1. Ms. Palmer is a 62-year-old female presenting to the ER with chest palpitations and syncope. The symptoms have been gradually getting worse over the past two months and have increased dramatically over the past three days. They happen during any activity. The patient presented with an eight-pound weight gain, swollen legs, syncope, palpitations, coughing, and is currently sleeping in a chair. Her previous medical problems are hypertension-controlled and pulmonary sarcoidosis. Her current medications are prednisone and lisinopril with no known drug allergies. She does not use tobacco, illicit drugs, or alcohol. She walks on a daily basis, drink drinks one cup of coffee per day, and is an elementary school teacher. Her mother died from a from sudden death at age 40 and father from a myocardial infarction at 59. Her physical exam showed jugular venous distention, wheezing, an S4 murmur, lower extremity edema. Labs and imaging support the diagnosis of sarcoidosis that has infiltrated the heart muscle. Our plan is to admit to the hospital where she will follow up with a cardiologist and radiologist for a PET scan. We will up her dose of prednisone to 60 mg, add furosemide and amiodarone. She will continue on her current lisinopril. Thank you.
2. Hi Dr. Rawlins, I just saw Ms. Palmer in room 6 and she is a 62 year old female who presents to the emergency department with a 2 month history of worsening dyspnea, fatigue, palpitations, and near syncope. She stated that her symptoms improved with rest um however they were brought on by most activity including her daily tasks. She denies any chest pain but also reported that um some orthopnea causing her to sleep in her chair at night. She stated that she was seen in a family practice office 3 days ago where they did a 2D echo, EKG, labs, and a chest x-ray . She stated that she was instructed by her family practitioner to come to the ER due to her worsening symptoms. Her active medical conditions include hypertension for which she takes lisinopril 10 milligrams and pulmonary sarcoidosis for which she takes prednisone 10 milligrams once daily. She reported that both medical conditions have been well controlled with her medications. She denied any allergies and reported that she had a cardiac cath about a year ago due to an abnormal EKG but there was no coronary occlusion. She denied any prior hospitalizations and reported that she is fully immunized. She reports that her mom died suddenly at the age of 40 and her father died of a myocardial infarction at age 59. She stated she has a good support system and lives at home with her spouse. And she stated she is sexually active with her spouse and that the relationship is monogamous. She stated she has a balanced diet and used to walk daily with friends until her recent symptoms um have prevented her from continuing to do so. She denies any tobacco use, alcohol use, or illicit drug use. And reported that she drinks about 1 cup of coffee in the morning and works as a 3rd grade school teacher. My physical exam showed bibasilar rales and wheezing on lung auscultation, heart sounds were regular with a systolic murmur and S4 heart sound and no carotid bruits. Her PMI was normal but she had JVD bilaterally and um I noted some pedal edema. Her lower extremity pulses were normal and her calves were of equal size and color and nontender to palpation and she had a negative Homin's sign. Her chest was nontender to palpation I also evaluated anterior Chapmans points, posterior TART changes, and her um thoracic spine and I had no osteopathic findings to report. Her chest Xray uh demonstrated mediastinal fullness with diffuse pulmonary infiltrates and um a normal heart size. Her Echo showed a restrictive cardiomyopathy with an ejection fraction of 55%. Her EKG revealed a normal sinus rhythm with nonsustained ventricular tachycardia and her labs revealed a normal troponin but an elevated BNP at 4000. Based on my findings I believe she has sarcoidosis cardiomyopathy NYHA class 3 and I explained that I believe the pulmonary sarcoidosis has begun to infiltrate her heart as well. I recommended that we admit her to the telemetry unit and consider consult with interventional cardiology for the placement of an AICD and consult with cardiology for a possible FDG-PET scan. I also recommended that we keep her on the lisinopril um increase her prednisone dose to 60 milligrams daily, um add furosemide 40 milligrams IV and also um an amiodarone drip of 150 milligrams um and that is all thank you.
3. Presented um today with shortness of breath and um fatigue. She is 62 years old and presented to the emergency room. She said rest makes her pain or her shortness of breath better um and also sitting up in her chair and exercise makes it significantly worse. So Ms. Palmer is a female and um her past medical history consists of diabetes, hypertension as well as hyperlipidemia. Um she's been experiencing these symptoms for about 6 months and went to her PCP about 3 days ago they sent her to us and now here she is. So her um medical history also includes diabetes not sure if I mentioned that. Um and I have my um notes in front of me. The patient has a history of a um bypass surgery um and got about 5 stents beginning placed the first one was placed 20 years ago the most recent one was placed a year ago and she was told she can no long receive that sort of treatment. Excuse me. She appeared well, um alert, however slightly fatigue and she didn't have any skin lacerations, or bruising um just fatigue shortness of breath were her chief complaints. She had no neurological signs. Her heart was beating fast she said some syncope and uh dyspnea and um better with lying down so um orthopnea and she had wheezing and rales when she came in. So the physical exam showed that she had jugular venous distention, as well as the wheezing the wheezing and the rales um she also had pedal edema and um even pulses. She said her mother had breast cancer and her father had Alzheimer's. She um is on a handful of medications. She’s on amiodarone, warfarin, clopidogrel, metoprolol, metoprolol-succinate. And um have had the history of the surgical procedure so the shunt. She has no allergies. Um and after all the diagnosis was done or all the um the physical exam was done uh we talked about our results together. Um I presented her EKG which showed a left bundle branch block so left ventricular hypertrophy but normal sinus rhythm. Her uh echocardiogram showed dilated cardiomyopathy and her xray showed cardiomegaly with pulmonary edema as well as her labs showed elevated troponin of 4 and her BNP of 4000. Um after this I uh originally had the differential of potential heart failure um maybe some musculoskeletal chest pain because she was in the best health to begin with. And um ischemic cardiomyopathy ischemic dilated cardiomyopathy and that is what it ended up being. Um so she was advised um to be admitted to the ICU and talk to an interventional cardiology who would get her set up with an AICD and a and um not place another stent but place another cardiac device. So she was being admitted on a low sodium diet with um absolutely full restriction to exercise. Um her nursing orders were strict IO, um daily weights taken, and DVT prophylaxis. Yeah moving ahead she’ll see all the specialists be in the hospital until she's feeling better um and we did shift her medications so she's only taking clopidogrel and warfarin and dobutamine now um and she was put on an insulin sliding scale when she was admitted because of her diabetes as well as given a bipap machine to help with her shortness of breath. The patient also has history of atrial fibrillation. The patient was um asked if they had medical insurance and they did they have pharmacy set up and they have a supportive home so they are in a good place moving forward and I'm hopeful that um they will be able to receive the care that they need and continue on their journey to find health.
4. Mr. Leslie Pal Palmer who is a 62 year old male presents with 2 weeks of fatigue, shortness of breath, and palpitations. Patient also reports instances of feeling like he would pass out. He says that he is not short of breath at rest but that even with walking short distances he is short of breath. Um I think I would give him an NYHA score of class 3. He is able to lay flat and denies any recent illness. He has a history of hypertension and is on lisinopril. His family history includes um history of sudden death in his mother and an MI myocardial myocardial infarction in his father. Um he reports a year ago that he had a catheter cardiac catheterization and that was normal. He does not smoke, drink alcohol, or do illicit drugs. He is a school teacher. Review of systems were positive for fatigue, warm to the touch skin, palpitations, near syncope, wheezing and shortness of breath. No chest pain or ortho orthopnea. Um vitals were remarkable for hypotension at 80/50 and hypoxia at 85% on room air. Physical exam showed systolic murmur with S4 gallop. He had a PMI point of maximal impulse that was displaced laterally. Um lungs were clear to association. There was no calf tenderness, no lower extremity edema. Uh PT and DP pulses were full and equal bilaterally. Uh labs showed a troponin and BNP within normal limits. EKG showed left ventricle ventricular left ventricular hypertrophy and tall septal R waves. Echo showed thickened interventricular septum with an EF of 60%. Um patient should be admitted to telemetry due to diagnosis of hypertrophic cardio familial hypertrophic cardiomyopathy. Uh secondary diagnosis would be hypertension. Um I advised the patient that we should discontinue lisinopril and start on disopyramide. Consult was done with interventional cardiology for AICD placement and cardiothoracic surgeon for either alcohol ablation or myectomy. Patient is in agreement with plan he was counseled on um the further plan and he was alerted of the cause of his symptoms. Thank you.
5. Good morning. Ms. Palmer is a 60 year old 62 year old female presenting to us with shortness of breath. Patient states that they are physical physically active and exe exercise routinely. They started developing difficulty breathing when exercising. This encounter occurred prior to our visit several weeks ago and has had a gradual onset. Patient states that they feel short of breath when exercising and describes it as its isolated only to the chest, is aggravated when exercising and relieved by stopping and uh by stopping physical activity. Patient has a prior history of cardiac catheterization and currently presents to us with a previous history of hypertension. Patient states they do not have any known allergies. Patient follows a balanced diet does not consume alcohol, tobacco, or any illicit drugs. The patient drinks coffee in the mornings and um family history consist of the mother passing away suddenly uh without reason and father passing away from myocardial infarction at the age of 59. Ms. Palm Mrs. Palmer is fatigued reports pre syncope, palpitations, and wheezing and she is currently on lisinopril 10 uh milligrams once per day. Patient was alert and oriented. Physical exam found J uh jugular venous distention, regular rate for heart rate, wheezing and rales. Uh upon physical exam, calves was non tender but presents lower ex extremity edema. Imaging found cardiomegaly and via 2D ECHO demonstrates left ventricular asymmetry and hypertrophy with ejection fraction of 60%. EKG presents tall R waves in uh septal leads. Troponin and uh BNP are within normal limits. Completion of physical exam and interview led to suspected diagnosis of familial hypertrophic cardiomyopathy. Patient is classified new york heart association 2. Is to be sent to the telemetry unit under serious condition. [\_\_\_] every 2 hours activity as tolerated. Nursing intervention consist of strict I and Os, O2 via cannula to maintain at 96%. Patient should be on DVT prophylaxis and patient can receive a regular diet. IV orders are KVO. We discussed the plan and is to discontinue lisinopril and hold it and administer disopyramide 10 uh 100 milligrams PO. No labs and images are needed. We plan to consult cardiology for AICD placement and we didn’t but we did not get to discuss cardiac surgery but should be consulted for septal myectomy. Patient was briefed and asked if she had any questions for her care and agreed upon the treatment plan. Thank you so much.
6. Patient I am reviewing today is a 65 year old male named Leslie Palmer. He presented with shortness of breath and fatigue when exercising um he mentioned he had several episodes of near syncope. He went to his family medicine doctor where they ran multiple tests and he was recommended to come to the ER if he kept having these symptoms. He uh again had shortness of breath, near syncope. He was breathless and fatigued when he tried to exercise and his heart was beating out of his chest. When going over his past medical history he had hypertension which he was on 10 milligrams of lisinopril for um he had a cardiac cath a year ago eh due to an abnormal EKG. When discussing his family history he mentioned his mother died suddenly at 40 years old and his father was deceased at 59 from a myocardial infarction. Uh when discussing his social history he denied use of tobacco, alcohol, and illicit drugs. He had a balanced diet with fruits and vegetables, protein, uh he went for regular walks before his shortness of breath and he was a elementary school teacher and had a uh spouse of over 30 years. Um he had no known drug allergies. And when reviewing the uh systems he appeared fatigue and complained of fatigue. He had no fever or chills, no weight changes um either loss or gain. Uh no rashes, no bruises, no lesions on the skin. Um HEENT findings were negative. So no headache, no stiffness of the neck, no visual or uh um auditory difficulties. Um for cardiovascular he did have those palpitations and near syncope but no chest pain. Um he complained of wheezing and dyspnea but orthopnea was okay. Um when discussing MSK he had no muscle pain, no joint pain, and no edema in his lower extremity. He had no dizziness or confusion or gait changes. Um when reviewing the um the labs his troponin and BNP were normal and when looking at the chest Xray it displayed cardiomegaly with uh no edema or infiltrates. And when looking at the ECHO it was described as asymmetry because of a thickened septum. And with all of these findings we uh came to the conclusion that his hi- oh along with his vital signs being 110 for his pulse, 130/90 for his blood pressure, 96 oxygen and respirations were around 16. Um after reviewing everything, we came to the conclusion that this was um familial uh HOCM so hypertrophic um myocard hyo HOCM and um when we looked at everything we recommended seeing a cardiologist and a cardiothoracic surgeon for septal ablation or a some other sort of surgery uh with to treat the septum including the um AICD placement from the cardiologist. Um this was the conclusion of this patient.
7. Today I saw Dr. Or Mr. Leslie palmer he’s a 62 year old male. He came in complaining of shortness of breath and fatigue uh and has been progressing throughout the last 6 months with the last 3 days getting gradually worse uh and very severe today. He came to the emergency department at the recommendation of his primary care physician who suggested that he come. Um he is having dyspnea even at rest and has to sleep upright so orthopnea as well. Uh past medical history pertinent for atrial fibrillation, hypertension, dyslipidemia, and diabetes. Diabetes for the last 15 years, atrial fib for past 5. His surgical history is positive for a coronary artery bypass graft and a and 5 cardiac stents. He has maxed out on stents and the cardiologist indicated no further intervention. Family history for maternal, his mom has breast cancer and his dad paternal has uh Alzheimer's but he is still alive. As far as social history is positive for tobacco use he is a smoker for the past 30 years um no alcohol no drugs. He is employed and has a regular balanced diet and he used to exercise but is now unable to due to the shortness of breath and fatigue. And he lives with his spouse his wife. Current medications atorvastatin 10mg, clopidogrel 75 milligrams once a day, the atorvastatin was once a day, furosemide 20 milligrams twice a day, metoprolol succinate 50 milligrams once a day, lisinopril 10 milligrams once a day, metformin 500 twice a day, and warfarin 2.5 milligrams twice a day. He is compliant in all those medications. No known drug allergies. His review his review of symptoms is uh positive fatigue, weight gain, um shortness of breath so the dyspnea the orthopnea, he also has positive wheezing and lower extremity edema. He is awake, and alert, and orient times four but he is fatigued. Uh vitals today temperature 98.6 normal, heart rate 90 normal, uh respiratory rate 22 so a bit of tachypnea, resp or blood pressure 80/50 so very low blo-blood pressure and oxygen saturation 86% so low. Uh jugular venous distention was present on physical exam but there were no carotid bruits. On auscultating his heart, I did hear a gallop but no murmur, no friction rub, and he did have tachycardia with a PMI pulse of maximal impulse displaced laterally. Lungs uh were positive for rales and wheezing but no chest wall tenderness. Um as far as his lower extremities I did auscultate or I did check his pulses those were full and equal. He did have some pedal edema but his calves were nontender and Homin sign negative. Imaging um we did chest x-ray results with cardiomegaly pulmonary edema. 2D echo with indicated dilated cardiomyopathy with ejection fraction less than 30. His EKG showed normal sinus rhythm but left bundle branch block. And his labs troponin was elevated at .04 and BNP was elevated at 4000. So I indicated that he's diagnosed with ischemic dilated cardiomyopathy. I did explain this to the patient. His new york heart association classification is 4 as he is unable to carry on physical activity even at rest. His disposition we should admit him to the ICU in serious condition check his vitals every 2 hours. I think he should be on strict bedrest and the nurses should strict ins and outs, daily weights, and check for DVT prophylaxis. I recommend a sodium low sodium diet and if we indicate fluids we should keep his vein open for now. Um as far as medication changes, I would like continue his warfarin and his clopidogrel but change all his other ones. Um add on disopyramide 100 milligrams once a day and change that metformin to an insulin sliding scale. Since his oxygen saturation is so low at 86 I would like to place him on BIPAP and uh order the labs serial troponin and PT/INR. For consultation, I'd like to consult interventional cardiology so that they can check for if he's a candidate for a pacemaker either AICD or CRT. Other than that we should get Mr. Palmer into the ICU and see if we can help um get his shortness of breath and fatigue figured out and get that oxygen saturation much higher. Alright thank you.
8. I met uh Mr. Leslie Palmer who's a 62 year old male um and presenting with episodic chest pain um sorry episodic near syncope associated with light headedness, palpitations, shortness of breath, um feeling raspy and wheezing for the past 2 weeks. Um he said symptoms get better with rest and describes it as severe in nature. Um episodes last 30 to 45 minutes. He denies any prior history of this um and says this new um in the past 2 weeks. Um his past medical history is significant for hypertension and he is currently on 10 milligrams of lisinopril for that um once a day. He has a history of a cardiac catheterization that came back normal um his family history was significant for his mother passing away at 40 from sudden what was predisposed to be sudden cardiac death. Um his father passed away at 69 from an MI. His review of systems was positive for um fatigue, lightheadedness, near syncope, palpitations, wheezing, and dyspnea. He denied any fever, chills, weight changes, skin changes, um any myalgias, joint pain, um chest pain, orthopnea, um no neck swelling, trouble swallowing um or anything of that nature. His vitals um his heart rate was elevated at 110 otherwise his vitals were normal. His oxygen was 96%. His respiratory rate was um 16. Blood pressure 130/90 um and his temperature was 98.6. Um on exam uh he had positive JVD. His cardiovascular exam was regular rate um no murmurs, rubs, or gallops noted. Um his PMI was displaced laterally um and we noted uh bibasilar rales and wheezing present. Um he had plus 1 pitting lower extremity edema but otherwise full DP PT pulses. Um no calf tenderness or Homin sign. Uh my assessment is that the patient was awake, fatigued, uh and oriented. Um and then going through his results um his chest x-ray showed cardiomegaly otherwise normal um 2D echo showed left ventricular asymmetry um with hypertrophy um EF of 60%. His EKG was normal sinus rhythm at 60 um that was the rate, with normal axis, um LVH criteria and peak R waves in septal leads. Um his troponin and BNP were both normal. Um and with this information I diagnosed the patient with familial hypertrophic cardiomyopathy. Um I gave him a class 2 New York Heart Association. Um and I gave him a secondary diagnosis of hypertension. Um I decided to admit him to telemetry. Uh his condition was serious at the time of admission. Uh I ordered vitals every 2 hours and activity as tolerated. For nursing orders, I added in a strict I O, uh daily weight, uh oxygen via nasal cannula 2 liters per minute um to maintain that sat of 96% or greater um in addition to DVT prophylaxis. For diet I ordered regular diet for him and then to keep the vein open for IV. Um and then as far as his medications goes I asked him to discontinue the lisinopril um and start the disopyramide at 100 milligrams PO. Um and for consults for this patient I um requested he be seen by interventional cardiology and cardiothoracic surgery um for potential AICD placement, septal myomectomy, and alcohol injection. Um and that is all I have for you today thank you so much for your time.
9. Pleasure of seeing Leslie Palmer a 62 year old female in the emergency department today. She complained of shortness of breath and fatigue for the last 2 months. Um with intermittent episodes of palpitations and feeling like she may pass out. She has orthopnea and must sleep in her recliner. She is limited in her ability to walk with her neighbors due to her symptoms. Her symptoms are relieved by rest. She is currently taking lisinopril 10 milligrams and prednisone 10 milligrams daily to treat hypertension and pulmonary sarcoidosis respectively. She was diagnosed with pulmonary sarcoidosis 25 years ago. She has no known drug allergies. One year ago she underwent heart ca- underwent heart catheterization which was negative. And she denies other surgeries or hospitalizations. Her family history is pertinent for a father who passed away at age 59 from a myocardial infarction and a mother who passed away unexpectedly at age 40 likely due to sudden cardiac death. She has a sister who has no medical conditions and is living. She eats a well balanced diet um does not use illicit drugs, tobacco products or alcohol. She consumes 1 cup of coffee a day. She’s an elementary school teacher. She lives at home with her husband. She has no children. She used to regularly walk with her neighbors before the onset of these symptoms . She denies fever, chills, or weight loss but endorses fatigue and an 8 pound weigh gain over the past 2 weeks. She denies any skin changes, such as rash, bruising, um lacerations. She denies any changes in her vision, uh changes in hearing, difficulty swallowing or headaches. She denies any gait disturbances or dizziness. She endorses lower extremity edema but denies joint or muscle pain. She denies chest pain but endorses palpitations and presyncopal sensations. She denies any syncopal episodes. She endorses shortness of breath, orthopnea and wheezing. She denies cough. Vital signs reveal that she is tachycardic at 110 beats per minute, hypertensive at 136/99, tachypneic at 20 respirations a minute. She is afebrile. And she is hypoxemic at 91%. Physical exam revealed um venous jugular venous distention pardon me, um no carotid bruits, she has a regular heart rhythm with a systolic murmur, and an S4 gallop, um. Pulmonary auscultation reveals bilateral rales. Lower edemity uhm um pardon me lower extremity plus 1 pitting edema is noted and normal pedal pulses are present. There is also no calf pain. Labs showed normal troponin levels and an elevated BNP at 4000. Chest xray shows pulmonary edema and pawnbroker’s sign suggestive of um sarcoidosis. Echocardiogram showed non-dilated ventricles with an increased ventricular wall thickness with an ejection fraction of 55%. Her EKG showed normal sinus rhythm at 100 beats per minute uh normal axis axis with um less than 30 second nonsustained ventricular tachycardia. Given her history of pulmonary sarcoidosis, I suspect she is having a restrictive cardiomyopathy due to cardiac infiltration of the sarcoidosis. She has a new york heart association class 3. Secondary diagnoses include hypertension and pulmonary sarcoidosis. I am admitting her to telemetry. I am continuing her lisinopril. I will be adding amiodarone 150 milligrams IV, increasing prednisone to 60 milligrams and adding furosemide 40 milligrams IV. I will order CMP labs and refer to interventional cardiology for an AICD placement and radiology for an FDG-PET scan. Thank you.
10. a 62 year old female presents with complaint of shortness of breath and fatigue. She was afebrile, tachycardic with a heartrate of 110, O2 sats of 91 which was low, pulse of 110, blood pressure 130/90, and respiratory rate of 20. Patient had previous viral infection approximately 2 weeks ago um and has continued to have heart palpitations, substernal dull chest pain, orthopnea, dyspnea, and shortness of breath at rest. Previous history positive high blood pressure and currently takes 10 milligrams of lisinopril once daily. Patient had previous visit to their PCP and they referred them to the ED for their symptoms. Patient has had muscle aches, joint pain, and weight gain of 8 pounds in the past 2 week. Um NYHA score 4 since they have experienced symptoms at rest. Um physical exam was positive for JVD but no carotid bruit bruits, regular heart sounds with no murmurs, PMI was displaced laterally but the chest wall was not tender. Bilateral rales and wheezing were auscultated. Lower extremity pitting edema was found but both pulses DP and PT were strong bilaterally. No calf tenderness was noted on physical exam. Negative family history for cardiac ifu issues. Father is currently living with Alzheimer’s in a home facility and the mother died of breast cancer at age 89. Patient does not use alcohol, tobacco products, but does drink 1 cup of coffee daily. They have a regular balanced diet and exercise consistently about 3 times a week. They have no known drug allergies and history of a cardiac cath 1 year ago. The troponin was elevated at 0.1 and BNP was elevated at 4000. Chest X ray was positive for pulmonary edema and cardiomegaly. ECHO showed dilated cardiomyopathy with a reduced ejection fraction of 30%. EKG was positive for PVCs, right bundle branch block, left axis, and sinus tach. This is consistent with myocarditis dilated cardiomyopathy. Um the patient will be admitted to telemetry, vitals q2 hours, and activity as tolerated. Um nursing orders to monitor ins and outs, daily weights, DVT prophylaxis prophylaxis, and start on O2 nasal cannula to maintain O2 sats above 96%. Diet is low sodium and fluid restriction. Keeping patient on lisinopril adding 625 milligrams acetaminophen by mouth q2 q6 hours and furosemide 40 milligrams IV. I ordered serial troponins, a CMP, and a repeat 2D echo. I also put in con-consults to interventional cardiology for AICD and CRTD placement and a cardiac biopsy. Um another consult to infectious disease for immunoglobulin and glucocorticoids. And a consult to radiology for immediate enhanced MRI to detect inflammation of the heart. Patient is expected to be admitted and discharged. Um they were instructed to maintain uh healthy weight and healthy lifestyle once discharged and activity once cleared by a cardiologist.
11. Mr. Leslie Palmer he is a 62 year old male. Presents to the ED with shortness of breath and fatigue. 2 weeks ago he was walking with his buddy and began to feel shortness of breath, felt tired, and felt like he ready to pass out. He felt concerned about that because every time he exercised he would feel like he was ready to pass out got really tired. Saw his family medicine doctor 3 days ago and it was they told him to get if it got worse to go to the emergency room and that’s why he’s here. He’s alert and oriented times 4. He is fatigued right now. His vital signs his heart rate was 110 a little high and his um pulse ox was 96% his temperature blood pressure and respiratory rate were within normal limits. Now with the HPI and review of systems he had no chest pain he did have palpitations but it got worse with activity and exercise but it did it got better with rest. And he was negative for orthopnea. Um past medical history he had a hypertension, he has a cardiac cath 1 year ago due to an abnormal EKG but the results were normal. Now his family medical history his mother had a sudden cardiac or sudden um cardiac death his father passed away of a myocardial infarction. She passed his mother passed away at age 40. His medications right now he’s on lisinopril 10 milligrams one-uh once a day. He has no known drug allergies. His social history was negative for anything pertinent. He’s an elementary school teacher he does use moderate amount of caffeine. And he used to exercise and was active but he can’t right now because of the fatigue. He has well balanced diet and he’s married. Now review of systems, he was positive for fatigue, palpitations, he was negative for chest pain and he had he was positive for presyncope episodes. He did have dyspnea. He was positive for wheezing. He was negative for hear- head, ear, eyes, neck and throat. Negative for skin, negative for musculoskeletal, and negative for neuro. On physical exam he did not have any jugular vein distention nor bruits. But he did have a heart murmur with an S4 heart sound gallop. And his lungs were clear bilaterally and equal and no lower extremity edema no um deep vein thrombosis as well. Negative Homin’s sign. His Xray showed cardiomegaly, no pulmonary edema. Um echo showed asymmetric hypertrophy with ejection fraction about 60% showing that there’s some hypertrophy going on. EKG had tall R wave in the septal leads and normal sinus with left ventricular hypertrophy of a cri-criteria. And labs were normal. With the EKG, echo, Xray this was leading me towards familial cardi- familial hypertrophic cardiomyopathy with um stage 2 NYHA 2 class heart failure. So we are gonna I was what we can run this over but thinking of admitting him telemetry, vitals every 2 hours, ins and outs, DVT prophylaxis, daily weights. Put him on some oxygen because that pulse ox was a little low put him on 2 liters um keep it above 96%. He’s serious. We are gonna have activity as tolerated though. And we’re gonna keep that vein open. We’re no- we’re not gonna do any fluids right now because its uh some type of heart failure we don’t need to do that right now. Now we’re gonna keep him on regular diet. We are gonna discontinue that lisinopril and put him on disopyramide sorry about that 100 milligrams 4 times a day. Make sure he doesn’t have any anti- or arrythmias. I did consult interventional cardiology for an automatic internal cardiac defibrillator. Make sure that it’s pumping well. And cardiothoracic surgery for septal myectomy and alcohol injection. Now sir, I hope you have a great day and this was Mr. Leslie Palmer great guy you have a good day.

