Spendlove Ayayee
NUR204
Comprehensive Health Assessment

Chief Complaint: Shortness of breath and Anemia

History of the Present Illness:

Mrs. Battle is a previously healthy 82-year-old man with a four-day history of dyspnea and hemoptysis and has a right-sided chest chain. He works as a postal office, and the symptoms began four days before he was admitted. While he was in new york, MS. The pain got worse, prompting him to go to the emergency room. There, he was diagnosed with pneumonia and placed on Levaquin 250 mg daily and Benzonatate 100 mg TID, which he has been taking for two days with only slight improvement. The pain is on the right- side midway down his ribcage, below the axilla. This pain is sharp, about 9/10 in severity, and worsens with movement and cough. The pain is pressed on the chest and does not recreate the pain. He feels that the pain has improved somewhat over the past two days. The hemoptysis does not improve since it began; there is no frank blood, but his sputum has been consistently blooded and tinged. The blood seems red at night. The dyspnea has been severe, and walking across a room is more difficult for him. He states that he feels as though there is a “rattling” in his chest. At baseline, he experiences no dyspnea on exertion and has no history of COPD or other respiratory problems. He is a smoker, smoking a little less than a pack a day for thirty-five years. History is notable that he experienced transient left lower leg swelling – from below the knee down – and pain several weeks ago during a cross-country haul. He also notes a four-day history of decreased appetite, poor sleep, and subjective fever and chills, with a measured fever of 100 in the hospital in Abilene. He had pneumonia about two months ago but has been healthy for the most part and denies any chronic medical conditions. Currently, he is comfortable, with morphine helping with the pain. He has no history of a clotting disorder, no cardiac history, and denies any chest trauma or aspiration. He has had no sick contacts.

Medications:.

Allergies: No known drug allergies.

Review of Systems:
Constitutional: Denies changes in weight, fatigue, night-sweats.
HEENT: No changes in vision, nasal discharge, headache.
CV: No palpitations, left-sided chest pain/pressure, edema.
Resp: See HPI
GI: No nausea, vomiting, diarrhea, constipation.

GU: No dysuria, increased frequency.
Neuro: No weakness, confusion, numbness, dizziness.
MSK: No weakness, arthralgias, myalgias.
Heme: No easy bruising, easy bleeding.
Skin: No new lesions or rashes.
Endocrine: No polydipsia, polyuria, heat/cold sensitivity.

Social History: Mrs. battle live in Brooklyn in an apartment with support from the family and children. She is a retired from postal service and a widow. Never used tobacco or alcohol.

Family History:
Mother: breast cancer in 70s
Father: ESRD in 70s
Son: Alive and healthy
Daughter: Alive and healthy

Past surgical history
Cholecystectomy
Right total hip arthroplasty
Right hand tender release around
Left total hip arthroplasty

Physical Examination: Vitals:

- Pulse: 71
- Resp. Rate: 18
- BP: 130/80
- temp
- Spo: 100% General: Alert, calm, well-developed fe male. Height/weight proportionate. No acute distress.
- HEENT: Pupils equal, round, reactive to light and accommodation. Extraocular movements intact. Moist mucous membranes in oropharynx. Some darkened teeth; possible caries. Small, reddened, raised area on left tonsillar pillar.
- Neck: Supple, without lymphadenopathy or thyromegaly. No carotid bruits.

- Lymph: No axillary, cervical, supraclavicular, pre-auricular, submental, or occipital lymphadenopathy,
- Cardiovascular: Regular rate and rhythm, with normal S1 and S2. No murmurs, rubs, or gallops. No JVD. 2+ pulses bilaterally – dorsalis pedis and radial.
- Lungs: Diffuse, bilateral crackles throughout lung fields. No wheezes. No accessory muscle use or cyanosis. Rhonchi from right lung base extending midway up lung field, very loud. No egophony. No tenderness to palpation.
- Abdomen: Normoactive bowel sounds. Soft, flat, non-tender, and non-distended. No hepatosplenomegaly; liver span approximately 10 cm.

