Patient Name: Ramesh Kumar

Age: 58 years

Sex: Male

Occupation: Farmer

Chief Complaint: Shortness of breath and dry cough for 2 months, progressive swelling of legs for 10 days

History of Present Illness:

Mr. Kumar, a known case of hypertension and type 2 diabetes mellitus for 15 years (on irregular medication), presents with progressively worsening shortness of breath (now NYHA class III) over the past 2 months, associated with paroxysmal nocturnal dyspnea and orthopnea. He reports a persistent dry cough, fatigue, reduced appetite, and bilateral pedal edema extending up to the knees for 10 days. No fever or chest pain. He notes unintentional weight loss (~5 kg) over 8 weeks and generalized muscle weakness.

Past Medical History:

- Hypertension (diagnosed 2009)

- Type 2 diabetes (diagnosed 2010)

- Hospitalized 1 year ago with acute exacerbation of COPD, required nebulization

Family History: Father died of myocardial infarction at age 65; mother had chronic kidney disease.

Social history: Smoker (20 pack-years, quit 2 years ago). Occasional alcohol use. No known TB contacts.

Medications: Intermittent oral antihypertensives, metformin (non-adherent), inhaled salbutamol as needed

Review of Systems:

- Respiratory: No hemoptysis, no chest pain

- Cardiovascular: Palpitations occasionally

- GI: Occasional constipation, no vomiting or jaundice

- CNS: No headache, no focal weakness

Examination:

- Vitals: BP 148/92 mmHg, HR 102/min, RR 26/min, SpO2 90% (room air), temp 98.4°F

- General: Mild pallor, bilateral pitting pedal edema, no icterus or cyanosis

- Respiratory: Barrel-shaped chest, bilateral basal crepitations, occasional wheeze

- Cardiovascular: Displaced, diffuse apex beat; S3 present; JVP elevated

- Abdomen: Soft, non-tender, no hepatosplenomegaly

- Neurological: Grossly normal

Investigations:

- Hb 10.4 g/dL, TLC 8,200/mm3, Platelets 2.2 lakh; FBS 188 mg/dL, Sr. Creatinine 1.6 mg/dL, K+ 5.1 mmol/L

- ECG: Sinus tachycardia, LVH

- Chest X-ray: Cardiomegaly, mild bilateral pleural effusion, prominent pulmonary artery segments, lower zone infiltrates

- 2D ECHO: LVEF 38%, global hypokinesia, mild MR/TR, dilated LA/LV

- Sputum AFB: Negative (x2)

Summary of Case:

58-year-old hypertensive, diabetic ex-smoker with prior COPD, presenting with chronic dyspnea, pedal edema, weight loss, and constitutional symptoms, found to have heart failure with reduced ejection fraction, moderate anemia, and mild renal dysfunction.

Provisional/Working Diagnoses:

1. Chronic congestive heart failure (likely ischemic, HFrEF) — new-onset decompensation

2. Diabetic and hypertensive nephropathy (stage 3 CKD)

3. COPD, stable (history, exam)

4. Anemia of chronic disease (renal/cardiac)

5. Pneumonia or TB less likely (no fever, negative AFB, but possible infiltrates on chest x-ray)

Plan:

- Admit, begin diuretics (IV furosemide), optimize anti-hypertensives and diabetic meds

- Monitor input-output, daily weights, electrolytes
- Cardiology and nephrology consults
- Further workup: repeat CXR, cardiac enzymes, viral markers
- Patient/family counseling regarding lifestyle, medication adherence, and prognosis