155.  Leslie Palmer. Patient presents with um shortness of breath and fatigue. Patient states that the symptoms began a couple week ago, and has progressively became worse over the last 2-3 days. Uh symptoms are exacerbated um with some exercise and only relieved by rest. Patient has not tried any umm, patient has not tried any other treatments besides rest is helpful when he like lays down. Yeah, medications currently taking, he’s currently taking lisinopril 10 mg. He is taking this for his diagnosis of hypertension. He is currently up to date on all immunizations. And only hospitalization um was a cardiac cath which was, um, which turned out to be normal about a year ago. Family medical history was normal on his mother’s side and on his father’s side, he, his father had passed away from a heart attack at the age of 59, myocardial infarction. Diet is balanced. Uh patient states that before symptoms occurred, he was walking daily, um caffeine intake was one cup a day, um he is employed as a 5th grade elementary school teacher where he does have insurance through them. Um He is sexually active with his wife. Um, when going over the review of systems, patient has presented with fatigue, palpitations, pre-syncope, and dyspnea. I went ahead and then performed the physical exam. Physical exam findings included uhm no jugular venous distension, he had a crescendo-decrescendo systolic murmur and with S4, uh the PMI was laterally displaced, uh patient presented with no edema in the lower extremities, and pulses were normal bilaterally. And lungs were clear on auscultation bilaterally. When looking over the tests that were ordered, the troponin level was at zero, which is normal, BNP was at 90 which is normal, uh x-ray showed cardiomegaly, it did not show pulmonary infiltrates. ECHO showed left ventricular asymmetry and a ejection fracture of 60%. EKG showed tall septal R waves and also met criteria for left ventricular hypertrophy. And it was a sinus rhythm. Um it was tachycardic. Patient did have a pulse of 110 beats per minute, blood pressure was slightly elevated at 130 systolic over 90 diastolic. Um Oxygen saturation um in the room was 96%. Respiratory rate was at 16 breaths per minute and temperature 98.6 F. Uh based on the um diagnostic labs that were ordered and tests that were ordered, physical exam, and past medical history, I believe this patient had has familial hypertrophic cardiomyopathy. Um I do suggest that we admit this patient to uh telemetry, and we stop the lisinopril, start him on 100mg of disopyramide um everyday by IV, um I also believe that we should refer the Mr. Palmer to interventional cardiologist where we, where we possibly can implant um AICD placement. I also believe that we should refer him to cardiothoracic surgery uh for alcohol injections and septal myectomy to um reduce the left ventricular outflow tract obstruction.

154. So I just met with Leslie Palmer. She’s a 62 year old female with a history of diabetes, hypertension, hyperlipidemia, and atrial fibrillation. She presents to the emergency department for the chief complaint of shortness of breath and fatigue. This patient states that approximately six months ago she started experiencing these symptoms even while she is at rest. she admits to dyspnea on exertion, orthopnea, and wheezing. she also states that she’s gained 8 pounds within the past two weeks that she noticed that her lower extremities are swollen. she denies chest pain or any palpitations. three days ago she saw her PCP who did labs on her and called her today and referred her to the emergency department which is why she’s here. she also states that she’s been smoking one pack per day for the past 30 years um and then she also told me about her surgical history. so 12 years ago she had bypass surgery and then within the past five years she’s also had five stents. her most recent stent was placed one year ago at her left anterior descending coronary artery and her most recent echo which was also one year ago indicated that her left ventricular ejection fraction was at 40%. When I looked at her vitals and even when walking into the room she clearly looked tachypneic. she showed that there was, she had 22 breaths per minute and she was also hypotensive at 80/50. Her oxygen saturation at the time was 86% on room air. so on physical exam um the patient was leaning over and gasping for breath. Um I saw um when I was auscultating her four posts, I saw that she was tachycardic with a split S2 um but I did not hear any murmurs rubs or gallops. Um when I was auscultating her lungs I heard bibasilar rales and then when I was assessing her lower extremity uh I saw one plus pitting edema bilaterally. but her pulses were normal and equal bilaterally. when I was looking at her labs, she had elevated troponin and BNP. Um Her troponin was 0.04 while her BMP was at 4000. her chest x-ray indicated that she had cardiomegaly and pulmonary edema and her echo showed that she had dilated cardiomyopathy with a left ventricular ejection fraction of 30% so if that is a 10% decrease uh from last year’s echo. when I was looking at her EKG the most prominent finding was that she had a left bundle branch block um indicative of that s2 split. Ah she had a normal sinus for them and her uh her heart what did have a left axis deviation, and a left ventricular hypertrophy voltage criteria. so based on her symptoms of shortness of breath and fatigue um that’s been worsening over the past six months, based off her physical exam and all of her imaging I would say that she has ischemic dilated cardiomyopathy. um she is class four for the New York standards of classification, um again her chest x-ray showed pulmonary edema so I will admit her. I believe that is the best course of action to admit her into the ICU and I’ve consulted interventional cardiologist uh for possible automatic implantable cardioverter defibrillator and or a cardiac resynchronization therapy um at this time. And thank you so much for listening to my presentation.

153. Mrs. Leslie is a 62 year old female patient with a history of hypertension presenting today complaining of shortness of breath and general fatigue. Her vitals are a heart rate of 110, blood pressure 130/90, respiratory rate of 20, and oxygen saturation of 91%. she states that her, she had visited her PCP three days ago with similar complaints and was told to go to her, was and was told to go to the ER if she if her symptoms persisted. patient states that around two weeks ago she felt sick with a fever and cough. she thought she had had a cold because symptoms had resolved within five days but the feeling of breathlessness and fatigue remained. She admits that she feels a dull and achy pain, uh sorry a dull and achy discomfort and feels out of breath during slight exercise light exercise which improves with rest. Patient admits that Sleeping supine makes symptoms worse causing her to sleep on her recliner. she denies any. She denies any, taking any other medications for her symptoms. she is an elementary school teacher and thinks that she could have gotten sick from school. She is currently taking lisinopril 10 mg daily for her hypertension, with no allergies and is up to date with her immunizations. Mrs. Leslie has had a catheter, cardiac cath procedure done one year ago with no hospitalizations. she admits that her mother has unfortunately passed away due to breast cancer, while her father Is currently living in a nursing facility suited for Alzheimer’s. She, Mrs. Leslie is also married. Currently she denies any fever or chills but States that she has noticed an 8-pound weight gain. She denies any new rashes, lesions, bruising, or any other skin changes. she also denies any new onset of headaches, hearing, or vision changes, or difficulty swallowing, neck stiffness, or neck stiffness. Patient admits to heart palpitations, slight chest discomfort stating it as dull and achy but denies any pre-syncope. she states that she does not have a cough but has noticed a new onset of wheezing, dyspnea, and orthopnea. Which she improves by sleeping on her recliner. She does, patient denies joint and back pain, but admits to muscle aches and some leg swelling. In terms of Mrs. Leslie’s social history she has a balanced diet and has been able to exercise twice a week twice a week before her symptoms started. She denies any illicit substance use, tobacco or alcohol use and her in, caffeine intake, her caffeine intake consists of drinking one cup of coffee every day. During her physical exam she has, I noticed JVD with no carotid bruits, a regular rate with no murmurs, friction rub, or Gallops. On Cardiac auscultation um she does have a laterally, laterally displaced PMI but no chest tenderness. On lung auscultation, she has bilateral rales and wheezing present. Exam of her extremity show nontender calves, a negative Homan’s sign, plus 1 pedal edema with DP and PT pulses full and equal bilaterally. Her OMM screen showed no significant TART changes and her Chapman points were nontender. I discussed with Mrs. Leslie that her heart rate, respiratory rate, and blood pressure was slightly elevated and advised supplemental oxygen to increase her o2 saturation. Her card, her chest Xray showed cardiomegaly with pulmonary edema. Her 2D echo showed dilated cardiomyopathy with a left ventricle ejection fraction fraction of less than 30% while her EKG showed sinus tachycardia with a right bundle branch block and left axis with premature ventricular contractions. I also advised that her lab values, troponin and BMP were elevated. With BNP being at 4000. I would place, I will place the patient as a new york heart association functional classification of 2 with a slight limitation of physical activity while also admitting the patient to Telemetry since her condition is serious and place a consult with the interventional cardiologist to consult for an AICD CRTD placement um and endomyocardial biopsy, with infectious disease consult to for immunoglobulin or glucocorticoid therapy and a radiologist consult for media enhanced cardiac MRI, nursing interventions include for strict intake of strict intake and output of, my nursing intervention include a strict monitoring of strict intake and output, monitoring of daily weight, and DVT prophylaxis, while also maintaining an oxygen saturation above 96% with nasal cannula with 2 liters per minute. her activity levels can be tolerated while having a slow, low sodium diet with IV fluids to keep her veins open. I would also like to start Miss Leslie on furosemide 40 mg IV every 12 hours and acetaminophen 625 mg by orally, every six hours every six hours, while continuing lisinopril 10 mg daily. The furosemide would be to remove some of the fluid uh to reduce the congestion on her heart, acetaminophen would be for her chest pain, chest discomfort and lisinopril would be for her high, uh hypertension. I would also like to repeat labs including CMP and serial troponin uh given that we are to monitor her cardiac health and electrolyte levels given that we are starting, would be starting furosemide as well as a repeat 2-D echo to evaluate, further evaluate her heart to further evaluate her heart health.

