Respiratory Findings from Emergency Department Reports

- Dyspnea
- Tachypnea
- Fever
- Cervical Lymphadenopathy
- Pneumonia

Patient has a past history of pneumonia 2 months ago. He has been taking Augment for the past several days, empirically for a presumptive sinusitis. However, he continues to have a frontal headache. Additionally the patient has had cough productive of green sputum and some dyspnea. This prompted him to come to the Emergency Department this afternoon.

PHYSICAL EXAMINATION:
On my examination the patient is alert and oriented. He is modestly febrile, neither tachypneic or tachycardic and he is normotensive.
HEENT: Normocephalic, atraumatic. Sclerae nonicteric. He has some frontal sinus tenderness. There is no maxillary sinus tenderness. Pupils are equally round and reactive to light. Extraocular movements are intact. Funduscopic exam reveals sharp disk margins. His TMs are clear bilaterally. His throat is without significant erythema or exudate. Temperature is 39.5 C.
NECK: supple without adenopathy or JVD.
LUNGS: His lung sounds have crackles and wheezing predominantly in the right lung fields posteriorly. There is also some wheezing left posteriorly.
ABDOMEN: His abdomen is soft and nontender without hepatosplenomegaly or masses.
EXTREMITIES: Without cyanosis or edema.
SKIN: Without rashes.
NEUROLOGICAL EXAM: Normal.

ED COURSE:
He was hydrated with crystalloid IV solution. The patient received an albuterol aerosol treatment and was feeling much more comfortable from a respiratory perspective subsequent to that. His wheezing had decreased.
A chest x-ray was obtained. Per the radiology interpretation it reveals bilateral interstitial pulmonary infiltrates.
The patient was discharged with antibiotic therapy. Patient should return for increased shortness of breath or recurring fever.

DISCHARGE DIAGNOSIS (ES):
BILATERALLY INTERSTITIAL PNEUMONIA. 4

Dyspnea

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Cervical Adenopathy

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DISCHARGE DIAGNOSIS (ES):
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Pneumonia: Acute and Historical