CHIEF COMPLAINT:, ""I can’t walk as far as I used to."",HISTORY OF PRESENT ILLNESS:, The patient is a 66-year-old African American gentleman with a past medical history of atrial fibrillation and arthritis who presented c/o progressively worsening shortness of breath. The patient stated that he had been in his usual state of health six years ago at which time he had been able to walk more than five blocks without difficulty. Approximately five years prior to admission, he began to note a decreased tolerance to exercise. This progressed with a gradual worsening in his functional capacity such that he is presently unable to walk for more than 25 feet. Over the two years prior to admission, he has been having a gradually worsening non-productive cough associated with shortness of breath. His shortness of breath is worse when he lies flat, and he periodically wakes at night gasping for air. He sleeps with three pillows. He has also noted swelling of his legs and states that he has had two episodes of syncope at home for which he has not sought medical attention. Approximately one month prior to admission he was seen in an outside clinic where he states that he was started on medications for heart failure. He stated that he had had a brother who died of heart failure at age 72.,He did report that he had had an episode of hemoptysis approximately 2 years prior to admission for which he did not seek medical attention. He denied any history of chest pain and did not report any history of myocardial infarction. He denied fever, chills, and night sweats. He denied diarrhea, dysuria, hematuria, urgency and frequency. He denied any

history of rash. He had been diagnosed with osteoarthritis of the knees and had undergone arthroscopy years prior to admission.,PAST MEDICAL HISTORY :, Atrial fibrillation on anticoagulation, osteoarthritis of the knees bilaterally, h/o retinal tear.,PAST SURGICAL HISTORY :, Hernia repair, bilateral arthroscopic evaluation, h/o surgical correction of retinal tear.,FAMILY HISTORY:, The Father of the patient died at age 69 with a CVA. The Mother of the patient died at age 79 when her ""heart stopped"". There were 12 siblings. Four siblings have died, two due to diabetes, one cause unknown, and one brother died at age 72 with heart failure. The patient has four children with no known medical problems.,SOCIAL HISTORY:, The patient retired one year PTA due to his disability. He was formerly employed as an electronic technician for the US postal service. The patient lives with his wife and daughter in an apartment. He denied any smoking history. He used to drink alcohol rarely but stopped entirely with the onset of his symptoms. He denied any h/o drug abuse. He denied any recent travel history.,MEDICATIONS:,1. Spironolactone 25 mg po qd.,2. Digoxin 0.125 mg po qod.,3. Coumadin 3 mg Monday and Tuesday and 4.5 mg Saturday and Sunday.,4. Metolazone 10 mg po qd.,5. Captopril 25 mg po tid.,6. Torsemide 40 mg po qam and 20 mg po qpm.,7. Carvedilol 3.125 mg po bid.,ALLERGIES:, No known drug allergies.,REVIEW OF SYSTEMS:, No headaches. No visual, hearing, or swallowing difficulties. No changes in bowel or urinary habits.,PHYSICAL EXAM:,Temperature: 98.4 degrees Fahrenheit.,Blood

pressure: 134/84.,Heart rate: 98 beats per minute.,Respiratory rate: 18 breaths per minute.,Pulse oximetry: 92% on 2L O 2 via nasal canula.,GEN: Elderly gentleman lying in bed in mild respiratory distress, thin, tired appearing, wife and daughter present at bedside, articulate.,HEENT: The right eye was opacified. The left pupil was reactive to light. There was mild bitemporal wasting. The tongue was moist. There was no lymphadenopathy. The sclerae were anicteric. The oropharynx was clear. The conjunctivae were pink.,NECK: The neck was supple with 15 cm of jugular venous distension.,HEART: Irregularly irregular. No murmurs, gallops, rubs. No displaced PMI.,LUNGS: Breath sounds were absent over two thirds of the right lower lung field. There were trace crackles at the left base.,ABDOMEN: Soft, nontender, nondistended, bowel sounds were present. There was no hepatosplenomegaly. No rebound or guarding.,EXT: Bilateral pitting edema to the thighs with diminished peripheral pulses bilaterally.,NEURO: The patient was alert and oriented x three. Cranial nerves were intact. The DTRs were 2+ bilaterally and symmetrically. Motor strength and sensation were within normal limits.,LYMPH: No cervical, axillary, or inguinal lymph nodes were present.,SKIN: Warm, no rashes, no lesions; no tattoos.,MUSCULOSKELETAL: No synovitis. There were no joint deformities. Full range of motion b/l throughout.,STUDIES:,CXR: Large right sided pleural effusion. A small pleural effusion with atelectatic changes are seen on the left. The heart size is borderline.,ECHO: LV size

is normal. There is severe concentric LV hypertrophy. Global hypokinesis. LV function is severely depressed. Estimate EF is 20-24%. There is RV hypertrophy. RV size is mildly enlarged. RV function is severely depressed. RV wall motion is severely hypokinetic. LA size is moderately enlarged. RA size is mildly enlarged. Trace aortic regurgitation. Moderate tricuspid regurgitation. Estimated PA systolic pressure is 46-51 mmHg, assuming a mean RAP of 15-20mmHg. Small anterior and posterior pericardial effusion.,HOSPITAL COURSE:, The patient was admitted to the hospital for workup and management. A diagnostic procedure was performed.