152. She is a 62 Year-old female who presents to the office today with the chief complaint of progressively worsening, constant shortness of breath and fatigue, patient also states that she has been experiencing dull dull chest pain that does not radiate, and is located in the center of her chest. patient states that severity of the chest pain to be two out of 10. Patient’s symptoms began two weeks ago following flu symptoms of rhinorrhea, fever, and cough. flu symptoms ceased five days ago. no medication has been helpful. patient’s symptoms are alleviated with rest and by sleeping in a recliner. and worsened when laying down flat and moderate exercise is conducted. patient is unable to exercise at the gym. review of systems is positive for fatigue, 8 pound weight gain, palpitations, chest pain orthopnea, dyspnea, wheezing, and lower extremity edema. all immunizations are up-to-date. patient has previously been diagnosed with hypertension for which she takes lisinopril 10 mg a day, surgical history includes includes outpatient cardiac catheterization one year ago, that showed normal findings and no coronary artery disease. patient has no allergies or history of hospitalization. patient eats a well-balanced diet and exercises at the gym two times a week but has been unable to do so due to the, due to her condition. um patient does not use any illicit drugs, smoke, or drink alcohol but does drink one cup of coffee a day. she’s an elementary school teacher and lives with her husband whom which she’s in a monogamous relationship with and has been for the last 30 years. patient’s father is 89 and living in a nursing home with Alzheimer’s and her mother is, uh passed away five years ago at the age of 80 to breast cancer. patient was alert uh alert, awake oriented but fatigued and in pain. Physical exam findings show JVD or jugular venous distention with no cardiac bruits. Regular rate was seen and no murmur, friction rub, or Gallop were heard. Bibas bibasilar rales were heard with no chest wall tenderness, one plus pitting edema of the lower extremities was seen, pulses were equal and full on, uh equal and full and calves were nontender. Patient’s vitals showed a blood pressure of 130/90 a heart rate of 110 pulse of 110 respiratory rate of 20 temperature of 98.6 and oxygen saturation of 91%. labs showed elevated troponins and a BMP of 400 4000 chest x-ray showed cardiomegaly, pulmonary edema, and normal mediastinum. echo showed, showed dilated cardiomyopathy with left ventricular ejection fraction less than 30%. An E EKG showed right bundle branch block, left axis deviation, tachycardia, and PVCs. patient was diagnosed with myocarditis dilated cardiomyopathy New York heart Association class 2 due to previous viral infections. Patient was admitted to telemetry in serious condition. vitals uh will be taken every two hours and activity will be as tolerated, nursing interventions will be strict I&O, daily weights, O2 nasal cannula, O2 stats maintained above 96% and DVT prophylaxis, a low sodium diet will be kept and patient will be on fluid lock with KVO. patient will be put on 2 uh 625 mg of acetaminophen by mouth, lisinopril of 10 mg by mouth will be maintained, and furosemide of 40 mg IV will be provided. labs and imaging orders include a repeat uh 2D echo, CMP and serial troponins. consult with radiology will be made for a media enhanced MRI, cardiology will be consulted for an AICD and CRTD placement as well as an endomyocardial biopsy and infectious disease will be consulted for immunoglobulins and uh glucocorticoids.

151. 2 year-old male presents to the emergency department department with complaints of dyspnea fatigue palpitations and the feeling of passing out after going on a walk with friends. He claims it started two weeks ago while on a walk and since then he stopped walking. He stated that the dyspnea felt better while laying down he also stated that it makes him feel weak and tired. In his review of systems generally he just felt fatigued but had no weight loss or gain or fever um. He had no skin no neurological no musculoskeletal problems no headaches no hearing loss no vision change, no trouble swallowing or no stiff neck. He claims to have palpitations but no chest pain. He has dyspnea that is better laying down, so no orthopnea. And he claims to have wheezing but no cough. Um he has a history of hypertension and he had a heart catheter placed an abnormal EKG one year ago. His father died of a myocardial infarction at 59 and his mom died suddenly of an unknown cause at 40. Uh patient is currently on 10 mg lisinopril and he has no known drug allergies. Um patient has a well balance diet exercises daily but stopped two weeks ago when symptoms presented. He has no history of alcohol tobacco or illicit drugs. he drinks one to 2 cups of coffee daily. he’s been married for 30 years and works as an elementary school teacher. Um his his vital signs were 96% oxygen 110 heart rate, temperature of 98.6°F, and a blood pressure of 139, uh 130/90 mmHg. on his physical exam um I found a positive systolic murmur, um his lungs were clear to auscultation bilaterally. No jugular venous distension, no carotid bruits no tenderness to chest palpation no lower extremity edema. His pulses were full and equal bilaterally and his calves were nontender. Um diagnosed him with familial hypertrophic cardiomyopathy secondary to hypertension. Um and I ordered him to be admitted to telemetry under serious condition and his vitals will be checked every two hours, um he can do activity as tolerated. The nursing instructions are to check weight daily, uh and then strict intake and output, uh DVT prophylaxis, nasal cannula, and then maintain O2 greater than 96%. Um he can have a regular diet, like I said he has no allergies, um no labs are needed to be ordered no imaging was needed to be ordered. Um and then for IV fluids keep vein open and then I added uh 100 mg of disopyramide uh by mouth four times a day, and then we’re going to discontinue the lisinopril. Um we’re gonna consult interventional cardiology for an automatic implantable cardioverter defibrillator and then we’re going to consult a cardiothoracic surgeon for septal myectomy and alcohol injection. Thank you. 2 year-old male presents to the emergency department department with complaints of dyspnea fatigue palpitations and the feeling of passing out after going on a walk with friends. He claims it started two weeks ago while on a walk and since then he stopped walking. He stated that the dyspnea felt better while laying down he also stated that it makes him feel weak and tired. In his review of systems generally he just felt fatigued but had no weight loss or gain or fever um. He had no skin no neurological no musculoskeletal problems no headaches no hearing loss no vision change, no trouble swallowing or no stiff neck. He claims to have palpitations but no chest pain. He has dyspnea that is better laying down, so no orthopnea. And he claims to have wheezing but no cough. Um he has a history of hypertension and he had a heart catheter placed an abnormal EKG one year ago. His father died of a myocardial infarction at 59 and his mom died suddenly of an unknown cause at 40. 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Um and I ordered him to be admitted to telemetry under serious condition and his vitals will be checked every two hours, um he can do activity as tolerated. The nursing instructions are to check weight daily, uh and then strict intake and output, uh DVT prophylaxis, nasal cannula, and then maintain O2 greater than 96%. Um he can have a regular diet, like I said he has no allergies, um no labs are needed to be ordered no imaging was needed to be ordered. Um and then for IV fluids keep vein open and then I added uh 100 mg of disopyramide uh by mouth four times a day, and then we’re going to discontinue the lisinopril. Um we’re gonna consult interventional cardiology for an automatic implantable cardioverter defibrillator and then we’re going to consult a cardiothoracic surgeon for septal myectomy and alcohol injection. Thank you.

150. Okay, Hi Dr. Rawlins, I just saw Leslie Palmer in room seven. he is a 62-year-old male who presents today with dyspnea and fatigue with more than ordinary movement for the past two weeks. He also admits some palpitations and wheezing with exertion but denies any chest pain. He said resting resolves his symptoms and he is comfortable at rest. he denies any recent illness prior two weeks ago. His active medical conditions include hypertension for which he takes lisinopril 10 mg daily. He denies any prior hospitalizations, but surgical history includes a cardiac catheter one year. He had not received any results from it but when his recent symptoms began, he called the office and they told him they did not find anything and so they referred him here. he is married and lives with his spouse, is sexually active and is in a monogamous relationship. he notes he has a balanced diet and denies alcohol, tobacco, or illicit drug use. He has one cup of coffee every day, prior to two weeks ago he walked daily with a group which he considered a social activity for him as well and he would like to get back to doing that. he is also a sixth grade teacher. He had told me that his father died at the age of 59 from a myocardial infarction and his mother died suddenly at the age of 40. His physical exam showed no edema, negative Homans sign, nontender and equal sized calves. And a nontender chest with palpation. he has a systolic murmur and laterally displaced PMI. His lungs are clear to auscultation bilaterally. I evaluated Chapman’s points, TART changes, and thoracic spine and did not find any osteopathic findings. He did not have any JVD or carotid bruits, his chest x-ray showed cardiomegaly and his echo showed left ventricle asymmetric ejection fraction of 60. His EKG showed normal sinus rhythm, tall R waves in the septal leads and left ventricular hypertrophy. His labs were all negative. From my findings, I believe he’s suffering from NYHA class 2 familial hypertrophic cardiomyopathy. I explained to him that I believed it had genetic cause. I recommended that we admit him to telemetry and consider consult with interventional cardiology for AICD placement and cardiothoracic surgery for septal myomectomy and alcohol injection. I also believe that we should discontinue his lisinopril and switch him to disopyramide. And keep his activity as tolerated. Thank you.

149. Female patient Miss Leslie Palmer who came into our emergency clinic uh for shortness of breath. 2 weeks ago this patient experienced cough, fever, runny nose, and a dull pain in her chest. Um that illness is since uh since resolved but their shortness of breath has either gotten worse or uh just not gotten better. Uh patient is in our emergency department after seeing her family care practitioner uh three days ago uh and they were encouraged to come in the ER as their shortness of breath did not improve. Patient has experienced dyspnea and orthopnea only relieved by sitting or sleeping in the recliner. Patient has also experienced chest pain uh pressure and dullness, a dull ache in their chest pain. Uh pain is constant and rated as a two out of 10. Okay, uh patient is, has also has also experienced an increase in 8 pound weight gain over the past week or so um along with the experiencing fatigue, fever but no chills, uh patient is also experiencing muscle aches but no headaches no neck tenderness or no neck tightness, no dizziness no confusion. Um along with the chest pain patient is also experiencing palpitations and fluttering in her chest, uh but no pre-syncopal episodes. for past medical history patient history of hypertension for the past 10 years that’s been well-controlled. Patient’s taking lisinopril for the hypertension 10 milligrams one time per day. And is diligent with her medication. Patient has no known drug allergies. uh patient one year ago did go for a cardiac catheterization uh for an abnormal EKG but catheterization showed no um no remarkable findings. Uh no previous hospitalizations, um and no pertinent medical history from uh from her mom or dad or siblings. Uh patient is up to date with her current immunizations. Patient has no history of uh illicit drug use, no tobacco use, no alcohol use. One cup of coffee every morning. Um along with before these this uh current episode of illness um regular exercise regularly and was on a balanced diet. Uh for my physical exam, I found that the patient had jugular venous distension bilaterally, um when palpating the inferior lateral chest wall um midclavicular chest wall on the left side, I noticed the point of maximal impulse for the heart had been shifted laterally. Um upon auscultating, the uh both lungs, um I heard bilateral rales and wheezing um in both the front and back um and plus one pitting edema uh in the lower limbs below the knee. Her Pulses were pedal pulses were were bilateral strong and uh equal. Um for the patient’s labs or, I’m sorry for the patient’s vitals, the heart rate is 110, respiratory rate is 20. temperature of 98.6, blood pressure 130/90. And a pulse oximeter of 91%. for the chest x-ray, uh the patient’s chest x-ray showed pulmonary edema and cardiomegaly. the Doppler or the um 2D echo showed uh dilated cardiomyopathy with an ejection fraction of less than 30 percent. Uh labs came back with elevated troponins and elevated um brain natriuretic peptide at 4000 and EKG showed sinus tachycardia, right bundle branch block, left atrial um sorry left axis deviation, along with a premature ventricular contraction. So I would like to admit this patient to the hospital for myocarditis with dilated cardiomyopathy. Um I’d like to admit to telemetry for uh constant cardiac monitoring. patient’s condition is serious. Uh no known drug allergies. Vitals uh I would like vitals taken every 2 hours, um activity as tolerated for the patient, nursing orders strict I/O daily weights taken DVT prophylaxis O2 nasal cannula um to make sure that her o2 saturation stays above 96% for diet while she’s in the hospital I’d like low sodium and oral fluid restriction. Um I’d like to get a saline lock setup, to keep the vein open for medication’s I’d like the patient to consider, to continue their lisinopril 10 milligrams once per day. I want to start the patient on acetaminophen 625mg every 6 hours along with starting furosemide IV uh IV 40 mg. Uh I would like the following labs, troponin continuous troponin levels, I’d get a CMP ordered for electrolytes and a repeat echo 2D echo um to image the heart. I’d also like to consult 3 different physicians, um interventional cardiology to talk to the patient about an implantable cardioverted defibrillator along with resynchronization device um for those to be placed for the patient. Um and also while we’re doing that, I’d also like to get an endomyocardial biopsy to determine the infectious agent. Then I’d like to talk to infectious disease as far as getting, starting the patient on immunoglobulins or glucocorticoids and I’d also like to consult the radiologist to get a contrast media enhanced MRI uh to get a clear higher resolution picture of the heart. Okay if you have any questions please let me know.

148. Case of Cardiac sarcoidosis. Um the patient presented in the clinic this morning feeling fatigued, shortness of breath, and fluttering of the chest for the past 2 months. She was saw seen by her primary care provider and it prompted her a visit to the ER. Her shortness of breath is worse when lying down and she’s experiencing near syncope. Upon reviewing um doing a review of systems of the patient she reported feeling fatigue, has experienced an 8 pound weight gain over the past couple of weeks, is experiencing um palpitations on top of the pre-syncope. um is exper, is especially exaggerated whenever she uh exerts herself and whenever she uh lies down. So orthopnea and has noticed some edema in her legs, the patient has a history of hypertension for which she takes 10 mg of lisinopril everyday and has a history of pulmonary sarcoidosis for which she takes prednisone 10mg a day. And she has a previous um cardiac catheterization history. Um the patient’s mom passed away of a sudden cardiac death and the patient father died of a heart attack. The Patient has been married for about 25 years and says that she has good social support . She eats a well balanced diet and walks for exercise. She does not report any history of tobacco, smoking, illicit drug use, or alcohol use. She drinks about 1 cup of coffee per day. And she’s living with her husband. She reports no um allergies to any medications um her vital signs a slightly elevated heart rate of 110 respiratory rate is a little bit elevated of 20 blood pressure of 136/99 which is elevated but not too concerning and oxygen saturation is low at 91%. Upon reviewing her lab work I saw an elevated bnp of 4000 and her chest xray showed pulmonary edema, um mediastinal fullness and a normal cardiac silhouette. Her cardiac echo showed rigid ventricular wall motion indicating restrictive hypertrophic, um no just restrictive cardiomyopathy. Um an ejection fraction of 55%. Which is preserved. And the ekg showed non sustained ventricular tachycardia with a normal sinus rhythm of 100 and a normal axis. Her physical exam was positive for JVD, lower extremity edema uh heart murmur, wheezing and bibasilar rales given the medical history, lab work and physical exam I am diagnosing the patient with cardiac sarcoidosis as my leading differential diagnosis. I admitted this patient to the hospital for telemetry and the patient is in a serious condition especially with the nonsustained vtach um I am going to monitor the patient’s vital signs every 2 hours and she will need assistance as she gets out of bed. For nursing instructions I prescribed strict Is and Os daily weight DVT prophylaxis o2 via nasal canula and maintaining an o2 stat of greater than 96% I prescribed her a low sodium diet as well for iv um kvo keeping the vein open and a saline lock. The medications I would like to continue for her is lisinopril um keep her on the 10 mg but I would like to increase the prednisone to 60 mg I would like to add amiodarone 150 mg iv and add furosemide 40 mg Iv um I would like to do repeat uh repeat um cmp, complete metabolic panel as well as follow up with interventional cardiology for ACID placement and pet scan with nuclear medicine. Thank you and that completes my case.

147. Mr. Palmer is a 62 year old male presenting with a chief complaint of shortness of breath and fatigue Mr. Palmer states that a couple of weeks ago he was walking with his friends and had shortness of breath palpitations wheezing lightheadedness and feelings of painting that continue um to occur when exercising he states symptoms go away at rest. patient has history of hypertension for which he takes lisinopril 10 mg every day and family history of sudden death with his mother and his father had a heart attack at 69 years old. patient also has history of cardiac Catheterization but no other surgeries or procedures. patient vitals were normal with oxygen at 96%. And respiratory rate of 16 except for elevated heart rate at 110 beats per minute and blood pressure of 130/90. patient is a math teacher living with his husband and follows a balanced diet with a cup of coffee a day and does not drink or smoke. Patient is unable to exercise due to symptoms. um patient had fatigue wheezing presyncope but no chest muscle or joint pain. patient does not have orthopnea fever chills weight changes gait changes headaches stiffness dysphasia confusion dizziness vision changes or hearing loss. patient’s physical uh exam showed PMI displaced laterally. no chest wall tenderness, positive jugular vein distention rales, wheezing no cough regular rate. No regurg murmurs, or gallops. patient had positive uh pedal pulses and pedal edema and nontender calf. Patient’s osteopathic screening exam displayed no Tart changes, and no chapman points were tender. patient’s chest x-ray showed cardiomegaly EKG displayed sinus rhythm, normal axis, left ventricular voltage criteria, tall R wave in septal leads. Um echo showed hypertrophic cardiomyopathy with left ventricle asymmetric um an increased intervention intraventricular septum hypertrophy. An ejection fraction of 60%. labs of troponins and BMP were within normal limits. patient was informed of his diagnosis of familial hypertrophic cardiomyopathy and new York heart association class 2 heart failure and informed of admission to telemetry. Discontinuation of lisinopril, starting of disopyramide 100 mg patient was referred to interventional cardiology for AICD placement and cardiac surgeon for a septal myectomy and alcohol injection. patient is to exercise as tolerated, um follow regular diet have oxygen cannula maintain oxygen above 96%. I’m giving DVT prophylaxis and use daily weight strict input output and vitals checked every two hours. patient had no additional questions and has support from husband OK.

