Homework

Name

Institution

Course

Date

Homework

Patient Initials: \_\_\_**JH**\_\_\_\_\_ Age: \_\_\_\_**82 years**\_\_\_ Gender: \_\_**Male**\_\_\_\_\_

**SUBJECTIVE DATA:**

**Chief Complaint (CC):** Patient is admitted to Sanatoga Center for rehabilitation following admission to Brandywine Hospital for dysphagia, encephalopathy, UTI, and AKI, as well as Pottstown Hospital for altered mental status with combativeness and aggressive behavior.

**History of Present Illness (HPI):** A debilitated 81-year-old male presented to Brandywine Hospital with ambulatory dysfunction, weakness, and several falls resulting in the worsening of lower extremity edema despite using Lasix. He was hospitalized from 12th July, 2020 to 12th October, 2020. The acute kidney injury (AKI) was normalized using IV fluids; weakness was attributed to deconditioning, while lower extremity edema was felt to be caused by right-heart failure and venous insufficiency. The transthoracic echocardiogram was normal. After infectious disease treatment and podiatry, the patient was discharged to Sanatoga Center till 12th December 2020, when he was admitted to Pottstown Hospital for altered mental status with combativeness and aggressive behavior. The patient was hospitalized until 1st January 2021, when he was discharged back to Sanatoga. Lab tests revealed hyperkalemia and AKI but were negative for the infectious source of the symptoms. Head CT Scans done on the first and second days of admission were both negative for acute pathology. Suspecting metabolic encephalopathy, Nephrology was consulted, where Lasix and continuation of IV fluids were prescribed while Digoxin was held for several days. Placement of the Foley catheter resulted in hematuria, which was cleared by CBI after consultation with Urology. As the patient's renal and mental function improved, Lovenox was stopped, and Eliquis started. Augmentin was prescribed for UTI as well as a middle ear infection. The patient was also diagnosed with mild to moderate oral stage dysphagia and suspected mild to moderate pharyngeal stage dysphagia, leading to a recommendation of nectar thick liquids and puree. On the last visit to Sanatoga Center, the patient reported constipation, throat pain, and mild ear pain.

**Medications:**

* Acetaminophen and Tramadol for mild pain and high temperature
* Aspirin for management of CAD
* Atorvastatin calcium for hyperlipidemia
* Augmentin for UTI and middle ear infection
* Digoxin for heart failure
* Dulcolax suppository and Milk of Magnesia suspension for constipation
* Eliquis for atrial fibrillation
* Entresto and Furosemide for CHF
* Finasteride for BPH
* Flomax for benign prostatic hyperplasia
* Flonase suspension for nasal congestion
* Gabapentin for neuropathy
* Melatonin for insomnia
* Mirtazapine and Sertaline for depression and insomnia
* Nystatin for prophylaxis against fungal infections in the groin and abdominal folds
* PreserVision AREDS 2 as multi-vitamin and minerals supplement
* Protonix for esophageal reflux
* Proventil HFA Aerosol solution for wheezing
* Solatol HCL for hypertension

**Allergies:** Patient is allergic to Wellbutrin and Amiodarone

**Past Medical History (PMH):** CAD, Diabetes type 2 with peripheral neuropathy, paroxysmal Afib, hypertension, hyperthyroidism, depression, macular degeneration, CHF, BPH, COPD, GERD, cellulitis, pancreatitis,

**Past Surgical History (PSH):** Back surgery, bilateral TKR, colon surgery, PPM/ICD implantation

**Sexual/Reproductive History:** Patient is not sexually active

**Personal/Social History:** Patient is a former smoker. He is widowed since 2000 after marriage for more than 40 years. He has 2 daughters, 1 son, 1 step-son Rick) and 1 adopted son (jeff).

**Immunization History:** Vaccines received by patient are Shingles vaccine, Pneumovax Dose I (33), PCV (Prevnar) 13 (133), TD Diphtheria/Tetanus (09), and TB 2 Step Mantoux Skin Test (96). He is not eligible for COVID-19 Vaccine Dose I (999).

**Family History:** None

**Lifestyle:** The patient was in the army for three years, getting out just before the Vietnam War. He worked several jobs, including milk delivery man, truck dispatcher, truck driver, for BP refinery, and as a master blender for gasoline. Prior to hospitalization, the patient was living with his adopted son, Jeff.

**Review of Systems:**

General: Patient has experienced general body weakness. The patient reports no subjective fever, chills, night sweats, and no major changes in weight.

HEENT: Patient reports headache, throat pain, and mild ear pain. He reports a history of macular degeneration.

Neck: Patient denies pain, stiffness, or injury

Respiratory: Patient reports no breathing difficulty and cough.

Cardiovascular/Peripheral vascular: Patient denies chest pain and palpitations.

Gastrointestinal: Patient reports dysphagia and constipation. He has no abdominal pain or changes in the stool. He reports no changes in appetite, diarrhea, vomiting, or nausea.

