

For my first history and physical presentation during my long-term care rotation, I evaluated a 77-year-old male who was admitted to subacute rehabilitation following hospitalization for obstructive pyelonephritis secondary to a 7 mm ureteral stone. The patient had undergone placement of a right percutaneous nephrostomy tube after unsuccessful ureteral stent placement. During the encounter, he reported a two-day history of productive cough with clear sputum, rhinorrhea, watery conjunctival discharge, and vesicular crusted lesions on the upper lip. On examination, the patient was afebrile and hemodynamically stable with clear lung sounds except for mild expiratory rhonchi, and the PCN site showed minimal drainage without signs of infection. Viral panel testing and chest imaging were negative for acute pathology. Based on the patient's clinical presentation and diagnostic results, the most likely diagnosis was an acute viral upper respiratory infection with concurrent herpes labialis triggered by recent hospitalization and physiologic stress. This case reinforced the importance of careful assessment in elderly patients, as respiratory infections can present with subtle symptoms and require close monitoring to rule out pneumonia or systemic infection.

For my second history and physical presentation, I evaluated an 80-year-old female long-term care resident who presented with a two-day history of constipation. The patient had a complex medical history, including atrial fibrillation, severe tricuspid regurgitation, chronic systolic heart failure with reduced ejection fraction, cardiac amyloidosis, and a prior cerebrovascular accident with right internal carotid artery occlusion. On physical examination, the patient had a distended but non-tender abdomen with tympany on percussion, and a digital rectal exam revealed a large amount of firm stool in the rectal vault, confirming fecal impaction. In elderly patients with multiple comorbidities and reduced mobility, constipation is a common issue due to decreased gastrointestinal motility, medication effects, and limited physical activity. Management focused on initiating bowel regimens, including stool softeners, osmotic laxatives, and enemas, while monitoring for complications such as bowel obstruction. This case highlighted the importance of performing a thorough physical exam, including a rectal exam when clinically indicated, as it can significantly guide diagnosis and management.

Throughout this rotation, I learned the importance of managing patients with multiple comorbidities by developing a comprehensive and individualized plan of care for each condition. Many residents in long-term care facilities present with complex medical histories requiring careful coordination of treatments for chronic illnesses such as heart failure, atrial fibrillation, diabetes, and hypertension while simultaneously addressing acute concerns. This experience underscored the importance of conducting a thorough, systematic physical examination, as subtle findings can significantly influence clinical decision-making in elderly patients. Additionally, I learned that effective management involves balancing medications, monitoring for complications, and prioritizing interventions that improve overall function and quality of life. Developing structured treatment plans for each comorbidity helped reinforce clinical reasoning and highlighted the importance of comprehensive care in the long-term care setting.