146. Today I saw Mr. Leslie Palmer, he is a 60 62 year old male presents to the emergency room room with the chief complaint of I feel I feel short of breath and fatigued. He was referred to the emergency room by his family medicine physician. The patient indicates the symptoms of dyspnea fatigue started 2 weeks and getting worse. And the symptoms with any physical and he has symptoms with any physical activities and that improves with rest. his vitals are as follows afebrile 98.6°F blood pressure of 130/90 indicating hypertension stage 2, tachycardia with a heart rate of 110 beats per minute, his blood oxygen level is at 96 within normal limits. Um past medical history for Mr. Palmer he had a 10 year um medical history of hypertension. past surgery includes a cardiac catheterization with a obstructive coronary artery disease found, family history mom died suddenly at the age of 40 dad died of a myocardial infarction infarction at the age of 59. Um mr. palmer he follows a a well-balanced diet, he exercise regularly he doesn’t use any drugs illegal drug, he doesn’t smoke, he doesn’t drink alcohol and he has a normal Intake, he is an elementary teacher and currently he’s married in a monogamous relationship uh medication taken are lisinopril for hypertension and he reports no known drug allergies. In today’s visits um the review of system includes um fatigue, there’s no fever, no chills, no weight gain, or loss, um the skin is negative for any for any changes. The head, HEENT, head, ear, eye, nose, and throat is negative for pain and changes. cardiovascular examination um it it shows a sinus rhythm is positive for a systolic murmur and a s4 heart sound. And a gallop. there’s no regurgitation present. Um The pmi is displaced laterally. Including um there’s no uh bruits heard over the carotid, there’s no jugular distension. The lungs are clear auscultation. The calf is non-tender, no pedal edema, dorsal pedis and posterior tibial pulses are full and equal. Mr palmer was diagnosed with a familial hypertrophic cardiomyopathy. Is confirmed by the echocardiogram showing left ventricular asymmetry um the ekg shows um tall r wave and septal waves also um indicates um left ventricular hypertrophy. Voltage criteria. The labs troponin and uh brain um brain natriuretic peptide. Were within normal. Um mr palmer falls in the new York heart association functional classification of marked limitation of physical activity .um Patient is admitted to telemetry. He’s in serious condition. vitals will be taken twice twice every 2 hours. Activity as tolerated. Um nursing interventions, strict IO, daily weight um oxygen um administer via nasal canula maintain at 96% he is also gonna be given DVT prophylaxis. His diet’s gonna be regular. IV fluids um we’re gonna keep the vein open. For medications, there’s no medication for pain, um medication for cardiovascular is gonna be disopyramide 100mg per per mouth um twice a day, four times a day um in addition to that uh he will be consulting the mr palmer is gonna consult interventional cardiologist and a cardiothoracic surgeon, um the cardiologist is gonna put a AICD placement. Automated implantable cardio defibrillator um septal myectomy. We perform an alcohol injection will be performed by the cardio cardiothoracic surgeon. Recording.

145. Miss Leslie palmer is a 62 year old white female with a history of hypertension who presents to the ED today with 5 day history of chest pain shortness of breath and dyspnea on exertion. She reports that she had cold like symptoms 2 weeks ago including fever, cough and sneezing. When her current symptoms began 5 days ago she reports that her sneezing coughing and fever had subsided but that she now had persistent dull chest pain shortness of breath and fatigue which was not improved by anything. She was evaluated at her PCP’s office 3 days ago when her symptoms did not improve, she was prompted to go to the hospital. She also notes that she cannot lay down at night to sleep because she has trouble breathing. She reports wheezing and heart palpitations and of note she is up to date on all of her immunizations. Her vitals include heartrate of 110 beats per minute blood pressure of 130/90 o2 sat on room air was 91% with a respiratory rate of 2 of 20 and her temperature was 98.6 her past medical history includes a cardiac cath one year ago she notes no known drug allergies. Her hypertension is controlled with lisinopril 10 mg daily by mouth. Her family medical history is positive for breast cancer in her mother who died at 80 years old and her father has Alzheimer’s at age 89 and lives in a nursing facility. She reports that her diet is balanced and regular and reports that she used to exercise frequently but has not been able to recently due to shortness of breath and fatigue. She denies any alcohol tobacco or illicit drug use but reports that she drinks one cup of coffee in the morning. She’s a 3rd grade elementary school teacher and is married with a husband. She on review of ROS she notes a weight gain of 8 pounds in the last 2 weeks, she noticed that her heart can feel like it is racing at times but denies any syncope or presyncope. She reports wheezing, shortness of breath, dyspnea on exertion, and orthopnea with bilateral edema of her lower extremities. I proceeded with the physical examination and found positive JVD bibasilar rales wheezing equal pulses bilaterally in the lower extremities and upper extremities with 1 plus pitting edema. She had no carotid bruits and no murmurs rubs or gallops. Her pmi was displaced laterally on her labs it showed an elevated troponin and BNP. Her chest xray showed cardiomegaly and pulmonary edema with patchy infiltrates her ekg showed sinus tachycardia, a right bundle branch block left axis deviation with PVCs her 2D echo showed dilated cardiomyopathy with an ejection fraction of less than 30%. With these findings, I diagnosed her with myocarditis with dilated cardiomyopathy and I admitted her to telemetry in serious condition with nursing checks every 2 hours and a low sodium diet and npo fluid restriction. She’s able to move around as tolerated but will receive o2 via nasal canula with a sat greater than 96%. Dvt prophylaxis Is and Os and daily weights will also be taken. I continued her current medication of lisinopril at 10 mg by mouth everyday. Started her on acetaminophen 625mg by mouth as well as furosemide 40 mg iv with a KVO saline lock. I also ordered a CMP, serial troponins and a repeat 2d echo while she’s admitted. I will consult with interventional cardiology for a possible aicd versus crtd placement and a possible endomyocardial biopsy I will also consult with radiology for an enhanced mri and with infectious disease for an immunoglobulin and glucocorticoid assessment. She has insurance and states that her husband will be able to support her through this time in the hospital. The patient was counseled appropriately had no further questions for me and understands and agrees to the treatment plan. Thank you.

144. Leslie Palmer is a 62 year old female patient who came to the emergency department today complaining of progressive shortness of breath and fatigue for two months she also reported an incident of palpitation and presyncope two months ago which occurred in her home three days ago the patient was seen by her primary care physician for her symptoms but when these symptoms worsened today she was advised to go to the emergency room today she reports of worsening dyspnea orthopnea and wheezing that occur with most activities and relieved only with rest. she sleeps sitting up in a recliner to help with her breathing when she sleeps. her symptoms have not been relieved by any medications or interventions thus far patient history is positive for hypertension sarcoidosis for which she takes lisinopril 10 mg and prednisone 10 mg daily she denies any allergies to medication’s her family history is positive for sudden death on the maternal side and myocardial infarction on the paternal side. patient reports having a cardiac catheterization performed one year ago with all results normal at that time the patient denied any history of tobacco alcohol or drug use she reported having a balanced diet with one cup of uh daily coffee and used to walk daily with friends prior to the onset of recurrent symptoms she lives at home with her husband and works as a fifth grade teacher. additional symptoms reported include 8 pound weight gain in two weeks time and lower extremity swelling skin HEENT and neurological symptoms and systems were all negative. Patient’s vitals today read as having a blood pressure of 136/99 heart rate of 110 respiratory rate of 20 and oxygen saturation at 91% the patient was awake alert and oriented though fatigued and was seated leaning forward at the start of the exam. Carotid bruits were negative but jugular venous distention was present upon examination. cardiac exam revealed a systolic murmur with an S4 Gallop, and lung exam revealed rales and wheezing bilaterally. Her abdominal screening was negative bilateral pitting edema of the lower extremities was also observed with a patient denying any pain osteopathic screening revealed ropiness at the levels of T4 through T6 on the right side of the patients thoracic back uh spine. This patients labs were significant for an elevated BNP echocardiogram revealed a restrictive myo uh cardiomyopathy and chest x-ray showed pulmonary infiltrates bilaterally with mediastinal fullness. EKG showed a nonsustained ventricular tachycardia. this 62 year-old patient with a history of hypertension and sarcoidosis has major presenting problems of progressive dyspnea and fatigue with additional symptoms of palpitations and pre-syncope. The most likely diagnosis is restrictive myocardiopathy due to sarcoidosis I recommended admitting the patient to telemetry for full-time cardiac observation in addition to consulting interventional cardiology for possible AICD placement and radiology for FDG pet scan. for medication’s I recommended with continuing her lisinopril increasing her prednisone dosage to 60 mg and adding Iv furosemide and Iv amiodarone. The patient consented with this plan.

143. Hi, Leslie a 63 year old elementary school teacher presented today with worsening tiredness and shortness of breath over the past 2 months. Um dyspnea occurs with most activity but it improves with rest. Her medical history included Hypertension pulmonary sarcoidosis and she had a surgical history of cardiac catheterization. she her parents had a history of sudden death and myocardial infarction and she currently lives with her husband. She’s currently on lisinopril 10 milligrams four times a day and prednisone 10 milligrams four times a day on doing the physical exam and review of systems I found fatigue weight gain jugular venous distention palpitations murmur gallop wheezing dyspnea orthopnea rales and lower extremity edema. The lab results showed ventricular tachycardia normal sinus rhythm mediastinal fullness and pulmonary edema. my assessment is sarcoidosis restrictive cardiomyopathy. And The plan includes telemetry admission with vital signs checked every 2 hours assisted ambulation low sodium diet with strict monitoring. Deep vein thrombosis prophylaxis, oxygen maintenance and daily weight checks. Regarding medication I want to continue lisinopril, and increase prednisone 60 milligrams four times a day and I also wanna administer amiodarone and furosemide intravenously. Amiodarone for 150 milligrams and furosemide for 40 milligrams. um I would like to perform a comprehensive metabolic panel as well due to the furosemide usage and for consultations I would like to consult interventional cardiology for AICD placement and radiology for FDG pet scan.

142. Hello the female patient presents to the emergency department with chief complaints of shortness of breath and fatigue. patient also notes a dull chest pain patient was awake alert and oriented these symptoms began gradually over the last two weeks the patient mentions that she is able to rest comfortably but has some difficulty with physical activity which causes shortness of breath and fatigue causing her to be at a NYHA class 2. The symptoms began two weeks ago which was when she developed an infection that caused the runny nose cough and fever and that is when the symptoms began. patient has orthopnea so she has been sleeping in a chair at night. her past medical history is of hypertension she had a cardiac Cath one year ago which she reported went well. her mother passed away at age 80 due to breast cancer and her father is in a nursing facility for Alzheimer’s disease. Patient reports a balanced diet no drugs no tobacco no alcohol one caffeinated beverage a day. is a fifth grade elementary school teacher would exercise two times a week at the gym before the symptoms began and has been married for many years she has no other hospitalizations reported patient has hypertension and is taking 10 mg of lisinopril and she has no known allergies. in regards to the review of symptoms patient generally generally reports fatigue and an 8 pound of unintentional weight gain. in regards to the skin, there are no abnormalities noted in regards to HEENT there are no abnormalities noted in regards to neurological problems there were no abnormalities noted. in regards to cardio cardiological symptoms the patient reports a dull chest pain. In regards to the pulmonary system, the patient reports orthopnea wheezing. In regards to the musculoskeletal system the patient reported muscle aches, peripheral edema and joint pain. In regards to the physical exam there was notable wheezing DPPT pulses were full and equal bibasilar rales, calf is nontender regular heart PMI is displaced laterally, no chest wall tenderness no carotid bruits and plus one pitting edema. vital signs showed a heart rate of 110 oxygen of 91% 98.6°F for her temperature, her heart rate was 110 and her blood pressure was 130/90 troponin level was slightly elevated at 9.1 MG/ML and BP was elevated to 4000 and PT/ML. chest xray displayed pulmonary edema and cardiomegaly echo showed dilated cardiomyopathy EKG had sinus tachycardia right bundle branch block left axis deviation and premature ventricular contraction all vitals lab and imaging results were discussed with the patient as well as treatment planned as well as treatment plan. patient will be admitted to telemetry for the uh diagnosis of myocarditis dilated cardiomyopathy her condition is serious. With vitals needed every two hours her activity is allowed as tolerated and the nursing intervention includes strict I/O daily weight DVT prophylaxis oxygen via nasal cannula and maintenance of oxygen stat at 96%. she has to have a low sodium diet with kVA of IV fluids and her medication will be lisinopril 10 mg PO acetaminophen acetaminophen 625 milligrams PO every six hours for chest for her dull chest pain. And furosemide 40 mg by iv. She will also have KVO during her hospital visit for the entirety of her hospital admission. She will need serial troponins CMP and a repeat 2-D echo. she’ll need a few consults including an interventional cardiologist for CRTD and AICD placement as well as a right ventricular endomyocardial biopsy and then an infectious disease specialist for immunoglobulins or glucocorticoids and then a radiologist for MRI. the patient arrived with her husband waiting outside and she had no further questions. Thank you.

141. So Patient is mr Leslie palmer who is a 62 year old male history of hypertension he is presenting with shortness of breath and fatigue that started 2 weeks ago and is worsening. Patient states that he was walking with his friends when he felt symptoms onset onset. Patient takes uh lisinopril 10 milligrams once a day um because of hypertension. He says that he is compliant with his medications. He did not take his lisinopril before coming to see us today he uh describes his shortness of breath and fatigue as generalized um symptoms are exacerbated by exertion and relieved by rest at rest he is OK he can breathe normally. Symptoms are intermittent and is rated 7/10. Uh for ROS positives were wheezing presyncope fatigue and palpitations. his vitals were 130/90 for blood pressure, heart rate 110 O2 sat 96 which he will be put on a nasal canula which I was told, I told him and temperature was 98.6 patient has surgical history of a cardiac cath that was done one year ago which came back normal at the time. Uh pertinent familial history is his father died from an MI at 59 and mother died from sudden cardiac death at 40. physical exam physical exam findings were positive for a systolic murmur with an S4, a PMI was laterally displaced and there was a gallop heard. There’s no JVD, no carotid bruit heard. Lungs were clear to auscultation bilaterally and abdomen showed no bruits or uh no pulsatile masses there was no edema in the lower extremities. Peripheral pulses were present equal bilaterally. Um the chest xray showed cardiomegaly the echo showed a thickened interventricular septum with left ventricular um hypertrophy and left atrium enlargement. There was global hyperkinesia with ejection fraction of 60%. Ekg showed a left ventricular hypertrophy left ventricular hypertrophy with a large r wave in septal leads um and it had a normal sinus rhythm. Patient states he has a well balanced diet, he walks daily, exercises daily, he denies tobacco or illicit drug use. No alcohol use. Patient is a school teacher and married for 35 years with his wife. Um So based off the presentation, patient was diagnosed with a familial familial hypertrophic cardiopathy nyha class 2 um he was told that he would be admitted into the hospital and he will we will be discontinuing the lisinopril and adding in disopyramide um I also notified patient that I will be referring him to a inner uh interventional cardiologist and cardiothoracic surgeon for potential sub sectomy or alcohol injection.

140. Leslie Palmer is a 62 62 year-old female presenting in the ER today with a chief complaint of shortness of breath and fatigue she states that this has been going on for six months now it has gradually gotten worse she went and saw her family doctor with symptoms 3 days ago and they referred her here she states shortness of breath with all activity and at rest um she sleeps in a chair sitting up at night because of orthopnea she currently has diagnoses of hypertension hyperlipidemia diabetes and a fib surgical history consists of a triple bypass graft procedure and an LAD stent placed one year ago in June 2022 current medication’s include lisinopril 10 mg orally once a day atorvastatin 10 mg orally once a day clopidogrel 75 mg orally two times a day metformin 500 mg twice a day furosemide 20 mg orally twice a day and metoprolol succinate metoprolol succinate orally 50 mg once a day. And then warfarin 2.5 mg orally twice a day family history um was mother passing passed away from breast cancer and father is alive with Alzheimer’s in a local nursing home um miss Palmer is an active smoker of 30 years and has considered quitting and would be open to learning about her options before feeling shortness of breath miss Palmer was active and is consistent with her balanced diet no alcohol use and no illicit drug use she is married and lives in a supportive household with her husband and as an elementary school teacher she has insurance coverage through work vital signs show a temperature of 98.6 heart rate of 90 BP blood pressure of 80/50 respiratory weight rate of 20 and O2 sat of a 86% pertinent physical exam findings showed positive JVD lower extremity edema and PMI displaced laterally. Upon auscultation tachycardia with split S2 rales and wheezing were heard. Calves were nontender and pulses were equal and strong bilaterally lab results showed elevated troponins levels of 0.04 and elevated BP BNP of four thousand chest x-ray showed showed cardiomegaly and pulmonary edema EKG findings depicted sinus tachycardia with a left bundle branch block present and ventricular hypertrophy voltage criteria. 2d echo show dilated cardiomyopathy with a left ventricular ejection fraction of less than 30%. all exam findings tests and imaging indicate diagnosis of ischemic dilated cardiomyopathy with um functional class 4 class D heart failure with a reduced ejection fraction of 30% with pulmonary edema and paroxysmal atrial fibrillation. Secondary dia diagnoses are hypertension high cholesterol and the diabetes. So Miss Palmer will be admitted to in serious condition to the ICU with vital checks every two hours and on strict bed rest. nurses will maintain strict intake and output daily weight checks and DVT prophylaxis. um diet in the hospital will consist of a low sodium diet and patient will be kept on saline lock keeping veins open. holding all medication’s except for clopidogrel 75 milligrams every day and the warfarin 2.5 mg BID. Um I’d like to add a dobutamine IV drip and insulin sliding scale as well as a respiratory therapy of bipap um with 50%. patient has been informed of all medication changes serial troponins levels and PT INR labs are ordered with no additional imaging at this time I will consult with interventional radio cardiology for CRTD and AICD placement. education about maintenance of health healthy diet weight reduction and no strenuous exercise until released by a physician has been covered with the patient.

