowel sounds. However, she currently has bowel sounds present, making this diagnosis less likely, though it should be monitored if symptoms worsen.

Plan:

#Constipation

- Start senna suppository as needed
- Start on Miralax 17 g scoop once a day
- Start fleet enema
- Order Abdominal XR
- Order BMP for electrolyte imbalance
- Order Mg, Phosphate, Ca, TSH panel

#HFref

- Follow up at HF clinic on 02/26/2026 with Dr. Rodriguez at The Brooklyn Hospital Center
- Reduce Furosemide from 40mg → 20 mg BID every other day due to hypotension
- Monitor Vital signs

#amylodisis

- Cardiology consult for amyloidosis
- Discontinue tamfamidis, & Amvuttra due to price and insurance

 # hypotenisve

- Elevate the extremities
- Use of compression stockings
- Hold Entresto due to low blood pressure as per directions to hold when BP <110/60
- Reduce Furosemide from 40 mg BID to 20 BID every other day
- Reduce Entresto dosage to 15-16 mg from 25-26 mg
- Monitor vital signs.

#LLE's Edema

- Tylenol 975 mg PO Q8H for discomfort.
- Lidocaine patch daily.
- Elevate the left lower extremity with pillows.

#Atrial Fibrillation

- Continue Eliquis 2.5 mg BID
- Continue Amiodarone 200 mg daily.

#RICA Occlusion

- Continue Aspirin and Lipitor.
- Continue routine monitoring.

#Cough

- Start Guaifenesin Liquid 100 mg/5 ml, 10 mL every 4 hours.
- Encourage hydration.

#Primary Essential Hypertension

- Reduce Entresto dosage to 15-16 mg from 25-26 mg
- Hold Entresto due to low blood pressure as per directions to hold when BP <110/60
- Reduce Furosemide from 40 mg BID to 20 BID every other day
- Monitor vital signs.

#**Diabetes**

- Repeat A1c current: 5.9 2/20/2026 previous: 6.1 on 2/18/2026.
- Discontinue F/s.

#GERD without esophagitis

- Continue prantozoale 40 mg

Patient Education: The patient was educated on the prevention and management of fecal impaction. She was instructed on the importance of maintaining regular bowel movements by staying adequately hydrated, increasing dietary fiber intake as tolerated, and participating in physical and occupational therapy to promote mobility and gastrointestinal motility. Patient was instructed to take prescribed bowel medications, including Miralax, senna suppositories, and enemas, only as directed by medical staff. She was advised to notify nursing staff if she does not have a bowel movement within 48–72 hours after treatment or if she develops worsening abdominal pain, nausea, vomiting, or increasing abdominal distention, as these may indicate worsening fecal impaction or possible bowel obstruction.

Patient was educated on acute cough management and potential causes, including viral respiratory infections or mucus production. She was encouraged to maintain adequate hydration to help thin respiratory secretions and to rest as needed to promote recovery. Patient was instructed to practice good hand hygiene and cover her mouth when coughing to prevent the spread of infection.

red flag symptoms requiring immediate emergency department evaluation, including:

- Fever or chills
- Severe or worsening abdominal pain
- Persistent vomiting
- Inability to pass stool or gas
- Increasing abdominal distention or swelling
- Chest pain or palpitations
- Shortness of breath or difficulty breathing
- Coughing up blood or purulent sputum
- Confusion, dizziness, or sudden weakness
- Rapidly worsening cough or respiratory distress