- Skin: Warm, dry and well-perfused. No rashes or other lesions. Some scattered freckles across arms and back. Tanned neck and forearms. Extremities: 2+ pulses in upper and lower extremities. No lower extremity pain or edema; legs are symmetric in appearance.

- Rectal: Deferred.
- Neuro: Alert and oriented to person, place, and time. Able to communicate well. Cranial nerves 2-12 grossly intact. 5/5 strength in all extremities bilaterally. Sensation intact in all extremities. Normal gait. 1+ DTR's in biceps, triceps, supinator, knee, ankle. No clonus.

- Psych: Appropriate affect.

Admission labs:
WBC: 9.7, Hgb: 10.5,
Hct: 32.8,
Platelets: 235,
MCV: 89.8,
ANC: 1.8
Sodium:138,
Potassium: 3.8,
Chloride: 103,
Bicarb: 26.1,
BUN: 8,
Creatinine: 1.0,
Glucose: 105

Imaging & other studies:

EKG: Normal sinus rhythm, with rate at 90. Normal intervals and axis. No hypertrophy, no evidence of ischemia. No evidence of right heart strain.

CT: Right basilar atelectasis/infiltrate identified, with small bilateral pleural effusions; bilateral pulmonary emboli seen. Also noted are a large hiatal hernia, probable pericardial cyst, and gallstones.

Problem list:
1. Pulmonary embolus
2. Possible pneumonia
3. Anemia
4. Smoking cessation

Assessment & Plan:
Previously healthy 82-year-old man presenting with shortness of breath, hemoptysis, and right-sided chest pain, with CT images demonstrating pulmonary emboli and infiltrates.

1Shortness of breath: A pulmonary embolus may be the cause of the symptoms of dyspnea, hemoptysis, and right-sided chest discomfort, and the CT confirms this diagnosis. The best course of action is to administer additional oxygen to maintain an acceptable level of oxygen saturation, reduce Mrs. Battle's chest pain, and anticoagulate him. It is possible to begin anticoagulation with low molecular weight heparin and Coumadin at the same time, and both treatments should last for at least five days. We will aim for an INR of 2 to 3.

2. Since the patient's hemodynamics are stable at the moment and there is no indication of right heart strain, thrombolysis does not appear to be necessary. Mrs. Battle is at risk for venous stasis because of his history of making lengthy trips back and forth to California; in fact, he has a history of lower leg pain and edema. Testing for several causes of hypercoagulability, such as antithrombin III deficiency, lupus anticoagulant or anticardiolipin antibodies, factor V mutations, prothrombin mutations, and lipoprotein would also be reasonable. Malignancy is a crucial concern to take into account, particularly given Mrs. Vasquez's history of smoking. It would be reasonable to screen for lung, colon, and prostate cancer..

3. Possible pneumonia: Although Mrs. Battle does not now have an elevated white count, she has a history of being feverish and was given a pneumonia diagnosis in Abilene (obtaining these records will be beneficial). The CT shows an infiltration that might be pneumonia-related. Blood and sputum cultures would be reasonable to get, though they would not yield much because he has been on antibiotics for what is thought to be community-acquired pneumonia. His vital signs need to be checked often. Although it's possible that the pulmonary embolus is the cause of all lung symptoms, it would be sensible to keep up the antibiotic treatment he's already begun to account for the likelihood of an infectious component..

3. Anemia: Hemoglobin levels at the time of admission were 11.5, and the MCV was 89.5, indicating normocytic anemia. We could check the reticulocyte count, blood smear, TSH level, and test for hidden blood in the stool to further investigate this. His creatinine level is 1.0 and he has no prior history of renal issues. He's never had a colonoscopy, therefore it should definitely be done as an outpatient procedure.

4. Smoking cessation: Mrs. Battle indicated desire in quitting smoking and acknowledged that her husband's respiratory difficulties make him less inclined to smoke. I advised him that since he would be in a disciplined setting without easy access to cigarettes, this would be a great time to quit. We can assist him in his effort to stop smoking by supplying a nicotine patch or other supplement as needed for cravings and by asking for a consultation on quitting. His brother and daughter have given him a lot of family support in this endeavor.