139.

A 62 white male mr Leslie Peterson presented to clinic today with chief complaint of dyspnea and fatigue, the patient notes dyspnea and fatigue for six months with exacerbation in the last few weeks. the patient visited primary care physician and upon preliminary review was recommended to visit emergency Department the patient has a long history of hypertension hyperlipidemia diabetes and atrial fibrillation. The patient underwent coronary artery bypass grafting as well as stenting in the LAD and the patient notes that they were indicated they are no longer a candidate for stenting. The patient’s past medical history includes or past um current medication list includes metoprolol succinate, metformin, lisinopril, atorvastatin clopidogrel warfarin and atorvastatin the patient was active prior to exacerbation of symptoms but is no longer able to exercise nor continue with activities of daily living living the patient presents with fatigue generalized fatigue exercise and resting dyspnea orthopnea and the patient was unable to indicate a localization of the fatigue or the pain um or muscle weakness there is no time constraint on symptoms as they occur throughout the day upon physical exam I noted plus one bilateral pitting edema on the lower extremity as well as rales and wheezing with an s3 heart sound the patient’s vitals were 90 heart rate of 90 o2 of 86 and blood pressure of 80/50. The patient was counseled as they presented concern um the patient is used to seeing hypertensive values. The patient does indicate weight gain of 8 pounds over the last few weeks um upon review of labs and labs indicated elevated troponin as well as elevated BNP brain natriuretic peptide reviewing imaging chest x-ray is positive for pulmonary edema as well as cardiomegaly echo indicates left ventricular and left atrial dilation with a reduced ejection fraction of 30% EKG indicates left axis left axis deviation with a left bundle branch block as well as pathological deep q waves in septal leads 2 and 3. The patient was counseled that they will be admitted um patient was counseled that they are experiencing ischemic dilated cardiomyopathy and will be admitted to the ICU for close monitoring. The patient was indicated to discontinue all medications except for clopidogrel and warfarin and was also noted that due to ekg changes and conduction due to dilation the patient will be started on dobutamine for inotropy and um to assist with hypovolemia. The patient will be admitted to the ICU with follow up serial troponins received. The interventional cardiology will be consulted for AICD and CRTD placement and the patient was aware is aware of this. The patient is on bed rest with nursing orders placed.

138. male patient presents to the emergency room um after the uh at the request of his primary care physician. Um he had uh fatigue and uh was tired um the symptoms only uh came about whenever he was well they were pretty constant um they occur when he was at rest um they occurred at any amount of exercise if he stood up um he had symptoms uh so dyspnea and orthopnea um he uh also presented with uh pitting edema um he his past medical history uh was hypertension high cholesterol he had diabetes and he also have a fib um he had no drug allergies um his family uh history was significant for uh his dad um uh is 89 and currently has Alzheimer’s his mom uh died at 80 of breast cancer. Um His surgical history Is that 12 years ago he had uh had open heart surgery un uh CABG um of the three vessels then he had a stent placed um each of the last five years um and the last one was uh for the left anterior descending artery um and his last echo showed uh ejection fraction of 40 percent uh his medications are uh he was on lisinopril uh 10 milligrams atorvastatin um clopidogrel um he was also on furosemide methyl uh succinate um he was also on uh metformin um and he also was on warfarin. Uh his review of systems uh was significant for uh fatigue um and also he had a weight gain of 8 pounds. Um like I said he had dyspnea and orthopnea he also presented with wheezing. Um his musculoskeletal exam uh or his review systems uh was significant for edema um he he didn’t have uh significant edema in his uh lower extremity um also he presents he uh claimed that he had a balanced diet and he uh usually exercises um used to but recently has not been able to um because for the last 6 months he uh has had these symptoms and they have gotten progressively worse. Um he rated them at a severity of 8 out of 10 uh he does smoke a pack a day um and the patient was um informed that if he did ever decide to quit that we do have resources available for him. Uh he does have a cup of coffee in the morning and uh he is a teacher an elementary school teacher he is married and is in a monogamous relationship and he is sexually active. um he uh he also um had a heart rate of 90 um his O2 was 86 uh he had a blood pressure of 80 over 50 a respiratory rate of 22 um and a temperature of 98.6 um these vitals were discussed with the patient and um we did uh have a plan in uh told him a plan. Um that plan was to admit him to the icu um among other nursing among multiple nursing orders he was um going to be um put on bed rest um vitals checked every 2 hours um we’re gonna hook him up for bipap um we’re going to give him uh so I would like to say that after reviewing the patient’s vitals he had a um heart a new York heart uh association um score of uh 4 uh because of his symptoms uh even while at rest. Um the patient’s um lab results and uh and uh echo results and ekg results um showed that he had a uh ischemic um cardio um dilated cardiomyopathy. He um his ejection fraction was at uh 30% uh his x-ray showed cardiomegaly and pulmonary edema. He uh did have a normal sinus rhythm but there was a left bundle branch block present. Uh his troponin was elevated his labs um did only slight troponin elevation. And uh his labs bnp was elevated at 4000. Um the patient was informed that he had ischemic cardio um dilated cardiomyopathy um the nurse was uh instructed uh to uh include daily weight um strict um food plan diet plan and also DVT prophylaxis diet was limited to low sodium um iv fluids were uh KVO um to keep the veins open uh no pain medicine was ordered but the patient was kept on clopidogrel and warfarin and moved um to dobutamine and also uh insulin sliding scale as well. No diuretics were ordered. Um the diagnosis labs were PT PTT INR um and serial troponins PTT INR uh was ordered to monitor um the uh where he is on blood thinners and then the serial troponin was just to uh recheck the troponin levels to uh just make sure no MI was taking place or anything along those lines. um Patient was referred to an interventional cardiologist um for AICD placement and CRTD placement. Um other than that um patient was um seemed to be alert and uh was not um was not um didn’t seem to be in drastic pain but did present with uh with with um prevalent symptoms um just looking through the uh patient’s medical history again um to make sure that I didn’t leave anything out. Um patient did note that uh when they went to bed uh that the symptoms did get much worse. Uh they had no illicit drug use alcohol use um the review of systems was negative for uh HEENT cardio neuro and skin. Um no allergies were present. And uh there was a uh the patient did present with um carotid bruits uh excuse me no carotid bruits but uh jugular venous distention was was noticed. Um there uh was also um tachycardia with a split s2 uh and the pmi was displaced laterally and the walls did show bibasilar rales um there was plus 1 1 plus pitting edema in the lower extremities um pulses were intact um yeah and the patient did have normal sinus rhythm on the ekg thank you

137. Palmer is a 62-year-old woman who presents to the Emergency room complaining of shortness of breath, fatigue on exertion and chest pain patient for 5 days patient states that uh the symptoms began following two weeks of flu-like symptoms including cough fever and shortness of breath. Patient states that pain is substernal dull constant and does not change upon exertion it does not improve or worsen patient states that she has no family history of cardiac issues patient states that she at one point had a a cardiac Cath one year ago that the it showed no negative results patient has a history of hypertension and is currently taking lisinopril daily 10 mg daily review of symptoms showed fatigue, palpitation, chest pain, dyspnea and wheezing on the patient. Patient’s vital signs were 110 pulse respiration 20 blood pressure 130/90 and then oxygen saturation of 91% physical exam showed jugular vein distension bibasilar rales pitting edema and laterally displaced point of maximal impulse. Her lab tests showed troponin of .1 and a BNP of 4000. Chest Xray showed pulmonary edema and cardiac ah cardiomegaly sorry uh her echo showed a left ejection fraction of less than 30% as well as a dilated left ventricle. Her ekg showed a left axis deviation a right bundle branch block and pre-ventricular collapse contraction sorry patient was admitted to telemetry patient was diagnosed with dilated myocardiopathy following infection patient was admitted to telemetry placed on um a low sodium diet with bed rest and action as um activity as tolerated with uh saline lock patient was given was prescribed lisinopril furosemide and acetaminophen as needed for the acetaminophen lisinopril furosemide um to treat the patient was given the patient was placed on sorry the for the cmp and follow up 2d echo were ordered for the patient once symptoms have subsided patient was consulted to cardiology infectious disease and radiology for an mri I’m sorry for observation of her heart for um possible immunoglobulin administration and for an MRI thank you

136. Leslie palmer is a 62-year-old female presenting to the emergency room uh today with uh history of fatigue, shortness of breath, palpitations and pre-syncope. she has um she has a 2-month history of these symptoms that are worse with activity. Um she has seen her primary care provider about it who has ordered several tests done um which she does not have the results of yet um patient states that she has begun sleeping in her recliner due to significant orthopnea um and recently her symptoms have gotten much worse um prompting her to present to the emergency room. Review of systems, uh pertinent positives includes um an 8 pound weight gain under uh general review of systems um significant lower extremity edema um under musculoskeletal um and then under cardiopulmonary uh the patient has significant palpitations uh pre-syncope wheezing um and orthopnea. Skin um HEENT and um neuro review of systems were all negative. Um prior medical history for this patient includes hypertension pulmonary sarcoidosis diagnosed uh 25 years ago per patient report um family history is significant for sudden death um of her mother when she was about 40 um cause is unknown um for her father um cause of death was uh myocardial infarction at age 59 patient’s uh pertinent social history um is positive for caffeine moderate use approximately 1 cup per day. Um no alcohol no tobacco uh no drugs um her diet uh is balanced exercise um she takes walks once per day but states that she’s been unable to um due to her symptoms and their worsening she lives at home with family and is an elementary school teacher uh patient’s medications include lisinopril 10 milligrams once daily and prednisone 10 milligrams once daily um there are no known drug allergies to report vitals today uh include a blood pressure of 136/99 temperature 98.6 pulse of 110 respiration rate of 20 and um pulse oxygen of 91%. Physical exam was positive for jugular venous distension an s4 gallop with systolic murmur um rales and wheezing and plus one pitting edema in the lower extremity uh labs showed an elevated BNP. Chest x-ray showed pulmonary edema and mediastinal fullness. Echocardiogram showed restrictive uh cardiomyopathy with increased wall thickness and an ejection fraction of 55% um with all these in mind um and the physical exam the primary diagnosis today is sarcoidosis restrictive cardiomyopathy with secondary diagnoses of pulmonary um sarcoidosis and hypertension. Um this patient um should be admitted um to telemetry under serious condition. Um nursing orders include um strict ins and outs daily weights DVT prophylaxis and oxygen via canula to keep um oxygen sats above 96% no imaging or labs to be ordered um diet includes a low sodium diet um to prevent further worsening of uh pulmonary edema um and peripheral edema um patient can be out of bed with assistance um no iv fluids at this time due to um the fluid overload but we do want um IV access established um and keep the vein open. Meds we want to um increase prednisone to 60 milligrams once daily um continue lisinopril 10 milligrams once daily and then add amiodarone uh 150 milligrams once daily um due to uh EKG showing um unsustained ventricular tachycardia. Um we also want to have consultations with uh nuclear medicine for an FDG pet scan and um cardiology for uh possible AICD implantation.

135. Leslie Palmer, who is a 62-year-old woman presenting to the ED today with a chief complaint of shortness of breath and chest pain. Um She had a two-week stint of runny nose, fever, and chest pain. She explains having chest pain to be dull and widespread over the chest uh starting two weeks ago and lasting constantly without any relief Mrs. Palmer had an eight pound weight gain in the last two weeks, presence of palpitations, and a dull, constant chest pain. Uh she has a history of hypertension in which she's taking 10 milligrams of lisinopril per day. Um her mother died of breast cancer and her father is currently residing in an Alzheimer's unit. The patient has a healthy diet and exercises, no sorry and exercises no history of smoking, alcohol, illicit drugs. Um she has no known drug allergies. Her vitals were heart rate of 110, oxygen sat of 91%, blood pressure of 130/90 respiratory rate of 20, and temperature of 98.6. Physical exam findings showed positive JVD, laterally placed PMI, wheezing, and also lower extremity edema. All other physical exam findings were negative. Chest x-ray showed pulmonary edema and cardiomegaly. Her troponin levels and BNP levels were also markedly elevated. Her echo showed dilated left ventricle of with an ejection fraction of less than 30%. And her EKG showed a sinus tach with right bundle branch block and uh PVCs. Leslie Palmer presented today with myocarditis dilated cardiomyopathy. Other differentials included ischemic dilated cardiomyopathy, sarcoidosis, and hypertrophic cardiomyopathy. Her orders include admit to telemetry excuse me for a serious condition, vitals taken q2 hours uh activity as tolerated strict in and out, strict ins and outs, o2 2 liters per minute on the nasal cannula with maintenance above 96%. Daily weight and DVT prophylaxis, um she's to be put on a low sodium sodium diet and an IV should be placed to keep the vein open. Medications should be given uh with 625 milligrams of acetaminophen every six hours. She can continue her lisinopril on 10 milligrams per day, uh and also adding furosemide 40 milligrams of her IV done every 12 hours. CMP and serial troponins, as well as a 2D echo should also be completed, um and that should be reviewed at a later time once they are completed. Um cardiology should be consulted for an AICD placement or a CRTD placement, as well as an endomyocardial biopsy. Infectious disease should be consulted for immunoglobulin or glucocorticoids, and radiology should be consulted for a media enhanced MRI.

134. I just finished meeting with Leslie Palmer. She's a 62-year-old female who presented with chest pain, shortness of breath and fatigue. She mentioned this started three weeks ago when she had a cold. She said the chest pain was on her left side, just above her left breast and rated it as dull, constant and achy and a 2 out of 10. She said it did not radiate anywhere. And for the shortness of breath, she said it was relieved by sitting up and bothered her more while lying down. She was awake, alert-oriented, but I did note she was fatigued. Her vitals were a heart rate of 110, so slightly elevated, a respiratory rate of 20, oxygen sats at 91%, which I told her was low, and her respiratory rate slightly high, probably as a compensation for that. Her temperature was normal at 98.6, and her blood pressure was slightly elevated at 130/90. However, she does have a history of hypertension so that may be normal for her. For her general review of systems, she had fatigue and a weight gain of 10 uh 8 pounds. um Everything else was negative. Her skin, heent, and neuro review of systems were all negative. For her her cardio, she had chest pain and palpitations, but no near syncope. And for her pulmonary review of system, she had wheezing, dyspnea, and orthopnea. And for her MSK, she had uh lower extremity edema that she mentioned. So as I said, her past medical history is positive for hypertension, for which she takes lisinopril 10 milligrams orally every day. She has no surgical history or hospitalizations or no known drug allergies. Her mother passed away at 80 years old of breast cancer. Her father is currently 89, who is living in a care facility with Alzheimer's. For her personal social history, she eats a well balanced diet. She says she was exercising regularly up until the chest pain and shortness of breath, and so she is not currently exercising. She denies any drugs, tobacco, or alcohol use and drinks one cup of coffee per day. Her occupation is an elementary school teacher and she lives with her husband, who she is married to. I asked her about the um shortness of breath, for which she said it occurs at rest. So that would be a grade 4 NYH scale. On physical exam I noted that she was positive for jugular venous distension. She did not have any bruits. Her heart rate was regular with no murmurs, regurgitations, or gallops. Her PMI was displaced laterally. She did not have any chest wall tenderness, but on auscultation she did have bibasilar rales and wheezing. On her lower extremity exam I noticed plus one pitting edema in the calves. Her calves were not tender um and her pulses were full and normal. Going over her lab work with her, I noted her troponins were high as well as her BNP was elevated at 4000. Her chest x-ray showed cardiomegaly and pulmonary edema and her echo showed a dilated cardiomyopathy with reduced ejection fraction. The EKG showed sinus tach, which was consistent with the monitor we had on her, and a right bundle branch block. So, based on the physical exam history and lab work I diagnosed um myocarditis dilated cardiomyopathy. So, we are admitting her to the hospital with telemetry, um serious condition, so we are gonna check vitals every two hours. Activity, I left as tolerated for nursing interventions, strict input output, um maintaining daily weight and DVT prophylaxis and putting a nasal cannula on to maintain her oxygen sats above 96. For IV fluids, we're gonna um add furosemide at 40 milligrams IV to help with the pulmonary edema, and so I want IV fluid status as keep veins open. I prescribed 625 milligrams of oral acetaminophen for the pain and told her she could continue her 10 milligrams of lisinopril daily for her cardiovascular system. Um No other respiratory therapy besides the nasal cannula. For lab orders, I ordered a CMP and serial troponins and a follow-up 2D echo as well. And then consulted radio radiology, cardiology, and infectious disease so that we could get an AICD placed a CRTD and do a biopsy as well as getting her glucocorticoids and a media enhanced MRI. So she'll be admitted into the hospital and we should check in with her frequently. But for now, that is all. Thank you very much

