Patient #023

Chief Complaint: This 67 year old black female presented with shortness of breath.

History of Present Illness: This patient had a history of type II diabetes, arthritis, anxiety and was in her usual state of health until two days prior to admission when she began to experience shortness of breath and chest pain. The pain was worsened by coughing and deep inspiration. The pain did not radiate and was not associated with diaphoresis, nausea or vomiting. She also complained of fever, chills, and a cough productive of yellow sputum. She denied cardiac problems, orthopnea, or PND. There was no tuberculosis exposure.

Past Medical History/Medications: She was hospitalized in 1971 for a depressive reaction and was started then on amitriptyline which she continued up to the time of admission at a dose of 75 mg qhs. For menopausal symptoms she was taking Premarin .625 mg/day and Provera 2.5 mg/day. She had diabetes that was diet controlled.

Social History: She quit smoking 30 years ago. She does not drink. She lives by herself and has two children. She is not working.

Family History: The family history was positive for diabetes in an older sister. There was no family history of cancer, heart problems, or strokes.

Physical Examination: She appeared well developed and well nourished and was in no acute distress. The temperature was 102.6 ^{o}F (39.2^{o} C), pulse 108, respirations 24, and blood pressure 140/80. There were no rashes. The extraocular movements were intact. The pupils were equally round and reactive to light. The fundi were normal. Tympanic membranes were normal. The oropharynx showed no erythema and no exudate. There was no meningismus and no thyromegaly. There was no lymphadenopathy. There were bilateral basilar crackles going half way up with no evidence of consolidation. The heart sounds were normal; there was a 2/6 systolic ejection murmur. The abdomen was soft. The spleen was palpable 6 cm below the left costal margin; there was no hepatomegaly. There were no masses. There was 1+ pitting edema. The neurologic exam including mental status, cranial nerves, strength and sensation was normal.

Laboratory Data:

			Normal
CBC	Hct	35	*38-47 %*
	Hgb	11.5	*12.3-15.7 g/dl.*
	WBC	5.9	*4-12 X $10^{9/L}$*
	Neut	56	*40-70 %*
	lymph's	27	*20-50 %*
	mono	5	*2-10 %*

Blood Smear: dohle bodies, toxic granulation, and atypical lymphocytes.

Chemistries	sodium	140	*135-145 mmol/l*
	potassium	4.5	*3.5-5.0 mmol/l*
	chloride	106	*100-111 mmol/l*
	CO2	23	*24-30 mmol/l*
	creatinine	1.4	*.6-1.0 mg/dl*
	BUN	18	*8-20 mg/dl*
	bilirubin, total	0.6	*0-1.2 mg/dl*
	glucose	187	*65-110 mg/dl*
	calcium	8.5	*8.5-10.2 mg/dl*
	magnesium	2.3	*1.5-2.8 mg/dl*
	phosphorus	1.9	*2.4-4.5 mg/dl*
	albumin	2.7	*3.5-5.0 g/dl*
	LDH	225	*108-215 U/L*
Blood Gases	pH	7.57	*7.35-7.45*
	pCO2	31	*35-45 mm Hg*
	pO2	42	*80-110 mm Hg (RA)*

Chest X-ray : bilateral basilar infiltrates.

Sputum gram stain: many polymorphonuclear cells and gram positive diplococci.

The patient was started on penicillin for pneumococcal pneumonia and was given IV fluids. On the second hospital day her laboratory results were as follows:

Laboratory Data:

			Normal
CBC	Hct	28	*38-47 %*
	Hgb	9.2	*12.3-15.7 g/dl.*
	WBC	6.1	*4-12 X $10^{9/L}$*
	platelet count	121	*150-440 X 10^{9}/l*
	retic count	1.5	*0.5-2.7%*
	Serum iron	16	*35-165 ug/dl*
	TIBC	249	*320-550 mcg/dl*
	% saturation	6	*20-45%*
	ferritin	587	*14-186 ng/ml*
	haptoglobin	368	*30-215 mg/dl*

Stool: guaiac negative

Coombs test: negative

With antibiotics the patient's condition improved.