Genitourinary: Patient has not experienced a change in odor, color, frequency, or urgency in the urine. Musculoskeletal: Patient reports ambulatory dysfunction. He has no muscular pain or change in range of motion. He denies arthritis, myalgia, and gout. He also denies painful joints.

Psychiatric: Patient reports depression and insomnia. Patient denies anxiety and mood changes. He denies suicidal or homicidal history.

Neurological: Patient reports peripheral neuropathy. He has not experienced the loss of consciousness. Patient denies a history of paresthesia, dizziness, gait and coordination disturbances, and seizures.

Skin: Patient reports no rashes, blisters, itchiness, or discoloration

Endocrine: Patient reports that he has Diabetes Type 2

Allergic/Immunologic: Patient has experienced allergy Amiodarone and Wellbutrin

**OBJECTIVE DATA:**

**Physical Exam:**

Weight: 212.6 lb Height: 69 Inches BMI: 31.4

Vital signs: 98 F, 64 bpm pulse, 18 bpm respiratory, SpO2 97% on room air, 120/78 mmHg regular BP.

General: Patient appears to be comfortable, resting in bed with no acuter distress. He displays appropriate judgment regarding his person, place, month, and year.

HEENT: Head- normocephalic. Eyes - He has no conjunctival injection. The pupils are round and display accommodation and reaction to light. The sclera appears white. Ears appear non-inflamed and intact. The nose has no congestion.

Neck: Patient’s thyroid and trachea are midline. His throat has no lesions, masses, or lymphadenopathy.

Chest: No chest deformities observed. PPM/ICD in the left chest

Lungs: Patient’s breaths are regular. Breathing sounds normal upon auscultation.

Heart/Peripheral Vascular: Patient’s heart rate and rhythm are normal. S1 and S2 identified. No clicks, murmurs, or rubs. Trace edema in lower extremities

Abdomen: Soft, with no pulsatile masses, ascites, guarding, or tenderness. No enlargement of the spleen or liver was noted. Bowel sounds are active.

Genital/Rectal: Rectal- no masses, hemorrhoids, or bleeding noted. Genital- external genitalia displays no rashes, piercing, lesions, or irritation. Bladder- no tenderness noted.

Musculoskeletal: No changes in the range of movement, deformities, or varicoses observed. No muscular atrophy, redness, or swelling is observed.

Neurological: Patient’s Cranial nerves II-XII are intact

Skin/Lymph nodes: No rashes, ulcers, blisters, or discoloration were observed on inspection. Lymph nodes show no signs of adenopathy

**Lab test results:**

* Na/K within the normal range
* BUN/CR ratio higher than normal
* Bicarbonate levels slightly lower than normal
* WBC higher than normal
* RBC lower than normal
* Hb lower than normal
* Platelets count normal

**ASSESSMENT:**

The patient was diagnosed with the following conditions;

* Acute renal failure-BUN/Cr was abnormally high (81/2.53)
* Urinary tract infection- Based on urine analysis
* Metabolic encephalopathy with combativeness- Likely due to UTI and AKI
* Dysphagia- Evaluation by speech therapy revealed mild to moderate oral stage dysphagia and suspected mild to moderate pharyngeal stage dysphagia
* Atherosclerotic heart disease- Affecting native coronary artery with no chest pain
* Major depressive disorder
* COPD
* Atrial fibrillation

**PLAN:**

Orders and follow-up:

1. Acute renal failure managed with IV fluids conservative measures, BUN/Cr ratio down to 31/1.22, which is slightly higher than normal. CBC, BMP, and other lab results will be checked during follow up in one week.
2. Urinary tract infection was treated with Ceftriaxone, which was replaced with Augmentin for 5 days.
3. Metabolic encephalopathy with combativeness was managed by treating the UTI and AKI.
4. Dysphagia was managed by a change in diet to nectar thick and pureed fluids.
5. Atherosclerotic heart disease is managed by continuing cardio-protective medications like atorvastatin, Entreso 97-103, ASA, and Solatol. BP and pulse are also monitored in order to adjust the regimen as required.
6. Major depressive disorder is managed by continuing the course of 150 mg Sertraline daily.
7. COPD is managed using Symbicort and albuterol inhalers as well as supplemental oxygen when needed.
8. Atrial fibrillation is managed by Eliquis for anticoagulation, as well as Digoxin and Solatol for rate control.
9. Illness perception by the patient and his community should be addressed to manage any potential psychological issues that might arise. Strategies to cope with the physical, social, and psychological burden of the disease need to be considered (Palominos et al., 2018).

References

Palominos, P.E., Gossec, L., Kreis, S., Hinckel, C.L., Chakr, R.M.S., Moro, A.L.D.,...& Xavier, R.M. (2018). The effects of cultural background on patient-perceived impact of psoriatic arthritis - a qualitative study conducted in Brazil and France. *Advances in Rheumatology, 59*(33), 1-9. https://doi.org/10.1186/s42358-018-0036-6