133. to you today so I had just finished seeing Mrs. Palmer. She's a 62 year old woman who presents to the emergency department today with complaints of cough, shortness, excuse me, with complaints of shortness of breath, um chest pain and fatigue. She claims that a couple of uh a few days ago, she had a viral infection for which she had cough, she had fever, and just general malaise. She saw her primary care physician for which she says that the symptoms resolved except for her shortness of breath and fatigue and currently she's experiencing chest pain. As of now she does not have a fever but she does have shortness of breath and fatigue. Uh when I asked her what aggravates uh the shortness of breath she says that any daily activities like walking around really makes her feel the shortness of breath and fatigue but sitting in a reclined seat so like sitting in her recliner um alleviates her symptoms. She also describes the chest pain as this dull chest pain. When I asked her about her past medical history, she told me that she has a history of hypertension for which she takes lisinopril 10 milligrams a day. She does not have any known allergies, um neither to any food or medication. When I asked her for past hospitalization, she claims that she had a catheter uh cardiac catheterization placed one year ago. Her family history, her mother passed away of breast cancer and her father's currently um in an assisted living facility dealing with Alzheimer's. When I asked her about her social history, specifically her diet, she claims that she has a well-balanced diet, that she eats a lot of meats, um vegetables, fruits and vegetables. She also claims um for her caffeine intake that she only takes one cup of coffee, no alcohol, no tobacco use, um and she does not take illicit drugs. Um exercise wise, she used to be able to go to the gym twice a week, but now with her shortness of breath, she's not able to do that. Um and her living situation is that she lives currently with her husband, and she is a school teacher for her occupation. Now, when going through uh the review systems. Uh for general general review of system, everything was negative except for um an eight pound weight gain within the last two weeks. All skin uh review systems were negative. All HEENT review systems were negative. Neuro, everything was negative. Pulmonary, the only positive findings were positive wheezing, cough, dyspnea, and orthopnea. For cardiac, the only thing that she claims was positive was palpitation and chest pain. And for MSK, the only thing that she claimed, uh that she reported was swelling of her legs and muscle aches. All else were negative. So for her physical exam, her vitals, her heart rate was 110, which was a little bit elevated. Her blood pressure was 130/90, uh as well elevated elevated, and excuse me, her temperature was 98.6 and O2 saturation was 91%. Um physical exam findings, she had a positive JVD. She had bibasilar wheezing, edema in her leg, and her PMI was displaced laterally. When I looked at her labs, she had elevated troponin and BNP. Um her chest X-ray did show edema and cardiomegaly, and her EKG showed premature ventricular contractions, uh left um excuse me left atrial deviation, right bundle branch block, and sinus tachycardia. So I reviewed the labs with the patient, I reviewed the chest x-ray with the patient, I reviewed her EKG um as well as her echo and her echo did show dilated um left ventricular wall dilation with decreased effusion rate, which is around 30%. So I explained all her labs to her. I went over the labs, chest X-ray, EKG, and then we went with the plan. So I told her, considering that she did have a viral infection in the past few days and all her signs pointed to dilated cardiomyopathy, I do believe this is myocarditis dilated cardiomyopathy um so her symptoms were due to her previous viral infection. So due to that, I'm going to place her on furosemide to be able to get rid of the edema she has in her legs and in uh her lungs. I also wanna continue her lisinopril for her blood pressure. I'm gonna give her acetaminophen for her chest pain. Um labs wise I am gonna repeat troponin to be to see um if it improves, and we're going to repeat an EK uh excuse me repeat an echo. I also recommended that we add a cardiologist, an intervention interventional cardiologist to the team to be able to see if she's a candidate for um a defibrillator, and add a radiologist to the team and an infectious disease specialist. So with all that, um I do believe the patient does have um hopeful outcomes, and I explained all this to her. She said that she had she was on board with the plan, she had social support at home and that she did have insurance to be able to cover the cost of all this. I also told her that we would be admitting her to the telemetry floor and not the ICU. So admit to telemetry floor. And then I also lastly explained to her that myocarditis was probably due to the viral infection she had before. The patient stated that she understood everything, she did not have any questions at the moment and agreed with our plan. And that was my encounter for today with the lovely Mrs. Palmer and I hope for the best. Thank you so much.

132. All right, so uh patient named Leslie Palmer presents uh complaining of an onset of fatigue, dyspnea, as well as orthopnea that's been present uh even at rest uh and it's been getting even worse for the past six months. Um After this, uh a review of the system was taken uh and the general review of systems uh noted fatigue as well as a weight gain of about eight pounds. Uh musculoskeletal review of system indicated a uh uh uh lower extremity edema. And the EENT was negative for anything. Pulmonary test uh um indicated uh dyspnea as well as orthopnea. Neuro test was negative. Skin test was uh negative, as well as cardio test was also negative. Um after this, uh a surgical history was taken in which the patient noted was noted to have uh uh have previously had a triple bypass cardiac surgery as well as a stent placement. Uh the medications that the patient was on was uh lisinopril10 milligrams, metoprolol succinate uh 50 milligrams, atorvastatin 10 milligrams, metformin 500 milligrams, furosemide 20 milligrams and clopidogrel 75 milligrams. Uh there was no noted allergies. As for the social history, the patient uh patient noted that uh his food intake was very balanced. Um his exercise routine uh the patient uh noted that uh he used to go he used to uh uh like to uh walk. However, now that the dyspnea and orthopnea uh has gotten even worse, it's too difficult to do these activities. So he does not exercise. Uh as for drugs, there is no drug drug use or illicit drug use. Uh there is no other, uh the patient has been smoking tobacco for the last 30 years or has been smoking for the last 30 years. Uh the patient has no alcohol intake. However, as for caffeine, the patient uh does drink one cup of coffee a day. And is also, as for the occupation, the patient is a school teacher and the patient is sexually active. As for past uh past hospitalizations, the patient uh had uh a hospitalization for the triple bypass surgery as well as the stenting. Um as for the family history, the mother was uh was noted to have uh died from breast cancer and the father the father is in a nursing home uh with Alzheimer's disease. Uh as for the past medical history for the patient, uh uh this includes hypertension, hyperlipidemia, uh diabetes, as well as atrial fibrillation. The vital signs were also uh noted. Uh the blood pressure was 80/50, which was uh told to the patient as being a little uh too low. Pulse was 90 which which was good. Respiratory rate was 22, which was noted to the patient as being too high. Uh the temperature was uh noted as 98.6 degrees Fahrenheit, which was noted as being normal. And uh O2 saturations uh was noted to be 86 uh 86%, which was noted to the patient as being abnormal and too low. Um going to the physical examination, um uh both pulses, radial pulses were present. Uh however, the pedal pulse uh the pedal pulse and posterior tibialis pulse was not taken. Uh uh there was a positive JVD. Uh Bibasilar rales uh were also noted on lung auscultation. Uh there was also pitting edema that was noted. Um uh after the after the physical examination, uh the labs were the labs were um examined and um discussed with the patient. Uh this included CBC and CMP, which were both normal. However, troponin was elevated, which was uh told to the patient as being a sign of potential cardiac uh damage um bmp was also elevated which was told to the patient as being a sigh of possible uh heart uh cardiac heart failure. And chest x-ray showed signs of uh pulmonary edema as well as cardiomegaly. EKG also shows uh showed a left left bundle branch block as well as a left axis deviation um and a normal sinus rhythm. Also a non-entrant reentrant non-reentrant ventricular tachycardia was noted to the patient, however, that was incorrect. Um after this, uh a diagnosis uh a diagnosis was made of a type New York scale type 4 ischemic dilated cardiomyopathy, uh which was told to the patient. Um and with this uh um the patient was told that he is going to be admitted into the ICU and that there's going to be a medication change. Uh the medication change includes uh changing uh uh holding off on all of the medications except for clopidogrel as well as uh clopidogrel uh as well as um warfarin ah and adding dobutamine uh to increase heart increase heart contractions and heart rate um to fight off possible cardiogenic shock, as well as uh adding a uh insulin sliding scale for the diabetes. Also, it was told to the patient that uh interventional cardiology would be uh would be consulted with for a possible AICD and a CRPD uh placement. CRPD was not noted to the patient, however, AICD was noted to the patient. Um after this this um uh the labs that needed to be taken were not noted to the patient. Or the labs that do need to be taken are serial troponin, as well as IV INR, are two labs uh that need to be taken uh after this. Um Yeah, I think that's it. All right, thank you so much. Also with that, uh this was not noted to the patient, but the patient needs to be put on a BiPAP, uh BiPAP 50% uh 50% um FiO2 and 16 by 60 for the BiPAP for oxygen saturation.

131. Case presentation on our new patient, Mr. Palmer um he's a 62-year-old male presenting with the chief complaint of dyspnea orthopnea and fatigue that started six months ago. that has gotten worse in the past three days. Um the patient went to their family family medicine doctor. Um they ran a couple of tests and the family medicine referred him to the ED the emergency department. Um he has a history of hypertension, cholesterol, diabetes, and A Fib, which he takes lisinopril, metoprolol succinate, metformin, atorvastatin, clopidogrel, and warfarin for. He has no known drug allergies. He has gained a couple of pounds in the past two weeks and also has bouts of palpitations. He also mentioned swelling in his ankle. Um he has a surgical history of a triple coronary artery bypass and five coronary stents put in. Regarding his social history, he has a history of tobacco use, smoking one pack per day for the last 30 years. He also drinks one cup of coffee a day. He currently lives with his wife and is generally active and walks regularly, but he has not been able to do so recently. Um regarding his family, his mother is deceased and passed away from breast cancer at 80, and his father is currently in a facility for Alzheimer's. Now in regards to his vitals temperature was 90 98.6 heart rate was 90 respiratory rate was 22 and blood pressure was 80/50 and oxygen sat was 86%. Cardiopulmonary and physical exam showed positive JVD tachycardia gallop rales and wheezing, all is present. The patient showed no signs of carotid or abdominal abdominal bruit. He had pedal edema and dorsalis pedis and posterior tibialis pulses were full bilateral. They were equal. Um his lab showed elevated troponin and BMP at 4000. X-ray showed pulmonary edema and cardiomegaly. Echo showed dilated cardiomyopathy with a reduced ejection fraction at 30% and the patient claimed that uh prior imaging showed that he had a ejection fraction of 40% so now it is lower an EKG showed normal sinus rhythm, left axis, and left bundle branch block. Homan's sign testing for DVT was negative. At this point ischemic dilated cardiomyopathy was suspected um so I spoke to him about the diagnosis and that the condition is serious. I also inquired about his social support and insurance. At this time he will be admitted to the E ICU. Vitals will be taken every two hours and activity are activity instructions are strict bed rest. Nursing interventions include strict ins and outs daily weight DVT prophylaxis and BiPAP 16 over 6 FiO2 at 50% for respiratory therapy. Diet is low sodium and KVO lock. Medication will include clopidogrel 75 milligrams four times a day warfarin 2.5 milligrams two times a day and dobutamine IV drip. Um the patient will also receive an insulin sliding scale for their diabetes. Serial troponin and PT INR will also be ordered. He will be consulted by an interventional cardiologist for possible AICD and CRTD placement. The patient claimed they had transportation to the hospital.

130. I'm presenting to you Leslie Palmer, who is a 62-year-old female who came into the hospital after her primary care doctor advised her to do so. She presented with a complaint of shortness of breath, fatigue, and palpitations, which occurred as a result of physical activity, like walking or even getting up. When she moves at all, her symptoms of palpitations, shortness of breath start to occur. And then a couple of minutes later, with some rest they'll go away. She'll occasionally wake up struggling to breathe and occasionally she'll have shortness of breath if she's laying down flat. But if she sits up she gets better. She has a past surgical history of getting a heart cath a couple years ago but she's never been hospitalized. She takes lisinopril 10 milligram and prednisone 10 milligram currently and she has no allergies. Her past medical history includes high blood pressure and sarcoidosis. Her medical issues have been handled relatively well until her new issues arised. Her father passed away of sudden unexplained death a few years ago, and her mother had a heart attack at 59. She doesn't smoke, use tobacco, or illicit drugs. Currently, she's a elementary school teacher who has been able to continue working and eat a healthy balanced diet. She used to walk daily, but recently she hasn't been able to walk as often due to her issues. My review of systems found that she had gained 8 pounds in the past week and had swelling in her legs. She also had the issues of dyspnea, wheezing, fatigue, and palpitations. The remaining review symptoms were negative. I performed a physical exam and found wheezing and lower extremity edema. Her lab test showed an elevated BMP. Her chest X-ray showed pulmonary edema with mediastinal fullness, but no altered cardiac silhouette. An echocardiogram showed restricted cardiomyopathy with an enlarged wall and a slightly decreased ejection fraction. Her EKG showed sinus tachycardia. After her appointment I would like to diagnose her with sarcoidosis restricted cardiomyopathy. NYHA class 3 and secondary hypertension and secondary pulmonary sarcoidosis. I ordered her to be admitted to telemetry with vitals every 2 hours, out of bed with assistance, strict IO, daily weight, a nasal canula to maintain an o2 saturation of 96 percent. She also will get daily weight, a low sodium diet, saline lock KVO for fluids. She'll continue taking lisinopril lisinopril 10 milligram and I will increase her prednisone dosage to 60 milligrams. And then I'll add amiodarone 150 milligrams and furosemide 40 milligrams via IV. She will get a repeat CMP to check for differences and she'll see a interventional cardiologist to consider putting in an AICD. She will also see a nuclear medicine radiologist to get an FD FDG PET scan to look for further issues.

129. presenting the patient that I saw, who was Leslie Palmer a 62-year-old male presenting with chief complaint of shortness of breath and fatigue. Patient states that the symptoms started a few weeks ago when he was with his friends. He started feeling lightheaded and like he was going to pass out. Patient is comfortable at rest but has symptom onset uh when he performs physical activity, such as going for longer walks. He also notes heart palpitations and rasping. ROS was positive for fatigue, lightheadedness, pre-syncope, palpitations, wheezing, and dyspnea on exertion. Past medical history was significant for hypertension. Past surgical history was significant for a heart cath one year ago that turned up normal. Past family history, his mom passed away or died when she was 40 years old due to an unknown cause. It was a sudden death. his father passed away or died when he was 69 from a myocardial infarction. For social history, he does patient does not drink, does not smoke, and does not use illicit drugs. He consumes a balanced diet and moderate caffeine. He exercises 3 to 3 to 5 times per week until the last few weeks. He has not been exercising due to his symptoms. He is a teacher and he lives with his husband. For medications, he takes lisinopril 10 milligrams once daily for his hypertension. He has no known drug allergies. His vital signs were normal except for an elevated heart rate of 110. Physical exam was positive for jugular venous distension bibasilar rales and wheezing, PMI displaced laterally, and 1 plus pitting edema in the lower extremities. Otherwise, the physical exam was normal. His chest x-ray showed cardiomegaly. His labs were normal, including troponin and BNP. His echo showed left ventricular asymmetric hypertrophy and left atrial enlargement with left ventricular hyperkinesia with a left ventricular ejection fraction of 60%. His EKG showed normal sinus rhythm, normal axis, and left ventricular hypertrophy voltage criteria with tall R waves in the septal leads. Based on these results and the patient's past medical history and his presenting symptoms, I believe that he has hypertrophic cardiomyopathy. I recommend that we admit him to telemetry. His condition is serious. He I recommend that we take his vitals every two hours. He can do activity as tolerated. Nursing interventions include strict ins and outs, daily weights, DVT prophylaxis, and oxygen via nasal canula to maintain oxygen saturations over 60 96%. His diet can be regular. IV fluids keep vein open. Medications I recommend we discontinue lisinopril and instead start disopyramide 100 milligrams four times daily. I recommend we consult with interventional cardiology to discuss AICD placement. I also recommend we we consult with cardiothoracic surgeon to discuss possible septal myomectomy and alcohol injection. Thank you.

128. Hi there um I'd like to do a case presentation today um on Ms. Palmer, um a 62-year-old female um came in today complaining of um chest pain, um dyspnea, and extreme fatigue. Um patient states that a week ago she'd been dealing with flu-like symptoms, specifically a cold, fever, um and those had subsided. However, her fatigue has persisted since then. Um patient has a past medical history of hypertension. uh she treats that with lisinopril 10 milligrams daily. Um patient has a past surgical history of a cardiac catheter a year ago, was performed was performed for having an abnormal EKG. Family history, um mother has a history of breast cancer um passed away um no pertinent medical history for father. Um in terms of uh review of systems um patient uh has gained 8 pounds in the last week stated uh additionally uh patient has uh palpitations that have been coinciding with her chest pain recently, she stated. Uh patient has also noticed uh severe orthopnea as well um when lying down and is now sleeping in a recliner. Has also wheezing and coughing. Um and in terms of um muscle pain, uh patient states that she has uh bilateral radiating muscle pain in her lower extremities as well. Um on physical exam, I noticed uh patient's blood pressure was elevated um at 130/90. Um the patient was also tachycardic at a heart rate of 110 beats per minute. Um uh upon auscultation, um I noticed the patient had bilateral rales in her lungs. Um additionally, patient uh had bilateral jugular venous distension as well, um and she had bilateral pitting edema um in her lower extremities. Um in regards to um my plan moving forward, um I think uh Ms. Palmer should be admitted to the hospital, um likely uh diagnosis being um myocarditis dilated cardiomyopathy. Um I uh think um moving forward we should be consulting cardiology for treatment of potential arrhythmia um consulting infectious disease to try and control potential inflammation um from infection um and as well as uh radiology for um considering an MRI to have a more in depth um look at the extent of damage to the heart. Um in terms of medications to be using um uh continue lisinopril uh for the patient to decrease blood pressure, and also consider adding furosemide as well um to try and remove excess fluid from the patient. Um and additionally, um uh using acetaminophen currently to uh decrease inflammation um and limit any further cardiac damage. Um that's all I have for you, thank you so much.

