Patient #171

Chief Complaint: This 71 year old black male presented with increased shortness of breath for two weeks.

History of Present Illness: Six weeks prior to admission, he presented to another hospital with shortness of breath and a productive cough. He was treated with antibiotics and bronchodilators, and improved. Two weeks prior to admission, he again experienced shortness of breath, and could not walk across a room without becoming dyspneic. He experienced shortness of breath at night, which was relieved when he got up out of bed. He developed a cough productive of scanty amounts of white sputum. He also developed some swelling of his legs. He denied fever, chills, night sweats, chest pain, hemoptysis, tuberculosis, or exposure to tuberculosis. He noted a decreased appetite, with a weight loss of 10 to 15 lbs over an unspecified period.

Past Medical History: He had a transurethral prostatectomy three months prior to admission.

Medications: Ampicillin, albuterol, theophylline, furosemide, bethanechol.

Allergies: none known.

Family History: positive for hypertension and coronary heart disease.

Social History: He worked in a quarry as a stone crusher for 35 years. He smoked 1 1/2 packs of cigarettes per day for 35 years, but quit 3 1/2 years prior to admission. He occasionally drinks alcohol.

Physical Examination: Thin black male in mild respiratory distress. BP 96/70; pulse 120; respirations 30; temperature 98^{o}F (36.6^{o}C).

The head was normocephalic and atraumatic, with bitemporal wasting. The conjunctivae were pink. The sclerae were anicteric. There were cataracts bilaterally. The pupils were equal, round, and reactive to light and accommodation. The oropharynx was benign. The neck was supple, without jugular venous distention. There was no lymphadenopathy. Pulmonary examination revealed use of accessory muscles of respirations. The lungs were resonant to percussion, with distant, bronchial breath sounds. Cardiac examination showed a normal apical impulse and normal sounds, without gallops or murmurs. The abdomen was soft, without tenderness, hepatosplenomegaly, or masses. Rectal

examination showed no masses; the stool was guaiac negative. The extremities showed no cyanosis, clubbing, or edema. The neurologic examination was normal.

Laboratory Data:

			Normal
Chemistries	sodium	136	*135-149 mmol/l*
	potassium	3.9	*3.5-5.3 mmol/l*
	chloride	105	*98-108 mmol/l*
	CO2	23	*24-32 mmol/l*
	BUN	19	*6-20 mg/dl*
	creatinine	1.4	*0.5-1.5 mg/dl*
	glucose	105	*70-110 mg/dl*
	calcium	8.1	*8.6-10.4 mg/dl*
	phosphorus	3.2	*3.0-4.5 mg/dl*
	magnesium	1.4	*1.8-2.4 mg/dl*
	protein, total	6.7	*6.0-8.0 g/dl*
	albumin	2.4	*3.6-5.0 g/dl*
	AST (SGOT)	24	*0-50 U/L*
	LDH	358	*300-665 U/L*
	ALP	135	*40-125 U/L*

			Normal
CBC	Hgb	13.1	*14.0-18.0g/dl.*
	Hct	38.5	*42-52%*

MCV	84	*84-99 fl*
WBC	11.0	*4.8-10.8 X* $10^{9/L}$
Neut	80	*40-70 %*
lymph's	8	*25-45 %*
mono	9	*2-12 %*
bands	3	*0-10 %*
platelet count	300	*150-400 X* $10^{9}/l$

Arterial blood gas on room air: pH 7.4, pCO_2 29.7, pO_2 66.6 (*nl=80-90*)**.**

Chest X-ray : pleural thickening with scarring, and a diffuse reticulonodular pattern bilaterally in the upper lobes and at the right base.

EKG: sinus tachycardia with left ventricular hypertrophy, and nonspecific ST-T wave changes

Sputum culture: normal respiratory flora.

Sputum: negative for acid fast bacilli, fungi, and malignant cells.

PPD and anergy battery: negative.