[redacted]
Physician
Specialty: Pulmonology

Progress Notes
Addendum

Encounter Date: 2/9/2023

Holy Cross Health

A Member of Trinity Health

PULMONARY CONSULT NOTE

2/9/2023:

[redacted] is a 86 y.o. female present for consultation at the request of **Referring Physician,** [redacted] MD, regarding the following;

CHIEF COMPLAINT:

Chief Complaint

Patient presents with

- discuss hst result

HPI:

Sleep medicine evaluation regarding obstructive sleep apnea and presents today for review of her recent home sleep study.

This is a 86-year-old female past medical history significant for CVA with expressive aphasia also no known history of congestive heart failure and atrial fibrillation on anticoagulation therapy who presents today as a new patient regarding further evaluation for obstructive sleep apnea. Patient clinically notes snoring at night according to her daughter and has had witnessed apneas as well as gasping episodes. Given the patient's expressive aphasia most of the history is obtained through the daughter. Apparently sleeps on her back the entire night. Notes 5 to 10 pound weight gain over the last year with a current BMI of 30.8. Sleep apnea was clinically suspected and underwent a home sleep study on December 3 which was a somewhat of a limited study given that there was less than 4 hours of monitoring time. However, home sleep study revealed an AHI index of 16 suggesting moderate obstructive sleep apnea associated with mild snoring throughout the night he had no significant nocturnal hypoxemia.. Awakens not well rested at times denies excessive daytime sleepiness. Denies morning headaches.

Neck circumference 15 inches

ESS equals 6

REVIEW OF SYSTEMS:

Review of Systems
Constitutional: Negative for chills, fatigue, fever and unexpected weight change.
HENT: Negative for congestion, ear pain, hearing loss, postnasal drip, sinus pain, sore throat, tinnitus and trouble swallowing.
Eyes: Negative for photophobia, itching and visual disturbance.
Respiratory: Negative for apnea, cough, chest tightness, shortness of breath, wheezing and stridor.
Cardiovascular: Negative for chest pain, palpitations and leg swelling.
Gastrointestinal: Negative for abdominal distention, abdominal pain, blood in stool, constipation, diarrhea and vomiting.
Endocrine: Negative for cold intolerance and heat intolerance.
Genitourinary: Negative for difficulty urinating, frequency and hematuria.
Musculoskeletal: Negative for back pain, joint swelling and neck stiffness.
Skin: Negative for pallor and rash.
Neurological: Negative for dizziness, syncope, light-headedness and headaches.
Hematological: Negative for adenopathy. Does not bruise/bleed easily.
Psychiatric/Behavioral: Negative for agitation, confusion and sleep disturbance.

MEDICATIONS:

Current Outpatient Medications:
- apixaban (ELIQUIS) 5 mg tablet, Take 1 tablet (5 mg total) by mouth 2 (two) times a day., Disp: 60 each, Rfl: 1
- aspirin 81 mg EC tablet, Daily, Disp: , Rfl:
- atorvastatin (LIPITOR) 40 mg tablet, Take 1 tablet (40 mg total) by mouth at bedtime. TAKE 1 TABLET AT BEDTIME., Disp: 90 each, Rfl: 2
- BACILLUS COAGULANS-INULIN ORAL, Probiotic CAPS Refills: 0, Disp: , Rfl:
- calcium carb/vit D3/minerals (CALCIUM-VITAMIN D ORAL), Take by mouth., Disp: , Rfl:
- digoxin (LANOXIN) 125 mcg (0.125 mg) tablet, TAKE 0.5 TABLET BY MOUTH DAILY, Disp: , Rfl:
- dilTIAZem (CARDIZEM) 90 mg immediate release tablet, Take 1 tablet (90 mg total) by mouth 3 (three) times a day. TAKE 1 TABLET BY MOUTH THREE TIMES A DAY, Disp: 180 tablet, Rfl: 1
- docusate sodium (COLACE) 250 mg capsule, Take 1 capsule (250 mg total) by mouth 1 (one) time each day., Disp: , Rfl:
- furosemide (LASIX) 20 mg tablet, Take 1 tablet (20 mg total) by mouth 1 (one) time each day. Daily, Disp: 30 each, Rfl: 2
- hylan (Synvisc-One) 48 mg/6 mL syringe injection, inject one syringe into RIGHT knee., Disp: ,

Rfl:

- potassium chloride 20 mEq tablet extended release, TAKE 1 TABLET ORALLY DAILY, Disp: , Rfl:
- valsartan (DIOVAN) 40 mg tablet, Bedtime, Disp: , Rfl:

PATIENT HISTORY:

Social History

Tobacco Use

- Smoking status: Former
  - Years: 2.00
  - Types: Cigarettes
- Smokeless tobacco: Never

Substance Use Topics

- Drug use: Never

No family history on file.

Past Medical History:

Diagnosis	Date
• A-fib (CMS/HCC)	
• ACC/AHA stage C heart failure with preserved ejection fraction (CMS/HCC)	
• H/O ischemic left MCA stroke	
• Hypothyroidism	

Past Surgical History:

Procedure	Laterality	Date
• CESAREAN SECTION, LOW TRANSVERSE		
• HIP FRACTURE SURGERY		
• HIP RESECTION ARTHROPLASTY		
• PELVIC FRACTURE SURGERY		
• THYROID SURGERY		

- TOTAL HIP ARTHROPLASTY

ALLERGIES:

Patient has no known allergies.