127. So Mr. Palmer is a 62 year old male who presents to the ER today um complaining of shortness of breath that started two weeks ago while he was walking with some friends after work. He says while he was walking it just kind of hit him suddenly and he got really short of breath, um he felt really fatigued and he felt like his heart was racing. Um he said after he rested all his symptoms went away but since then every single time that he's uh done any bit of like uh light exercise, like moving around and walking like he did, um he starts to get that shortness of breath. Um he says he also will intermittently get the palpitations. Because of this, he went and saw his family medicine physician three days ago, and um they did some labs and imaging, and then I guess they got the results today, and he said that he was called by them today and told to come to the ER so that we could evaluate him. Um he doesn't have any other complaints. Um he hasn't noticed any leg swelling. Um he hasn't noticed any like recent fever, chills, cough, um no recent rash. Uh he hasn't been sweating with any of these events. Um what he said his initial complaint has been the only thing that's bothered him. Um he says something like this has never happened before. Um uh he doesn't complain of any chest pain right now, but about a year ago he says that he did uh have a heart cath after he had um an abnormal EKG on like a routine physical. He said that um his heart cath showed uh he had no blockages, so um he hasn't had any issues with that since then until this event. Um he has a history of high blood pressure. He takes lisinopril lisinopril 10 milligrams um once a day for that. Um he doesn't smoke, doesn't drink, um hasn't used any illicit drugs like cocaine ever in the past. Um he's an elementary school teacher. He has a regular diet and he says that he regularly exercises everyday after work he'll go on a walk with his friends but he hasn't been able to do that in the last two weeks because of his symptoms. Um his family history is significant um his father died of a heart attack at the age of 59 and his mother died unexpectedly um at the age of 40. He says he doesn't know why. Um on physical his he's tachycardic, heart rate of 110, um he was hypertensive with um uh blood pressure of 130 over 90. He says he has been taking his meds and he hasn’t missed any doses. Um he also says he doesn't have any medication allergies. Um his O2 sat was 96 on room air. Um he's awake, alert, um sitting comfortably. While I talked to him, he was able to lay down without any shortness of breath while I did his physical. Um he didn't have any JVD or a bruit, a carotid bruit um or abdominal uh bruit or palpable aneurysm that I could feel. Um his lungs were clear to auscultation bilaterally. He uh had a regular rhythm on uh while auscultating his heart he did have an S4 murmur uh systolic. Um no rubs, but he did have the gallop. Um he didn't have any chest wall tenderness. He didn't have any edema. Uh he had good, strong DP and PT pulses. Um his calves were equal in size and Homan sign was negative. Um when reviewing his um labs from the doctor's office they did a troponin a BNP on him. Both were normal. Um his EKG had some um LVH, but it was um normal rhythm and rate. Um on his chest x-ray he had cardiomegaly but his lungs were clear bilaterally. His airways were intact, trachea midline. Um he didn't have any fractures. The only thing significant was cardiomegaly. Um his echo, he had um an enlarged intraventricular interventricular septum um which I assume is why they sent him over. So um I told him we would admit him, um put him on some oxygen just to get that up a little bit since his O2 sat is like 96, it could be better. Um then we would have the interventional cardiologist and the cardiothoracic surgeon follow up with him while he's in hospital um and we would start him on the dipyridine instead of him taking the lisinopril. Um and then he's on uh exercise um restrictions until he's cleared by another physician. And he was agreeable to be admitted to telemetry.

126. case of Leslie Palmer, he is a 69-year-old male presenting to the ER with a history of shortness of breath, fatigue, and some heart palpitations upon physical exercise. He states that he used to walk regularly with his friends but is having trouble doing that due to shortness of breath. He also states he has been wheezing. He has been diagnosed with hypertension which he takes lisinopril for. Um his he has no known drug allergies. His current vitals are heart rate of 110, uh oxygen of 96. His BP was 130/90, and his temperature was 98.6. uh for his social history, he states he eats a well-balanced diet diet, he exercises regularly, he drinks a cup of coffee a day, and denies alcohol, tobacco, or illicit drug use. He is currently retired and sexually active in a monogamous relationship. His family history did reveal that his mother died suddenly of an unknown cause at 40 and his father died of an MI 59. Upon physical examination it did reveal that he had positive JVD a PMI that was displaced laterally and you could hear wheezing and rales bilaterally upon auscultation. He also presented with lower extremity edema. His x-ray results showed cardiomegaly and his echo showed left ventricular asymmetric hypertrophy. His left atrium was enlarged, and there was some hyperkinesia with an LVEF of 60%. His EKG showed left ventricular hypertrophy with tall R waves in the septal leads. In summary, Leslie Palmer presents with shortness of breath, heart palpitations, cardiomegaly, which point to a familiar hypertrophic cardiomyopathy. And his NI NYHA scale was about a 2 because um with some physical exercise would produce the symptoms. His condition is considered serious. He will have his vitals monitored every two hours. Activity is as tolerated and nursing instructions are strict in and outs, daily weight, DVT prophylaxis, O2 via nasal cannula maintain O2 sats above 96%. His diet is normal and IV fluids are saline lock. His medications we will discontinue lisinopril and initiate disopyramide. The we will also consult interventional cardiology for AICD placement, as well as the cardiothoracic surgeon for possible future septal myectomy or alcohol injection to reduce LVOT. Thank you. Bye.

125. Hello, today we have 62-year-old Ms. Palmer presenting to the ER with chief complaint of shortness of breath and fatigue. She states she had flu-like symptoms two weeks ago, which included cough, runny nose, as well as a fever. These symptoms cleared up and then were followed by shortness of breath, fatigue, and a chest ache five days ago. She went to her PCP the same day, who told her to wait and see how the symptoms progressed. Today the symptoms became worse, so she came here to the ER. The patient reports that some exercise makes her chest ache worse, putting her in line with a New York Heart Association class of two. In contrast, sitting up makes the shortness of breath better, which is why the patient has been sleeping in a chair at night. She rates the pain as a 2 out of 10 and describes it as being dull in her chest and says that there's no radiation of the chest pain. The patient underwent a cardiac cath one year ago after she had an abnormal EKG which found nothing out of the ordinary. She has a history of hypertension for which she takes lisinopril. Her positive review of symptoms review of systems symptoms include fatigue, 8 pound weight gain over the last two weeks, achy and swollen lower legs, chest pain and palpitations, as well as some orthopnea. Her vitals vitals are as follows, 130/90 blood pressure, 110 heart rate, 20 respiration rate, 98.6 temperature, and 91% O2 on room air. Physical exam was positive for JVD bilaterally, wheezing, and rales bilaterally bilaterally on auscultation, pedal edema, as well as a laterally displaced PMI. Her labs showed increased BNP and troponin. The car the chest x-ray indicated cardiomegaly as well as pulmonary edema. And her ECHO showed uh dilated cardiomyopathy with an ejection fraction less than 30%. EKG was normal sinus rhythm. Based on the symptoms and workup, I believe she has myocarditis dilated cardiomyopathy. I suggest we admit her to telemetry, continue her lisinopril while adding acetaminophen and Lasix and have interventional cardiology, infectious diseases and radiology follow up with on her. Additionally, I would like to administer IV fluids, a diet diet low in sodium, daily weight checks, DVT prophylaxis, oxygen by nasal cannula maintaining oxygen sats over 96%, and activity as tolerated. We will perform serial troponins and the CMP, as well as a repeat 2D echo to aid in care. Thank you.

124. All right, so the patient today was a 62-year-old female named Leslie. Uh She presented to the office with complaints of dyspnea and um with dyspnea and fatigue, she um stated that she was sick with a viral illness two weeks ago with um fever, cough, chills, um all of that sort of stuff. She started feeling better, but then she started having um the shortness of breath symptoms, um and exercise intolerance. Um she said that she has trouble breathing when she's laying down, um and she's had to been she’s had to sleep in her recliner uh because she can't breathe, so she also has orthopnea. Um she would be considered an NYHA Class 2 because she has slight uh restriction in her activity. Uh she described her diet as balanced. She denied uh illicit drug use, tobacco use, alcohol use, one cup a day of coffee. Um she was working out two times uh a week at the gym, but then she had to stop due to her symptoms. Um she's an elementary school teacher um and she teaches the third grade um and she's married. Uh she has a past medical history of hypertension uh for which she's taking 10 milligrams of lisinopril daily. Um she has no known drug allergies. She had a cardiac catheterization um about a year ago and the results of that were normal. Um her mother passed away from breast cancer and her dad is 89 with dementia and he's in a nursing home right now. Um she talks about how she's gained eight pounds. Um she was having trouble breathing, she's wheezing, uh she felt like she's having heart palpitations um as well as chest pain. Uh her vital signs, her temp was good, blood pressure was a bit high at 130/90 um her o2 sat was a bit low at 91 um and her heart rate was a bit high at 110 beats per minute. Um her chest x-ray showed cardiomegaly as well as um a pulmonary infiltrate with a pulmonary edema. Um her troponin levels were raised at 0.1 and BNP levels were raised at 4,000. Um her EKG showed tachycardia, um a left axis deviation, and a right bundle branch block. Uh her echocardiogram showed die dilated cardiomyopathy with reduced ejection fraction. Uh all of this led me to believe that she had myocarditis uh due to that viral infection, um with dilated cardiomyopathy with reduced ejection fraction um I told her that we needed to admit her to telemetry, that we were going to add 625 grams of acetaminophen for pain control, as well as 40 milligrams of furosemide to get uh rid of some of the fluid. Um I'd like to repeat the troponins um and then also repeat the CMP since we started that furosemide. um I'd like to consult with a radiologist to get a contrast MRI to see where the inflammation is in her heart. Um I'd also like to consult uh intermediate cardio, interventional cardiology um to talk about placing a CRTD or an AICD. Um I'd also like to get a repeat on the 2D echo um and then I’d also like to consult infectious disease to see if we can figure out um the cause of the virus that caused this myocarditis. That is all.

123. She's a 62-year-old female who presented to the emergency department due to extreme fatigue and shortness of breath. She did include that about two weeks ago, she was sick with a fever, cough, runny nose, and she thought she just had a cold. She was able to continue to exercise through this time, um but it was just causing some fatigue and shortness of breath. Um she said about five days ago, her symptoms resolved and she thought she was getting better, but then she went to her primary care doctor three days ago because she was still having really bad fatigue when she was trying to do activities. The fatigue and shortness of breath does not occur at rest. I took a history of the patient. Um she does have a medical history of hypertension, and surgical wise she had a cardiac catheter done, but she said there were no significant findings with that. Um she does take one medication, which is lisinopril 10 milligrams. As far as family history, her mom passed away from breast cancer about five years ago and her dad is currently in a home. He has Alzheimer's or dementia but he's still living. As far as her social history, she does not use any alcohol, tobacco, or illicit drugs. She works as an elementary school teacher. She said her diet is good and balanced. Her caffeine use is moderate. She says about a cup a day. Um as far as exercise, she does remain active. She likes to go to the gym about three times a week but has been unable to since her cardiac symptoms, shortness of breath, and fatigue started. And as far as living situation, she is married and stated she feels supported and comfortable at home. She has no known drug allergies. As far as her ROS, she did have fatigue and a recent weight gain she stated of about eight pounds. There were no skin issues, umno headache or neck stiffness. She did feel chest palpitations, and she was also positive for wheezing, dyspnea, and orthopnea, meaning she was more out of breath while she was laying down. She also did notice some lower extremity edema. As far as her appearance, she was awake and oriented. She was just extremely fatigued. Her vital signs, her temperature was 98.6, so no fever. Blood pressure was 130/90. Oxygen was 91. Heart rate 110, and respiratory rate was 20. For physical exam, I didn't hear uh no carotid bruit was present, but she did have JVD. As far as her heart, she had a regular rate. No murmur, friction rub, or gallop were heard, but her PMI was displaced laterally. Wheezes and rales were also present, but she had no chest wall tenderness. She had no calf tenderness. Um her lower extremity pulses were full and equal, and she did have plus one pitting edema. As far as her chest X-ray, this indicated cardiomegaly as well as pulmonary edema, which I explained to the patient. And her echo was indicative of a dilated cardiomyopathy with a left ventricular ejection fraction less than 30%. Her EKG came back as sinus tachy tachycardia with a right bundle branch block. In her labs, her troponin was elevated and her BNP level was 4,000. Now knowing all of this plus her history and her diagnostics, I did make the diagnosis of myocarditis dilated cardiomyopathy. Um she was at a NYHA classification of 2 because she was still able to do some activity and her symptoms did get better at rest, but they also were triggered when she was exercising. Um therefore, I told the patient that we did are going to need to admit her specifically to telemetry. Her condition was serious. Um she's going to be getting vitals every two hours. Activity is as tolerated. Um as far as nursing interventions, she needs strict I IOs, daily weights, DVT prophylaxis, maintaining her O2 stat above 96%, and she's also gonna get an O2 nasal cannula. Diet wise, she should be low sodium. IV fluid should be KVO, so just keeping that vein open. And then as far as medications, I instructed the patient we were gonna be giving her a pain med, so that's acetaminophen 625 milligrams by mouth. She can stay on her lisinopril, which is 10 milligrams by mouth daily. That's what she's already taking and she will continue to. And then we're also adding furosemide 40 milligrams by IV. She needs no type of diabetic diabetic intervention, no BiPAP. And for labs, I'm ordering serial troponins as well as a CMP. And she's going to be met by an interventional cardiologist, infectious disease, and radiologist. And they are gonna consult about an AICD placement, a CRTD placement, doing a media enhanced MRI, as well as a myocardial endomyocardial biopsy. The patient was instructed of all of this, that she would be admitted, doing additional labs and testing, that we were going to keep her on some medicine, as well as add a painkiller and a medicine that was going to improve her cardiac function. And patient was agreeable to the plan. She stated she has a good support system at home, as well as insurance, and she was comfortable moving forward with this.

122. Mr. Leslie presented to the clinic today. He's a 62-year-old 62 year old male I'm gonna restart 62 year old male, Mr. Leslie presented to the clinic today uh three days after um something concerning came up with his, from his family medicine doctor. Um he was, um he has a fairly extensive past medical history, hypertension, hyperlipidemia. Um he is a type one diabetic and smoked uh for 30, a pack a day for 30 years. But he, um more concerning right now is um is his elevated blood work. Uh his troponin high troponins, he has um severe orthopnea, and and very, very uh extensive undue dyspnea on exertion. So um even having dyspnea at rest. But um he has a history of A Fib. He's had um he’s had an open heart surgery, he's had a CABG, he's had a CABG coronary artery bypass graft, um he's had a cardiac stent, one one a year for the last five years. Um none nn his parents didn't necessarily have any sort of um similar issues, he was like I mentioned, he was he is a smoker. Um for his stance on blood he's on clopidogrel, metoprolol, he's on furosemide, lisinopril, um warfarin, metformin. He doesn't have any allergies. Um he has gained eight pounds of edema in his lower extremities that he noted on during the review of systems there's um very few pertinent negatives on our um thing except he has not experienced any chest pain or discomfort. No palpitations, though he says he has uh some sort of on and off A Fib, paroxysmal A Fib, atrial fibrillation. Um and walking in, noticed his blood pressure to be 80/50, um heart rate of 90, respers respers a little bit elevated um a bit a bit um tachypneic if you will and very low O2 sats, spo2 around 86%. Um did have jugular venous distension on physical exam. Um no murmur, friction rub, gallop. Um his PMI was displaced bilaterally and and um sure enough he had a cardiomegaly uh on chest X-ray. Rales sure enough were present um did in fact have pedal edema. Um normal pulses and extremities, uh he does have an ejection fraction um of less than 30% on on 2D echo, uh PLAX view. Um BNP was elevated, troponins elevated um also um classified his as an New York Heart Association, New York Heart Association class 4 heart failure. Um likely now going the direction of adding dobutamine on top of uh the not working um Intervascularly, very dry, nearly as a potato chip, um and he he cannot take any more diuretics, so we're gonna add dobutamine. um so I'd like to add dobutamine. Definitely gonna admit him to the ICU as a critical patient. Um monitor him every two hours. Strict Is and Os, DVT prophylaxis. Um have him take good care of him, do a KVO, um no standing fluids, because he's in pretty bad severe heart failure, um isn't having any pain, but I'll I’ll keep his thinners going. I would like to keep his thinner going thinners going do not not adding any sort of diuretics. Um I put him on an insulin sliding scale instead of his metformin. Um of course, monitoring PT INR, and then I'm gonna have interventional cardiology take a look at them, though they had um they said no more stenting or or CABG bypasses. But but it is likely that I would recommend maybe a because of a left bundle branch block and a left axis axis on EKG, I'd recommend a cardio resynchronization therapy device as well as uh an automated internal cardiac defibrillator um if if noted um if deemed so by the interventional cardiologist. Um that is all I have um we will keep an eye on him, watch him very closely. We'll send him up to the ICU now, if that is okay. All right, Security Detective Tate, out.

121. Mrs. Palmer, who is a 62-year-old female with a history of pulmonary sarcoid and hypertension. She comes to the ED today with episodes of shortness of breath, near-syncope, um as well as fatigue and palpitations and orthopnea. She says that this has been going on for about two months and worsening since onset. She saw her primary care physician for her symptoms about three days ago and had some tests done. She's unsure of what tests were done and she hasn't gotten those results back yet. Um she called them today due to exacerbation of her symptoms and was referred to the ER. She says that her her symptoms are exacerbated with most of her activity. She notes that she was previously very active walking about five times a week, but now is unable to do that due to her symptoms. She also notes orthopnea, noting that she is now sleeping in the recliner due to shortness of breath when lying flat. She denies any loss of consciousness she denies short uh chest pain. She does endorse an eight pound weight gain in the past two weeks, as well as some lower extremity swelling. She also endorses some subjective wheezing. Um her history, as I said, she has pulmonary sarcoidosis which she is on chronic um prednisone, 10 milligrams. She also has hypertension, for which she's on Lisinopril, 10 milligrams a day. She had a clean cardiac cath about a year ago after an abnormal EKG at her PCP. She denies tobacco use, alcohol, illicit drug use. She lives at home with her husband, who she says is supportive. She does have insurance through her job as a fourth grade teacher. Um vitals were significant for slight tachycardia at 110 with slight hypertension at 136/99. Her SpO2 was slightly hypoxic at 91%. She was afebrile. Physical exam was significant for a systolic murmur um with an S4 gallop. She did have positive JVD, but no carotid bruits. She had bibasilar rales and wheeze in her lungs, in both lungs. Um she did have one plus pedal edema with no calf tenderness and negative Homan sign. Labs were remarkable for an elevated troponin of 4,000, or elevated BNP of 4,000, I'm sorry, and a negative troponin. Chest X-ray showed mediastinal fullness um consistent with pulmonary sarcoid. She had no cardiomegaly and no pulmonary edema. EKG did show a sinus tachycardia at a rate of about 100. She had a normal axis. She did have a run of non-sustained uh V-tach on the EKG, um but her rhythm in the room was a normal sinus. Echo did show restrictive cardiomyopathy with increased wall thickness. EF was normal at 55%. I believe that her symptoms are due to uh sarcoidosis restrictive cardiomyopathy with an NYHA scale of 3. Um for her, I would like to admit her to telemetry um and give her amiodarone for the non-sustained V-tach. Keep her on her lisinopril and increase her prednisone dose to 60 milligrams uh a day um PO. I also would like to give 40 milligrams of furosemide IV um for fluid overload. Um as far as labs, I would like to order a CMP to keep an eye on her potassium because we're giving that furosemide. Um I don't believe she needs any uh diagnostic imaging orders at this time but I do want to consult radiology for a possible um FDG PET scan to look at the um infiltrates in her heart. I would also like to consult interventional cardiology for an A possible AICD placement given the NSVT.