VITAL SIGNS:

Visit Vitals

BP	113/74 (BP Location: Right arm, Patient Position: Sitting, BP Cuff Size: Adult)
Pulse	80
Temp	36.8 °C (98.2 °F) (Temporal)
Resp	16
Ht	1.27 m (50")
Wt	62.6 kg (138 lb)
SpO2	95%
BMI	38.81 kg/m^2
Smoking Status	Former
BSA	1.4 m^2

PHYSICAL EXAM:

Physical Exam

Constitutional:
General: She is not in acute distress.
Appearance: Normal appearance. She is not toxic-appearing or diaphoretic.

HENT:
Head: Normocephalic and atraumatic.
Mouth/Throat:
Mouth: Mucous membranes are dry.
Pharynx: Oropharynx is clear. No oropharyngeal exudate or posterior oropharyngeal erythema
.

Eyes:
General: No scleral icterus.
Extraocular Movements: Extraocular movements intact.
Conjunctiva/sclera: Conjunctivae normal.
Pupils: Pupils are equal, round, and reactive to light.

Neck:
Vascular: No carotid bruit.

Cardiovascular:
Rate and Rhythm: Normal rate and regular rhythm.
Pulses: Normal pulses.
Heart sounds: Normal heart sounds. No murmur heard. No friction rub. No gallop.
Pulmonary:
Effort: Pulmonary effort is normal. No respiratory distress.
Breath sounds: Normal breath sounds. No stridor. No wheezing, rhonchi or rales.
Chest:
Chest wall: No tenderness.
Abdominal:
General: Abdomen is flat. Bowel sounds are normal. There is no distension.
Palpations: Abdomen is soft. There is no mass.
Tenderness: There is no abdominal tenderness. There is no right CVA tenderness, left CVA tenderness, guarding or rebound.
Hernia: No hernia is present.
Musculoskeletal:
General: Normal range of motion.
Cervical back: Normal range of motion and neck supple.
Lymphadenopathy:
Cervical: No cervical adenopathy.
Skin:
General: Skin is warm and dry.
Coloration: Skin is not jaundiced.
Findings: No bruising or rash.
Neurological:
General: No focal deficit present.
Mental Status: She is alert and oriented to person, place, and time. Mental status is at baseline.
Cranial Nerves: No cranial nerve deficit.
Psychiatric:
Mood and Affect: Mood normal.

DATA REVIEW:

No orders to display

ABG:

ECHO:

No results found for this or any previous visit.

Pulmonary Functions Testing Results:
No results found for: FEV1, FVC, FEV1FVC, TLC, DLCO

Home sleep study dated December 3, 2022 reviewed with the daughter and patient which was somewhat of a limited study given short duration of monitoring time he had did reveal an AHI index of 16 suggesting moderate obstructive sleep apnea associated with mild snoring.

ASSESSMENT/PLAN:

1. **OSA (obstructive sleep apnea)** **Home sleep test**
2. Atrial fibrillation, unspecified type (CMS/HCC)
3. Congestive heart failure, unspecified HF chronicity, unspecified heart failure type (CMS/HCC)
4. ACC/AHA stage C heart failure with preserved ejection fraction (CMS/HCC)
5. Hypothyroidism, unspecified type

The patient will more than likely benefit from CPAP therapy however, I have recommended that she repeat home sleep study and have recommended a 2 night home sleep study and follow-up in the CPAP clinic for review.
Patient was counseled regarding sleep apnea and potential cardiovascular complications
Weight loss would be beneficial and the patient should avoid the supine position while sleeping
Alcohol and other sedatives should be avoided at night
Avoid driving if excessively sleepy
Follow-up in the CPAP clinic for review of repeat sleep study once completed after which more than likely CPAP therapy will be initiated and will follow-up in the CPAP clinic for mask fitting.

I have discussed at length the plan of care and differential diagnosis with the patient and/or the patient's family. The patient and/or the patient's family was given time to ask questions and raise concerns which were answered and addressed to the patient's/family's satisfaction.

Frank Sorhage, MD
Pulmonary & Critical Care Medicine

Electronically signed by Frank Sorhage, MD at 2/9/2023 4:53 PM
Electronically signed by Frank Sorhage, MD at 3/10/2023 8:50 AM

Office Visit on 2/9/2023 *Note shared with patient*

Additional Documentation

Vitals: BP 113/74 (BP Location: Right arm, Patient Position: Sitting, BP Cuff Size: Adult) Pulse 80 Temp 36.8 °C (98.2 °F) (Temporal) Resp 16 Ht 1.27 m (50") Wt 62.6 kg (138 lb) SpO2 95% BMI 38.81 kg/m² BSA 1.4 m² Pain Sc 0-No pain

Flowsheets: Vital Signs, Vitals Reassessment

Orders Placed

Home sleep test

Medication Changes

As of 2/9/2023 4:00 PM

None

Visit Diagnoses

Primary: **OSA (obstructive sleep apnea)** G47.33
Atrial fibrillation, unspecified type (CMS/HCC) I48.91
Congestive heart failure, unspecified HF chronicity, unspecified heart failure type (CMS/HCC) I50.9
ACC/AHA stage C heart failure with preserved ejection fraction (CMS/HCC) I50.30
Hypothyroidism, unspecified type E03.9