120. 65-year-old female, Ms. Palmer, reports to the emergency department today with complaints of shortness of breath, palpitations, and fatigue. Her onset has been worsening for the past two months but has gotten especially bad in the past three days since visiting with her primary care physician on Friday. She was advised to go to the emergency department because of her symptoms. She's comfortable at rest, awake, alert, and oriented, and also reports multiple episodes of near-syncope um within the past two months. Uh she has a past medical history of hypertension and pulmonary sarcoidosis. Uh her past medical her past surgical history uh includes a heart catheter that she said that it was normal. Um her mom passed away at 40 years old sudden sudden death, and her father passed away at 59 years old for a myocardial infarction. Um her social, she has a well balanced diet. She enjoys going on walks. No illicit drug use, no tobacco, no alcohol. She's currently an elementary school teacher. She reports having one cup of coffee per day before work so she can get through. Um and she's been married for the past 30 years, has one sexual partner. So her current medications include lisinopril and uh prednisone for the sarcoidosis and uh lisinopril for the hypertension. She has no known drug allergies. Um she reported fatigue, so the only pertinent positives for her review systems were fatigue, palpitations, wheezing, and lower extremity swelling especially um around her ankles. Her physical findings were positive for JVD um positive for or negative for bruits uh positive for palpitations and there was a murmur present, uh early systolic murmur. Uh she reported wheezing and bibasilar rales on um auscultation. She um lower extremity edema was found on physical exam as well. Um of her labs, all were negative besides her BNP, which was elevated to 4,000. And her chest x-ray showed pulmonary edema, mediastinal fullness, and a normal cardiac silhouette. Her echo showed restrictive cardiomyopathy with increased wall thickness and an ejection fraction of 55 percent. Her EKG showed normal sinus rhythm with non-sustained left ventricular tachycardia. Um that's what I saw afterwards, after talking to the patient. Uh new York heart Association Class 2 because she did not report having difficulty with activities besides um exercise. Um and and so this is secondary to her hypertension and her pulmonary sarcoidosis. So the patient was admitted to telemetry uh with a diagnosis of sarcoidosis uh restrictive cardiomyopathy secondary to sarcoidosis. Um it is, it's a serious condition. She will be getting vitals q2 hours and out of bed with assistance. Um and nursing instructions include strict ins and outs, daily weight, DVT prophylaxis, and O2 via nasal cannula to make sure that it's at least 96 percent um I recommended a low-sodium diet so that we can get some of the fluid off. Uh we included uh keeping the vein open for fluids. Her we will continue the lisinopril but we will also add on, place the furosemide 40 milligrams IV and um increase her prednisone to 60 milligrams, and we'll be administering amiodarone 150 milligrams via IV, uh because of the ventricular tachycardia, and we will also be ordering a CMP panel for labs, and so we can further monitor the sarcoidosis. And we'll be consulting interventional cardiology for defibrillator AICD placement, and we'll be consulting radiology to get a uh a PET scan to further show the sarcoidosis

119. Mr. Palmer is a 62-year-old male who presented to the clinic today with a chief complaint of shortness of breath and fatigue. His vitals show a blood pressure of 80 over 50, a heart rate of 90, SpO2 of 86, pulse of 90, and temperature of 98.6. Mr. Palmer stated that these symptoms have been going on for the past six months and have worsened progressively. He visited his primary care physician a few days ago and symptoms have exponentially worsened since. He states he is unable to perform any physical activities as he experiences extreme shortness of breath but is okay at rest. He states that he cannot breathe when laying down and laying down to sleep and therefore has to sleep upright. Patient denies any pain and no medications were taken to help with the symptoms. Patient has not experienced anything like this before and rates his discomfort at a 10 out of 10. Review of symptoms showed showed fatigue, weight gain, wheezing, orthopnea, dyspnea, and lower extremity edema. Mr. Palmer's other medical conditions include hypertension, hyperlipidemia, diabetes, and atrial fibrillation for which he takes metoprolol, 50 milligrams once a day, lisinopril, 10 milligrams once a day, atorvastatin, 10 milligrams once a day, metformin, 500 milligrams twice a day, furosemide, 20 milligrams twice a day, clopidogrel, 75 milligrams once a day, and Warfarin, 2.5 milligrams twice a day. He has a history of a tertiary bypass performed 12 years ago and five stents placed, one of which was a left anterior descending stent placed in June of 2022. Patient has no pertinent family history. Patient's social history includes a balanced diet with moderate caffeine intake, no alcohol or illicit drug consumption. Patient smokes one pack per day for the past 30 years and appropriate counseling was provided. Patient is married and has a stable occupation. Pertinent physical exam findings include positive jugular venous distension with no bruits, heart auscultation revealed a tachycardia with a split S2 and no murmurs. Palpation revealed a laterally displaced PMI and no chest wall tenderness. Lung auscultations revealed bibasilar rails and wheezing with plus one pitting edema noted with full pulses and negative homan sign or calf tenderness. OMM examination revealed no TART changes or tenderness upon palpation of Chapman's points. Labs include elevated troponin at 0.4 and elevated BNP at 4,000. X-rays show cardio cardiomegaly pulmonary edema. Echo revealed dilated chambers with an ejection fraction of less than 30 percent. And EKGs revealed normal sinus rhythm, meaning left meaning left left m ventricle hypertrophy voltage criteria and left bundle brand block. A likely diagnosis in this case is ischemic dilated cardiomyopathy. Mr. Palmer was counseled was counseled on his smoking habits and advised that this may worsen the problem. The patient was also advised that this condition is likely due to his past cardiac medical history. The patient was admitted to telemetry and has a NYHA-4 classification. All current medications will be withheld except clopidogrel and warfarin, and dobutamine and an insulin sliding scale will be started. Patient was on BiPAP to assist with oxygenation. A PT, INR, and serial troponin will be reordered and monitored. Patient is on strict bed rest with IO, daily weights, monitoring, DVT prophylaxis, low sodium diet, and KBO. Vitals will be checked Q2H. Interventional cardiology was consulted and a patient will be taken for AICD and CRTD placement. Thank you.

118.

presenting with a chief complaint of shortness of breath and fatigue. He was alert, awake, and oriented, but obviously fatigued.um he stated that these symptoms have become progressively worse over the last six months. Mr. Palmer states that all activity exacerbates his shortness of breath and fatigue, and he does confirm that he's still having symptoms at rest. He states that lying flat worsens his condition, nothing improves it, and that he has been sleeping in his chair at night. um his respiratory rate was high at 22, his blood pressure was low at 80 over  50, and his oxygen saturation was low at 86%. The patient has a past medical history of hypertension, hyperlipidemia, diabetes, and atrial fibrillation, for which he takes lisinopril 10 milligrams once a day, warfarin 2.5 milligrams twice a day, clopidogrel 75 milligrams once a day, metformin 500 milligrams twice a day, atorvastatin 10 milligrams once a day, furosemide 20 milligrams twice a day, and metoprolol succinate 50 milligrams once a day. And the patient also reported a triple bypass previously and that he's had five stents with the last being in June, 2022 for a left anterior descending occlusion. The patient said that at that time, his physician told him he was not going to be a candidate for any more procedures and he's had no other hospitalizations besides for those cardiac procedures. He has a maternal family history of terminal breast cancer and a paternal family history of Alzheimer's. The patient did endorse fatigue and eight pound weight gain over two weeks, wheezing, dyspnea, orthopnea, and edema of the lower extremities today. His physical exa- exam showed JVD without carotid bruits, tachycardia with a split S2, laterally displaced PMI uh bibasilar rails and wheezing on auscultation of his lungs. He had a uh plus one pitting edema with intact distal pulses and non-tender calves in his lower extremities. His labs showed a troponin of 0.04 and a BNP of 4000, both of which are high. His chest x-ray showed cardiomegaly and pulmonary edema. His 2D echo showed a dilated left ventricle with an ejection fraction of 30 percent, and his EKG showed a left axis displacement with a left bundle branch block. I diagnosed him today with ischemic dilated cardiomyopathy due to his previous cardiac history, his physical exam, and the labs I got back today, as well as that imaging. He is a New York Heart Association stage four and should be admitted to the ICU. His condition is serious. He has no known drug allergies. I'd like him to have vitals every two hours, strict bed rest, strict input output, daily weights, and deep vein thrombosis prophylaxis. I'd like him on a low sodium diet. I'd like him on an IV fluid protocol of fluid lock, keep vein open. I'm going to hold all meds except his clopidogrel 75 milligrams once a day, and his warfarin 2.5 milligrams twice a day. I'm going to add a dobutamine IV drip and an insulin sliding scale. The patient should be on BiPAP with an input of 16 and an output of 6. I would like him to have serial troponins to monitor his um troponin level since it was high earlier. And I'd like him to continue having um PT INRs to monitor his clotting as we have him on both clopidogrel and warfarin um. I will be consulting interventional cardiology to discuss the possible placement of a CRTD or an AICD. And then after discharge, the patient will be instructed to maintain a healthy diet, weight, and then avoid strenuous activity until he is released by his cardiologist. Overall, I think his outlook looks pretty good. And please go see him whenever you're ready. Thank you.

117. I mean, Mr. Leslie Palmer, a 62-year-old male who presents to the ER with dyspnea and orthopnea and fatigue. He believes it's been going on for six months and has gotten progressively worse. He went to the family physician. Last week, they had run some labs, but they have not given him any updates on that. So he came in today because he felt more worse. He does not, uh he used to work out, but he's not alleviated by rest now. So he's been lessening his working out. And he is a NYHA class four candidate because of the rest, and he only can sleep in his chair. But laying down flat makes it worse. His vitals were 98.6 temperature. His heart rate was 90. His blood pressure was 80 over 50. His respiratory rate was 22, and his O2 stat was 86. His social history is good, but he's still a pack a day smoker and a moderate caffeine user with one cup a day. And he lives with his wife for 30 years. He feels well supported and happy with her. He also is a school teacher for eighth grade and he feels that he likes his job. His medical history that's pertinent is that he has hypertension, hypercholesterolemia, atrial fibrillation, and diabetes. His diabetes, he feels, is well-regulated by his medication. He is on lisinopril, 10 milligrams, atorvastatin, 10 milligrams, clopidogrel, 75 milligrams, metformin, 500 milligrams a day, furosemide, 20 milligrams a day, metoprolol  succinate, 50 milligrams a day, and warfarin, 2.5 milligrams a day. He has had a history of uh CABG and five stents over the past five years. His cardiologist says that he does not want to do any more since his last stent was June, 2022. His father has history with Alzheimer's who is still with us and in uh a nursing home right now. His mother died from breast cancer five years ago and his physical exam showed a positive for JVD, uh plus one pitting edema in his lower extremity and his pulses were equal. His uh DP and PT pulses were equal. He has bilateral rails and wheezing present on his evaluation. No murmur or rub. Plus tachycardia split S1. EKG showed a left bundle branch block with LVH criteria, normal sinus rhythm. His troponin levels were 0.04 elevated. BMP and his chest xray showed cardio- cardiomegaly and pulmonary edema. His echo showed dilated left ventricular with 30 percent ejection fraction. We all agreed, we I believe I should admit him to the ICU. So that is what we did. We're going to have to bring in an interventional cardiologist who can do an AICD and a CRTD. We're going to put him on dobutamine and take off his other medications. He can stay on clopidogrel and warfarin. We'd like to stop every other medication, put him on insulin sliding scale, give him BiPAP for that 86 O2, put him on a low-sodium diet, strict bed rest, and monitor his serial troponins.

116.

report on a patient I saw in uh clinic today. uh Mr. Leslie Palmer presented today with complaints of um some shortness of breath, some fluttering, wheezing, uh near syncope upon walking with friends for approximately 45 minutes. uh patient states that it's been happening now for a couple of weeks. They do not have any pain or any coughing though. The symptoms are alleviated with rest. Um it's really just the walking extensive amounts of time or any uh larger exertions cause that near syncope. The patient said that they are able to do everyday activities around the house uh without any symptoms, but they said when they do have those symptoms, they would rate it a 10, that it was absolutely terrible. They felt like they would absolutely uh pass out without rest. So um looking a little bit more into the patient's history, their um mother does, or had a sudden death at the age of 40. Their father died of a myocardial infarction at the age of 69. The patient himself did present with hypertension and he was taking uh lisinopril for that, 10 milligrams, but he also does not have any uh allergies to any drugs. Patients said that they haven't been hospitalized for anything, but they did have uh a heart cath approximately a year ago. It was an outpatient procedure and um all the results came back normal. No other surgeries other than that. um patients said that they do have a balanced diet. They exercise pretty regularly, but obviously they've been limited now  uhwith the oncoming of symptoms. With exercise, uh they report, and that was three to four times a week typically before symptoms caught on. They report no drug use, no tobacco use, no alcohol use. Normal caffeine intake, about a cup of coffee a day. uh they are employed as a seventh grade math teacher umand they are uh married to a man monogamous relationship of 22 years. uh patient reports no general findings, uh no neuro findings. Patient does, as I said before, complain of a flutter, near syncope, but uh without any chest pain. Patient does have shortness of breath and wheezing. The shortness of breath is uh when they're standing upon exertion, it's not specifically when they lie down. Presented today, they were slightly tachycardic with a heart rate of 110, which I discussed with them um as being possible that it's a pathology, but also with theuh with the idea of white coat syndrome, it could have easily been just because of their current presentation. Their oxygen saturation was 96% um and their blood pressure upon presentation was 130 over 90, with a normal temperature of 98.6 and normal respirations of 16. With the patient's presentation and physical exam um, with physical exam findings, I did find that they had pitting edema, um minor pitting edema of the lower extremity.Um I did hear the bilateral rails. I heard the wheezing. I heard um, upon examination of the aorta and the PMI, I didn't find any aortic aneurysm, but I did find a displaced PMI laterally, bilaterally. Um and upon my osteopathic screening was negative, and upon my physical exam as a whole, I did come to the conclusion that the most likely diagnosis for Mr. Palmer was familial hypertrophic cardiomyopathy. I did inform him that that could be a cause of his mother's unfortunate passing. And it is something that's inherited typically. I admitted Mr. Palmer uh to telemetry so he can have constant heart monitoring. And um I am switching his medication. I did not note it on the form, but I have notified the nurse that I'm switching the medication from lisinopril to disopyramide and I am going to have his vitals checked every two hours. We're going to refer to the cardiologist for a uh, for a pacemaker placement and as well as to the cardiothoracic surgeon for a possible myomectomy or alcohol injection to help with that septal hypertrophy. I reviewed his results. He understood the EKG findings of left ventricular hypertrophy, as well as the X-ray finding of cardiomegaly, as well as the echo. So Mr. Leslie was alert. He was well and oriented and he had no further questions regarding my workup um  and yeah I told him that he would follow up with you and if you have any questions please feel free to reach out. He's a pleasant dude and hopefully he gets up and at him sooner rather than later. Thanks.

115. Leslie Palmer is a 62-year-old female presenting with dyspnea, chest pain, and orthopnea following a cold that began two weeks ago. The patient states she is unable to exercise due to the dyspnea, which occurs with slight activity. The patient takes 10 milligrams of lisinopril QD for hypertension and states she had a routine cardiac cath one year ago. No known drug allergies, alcohol, or drug use were reported. Patient admits to an eight-pound weight gain over the past two weeks with heart palpitations. Heart rate was 110, O2 was 91, respiratory rate was 20, pulse was 110, BP was 130 over 90, and temp was normal. Physical exam findings were positive for JVD, a laterally displaced PMI, bibasilar rails, wheezing, and a one plus pitting edema in lower extremities. Posterior tibial pulses were full and equal. Troponin and BNP levels were elevated. An EKG showed a right bundle branch block with sinus tachycardia. Chest X-ray showed cardiomegaly and pulmonary edema. And an echo showed a dilated left ventricle with an ejection fraction of 30%. Patient was diagnosed with myocarditis and will be admitted to telemetry. Patient will be placed on nasal cannula with two liters per minute of oxygen flow with oxygen stats being maintained above 96%. Patient will continue taking her lisinopril as prescribed, be given 625 milligrams of acetaminophen PO Q6 hours for chest pain and IV furosemide 40 milligrams Q12 hours for edema. Interventional Cardiology, Infectious Disease, and Radiology were consulted.

114. Our first patient is 62-year-old Mr. Leslie Palmer. He presents with a six-month history of shortness of breath and fatigue. Um he has symptoms even at rest and has recently been sleeping in his armchair at night due to orthopnea. Symptoms of dyspnea, wheezing, and fatigue increase with any kind of activity and return to baseline at rest. Um he has also noticed an eight-pound weight gain in the past two weeks and has noticed swelling in his lower extremities. Um in terms of medical history, he has a long standing history of hypertension, hyperlipidemia, diabetes, and atrial fibrillation for which he is taking atorvastatin, clopidogrel, furosemide, metoprolol succinate, uh lisinopril, metformin, and warfarin. He has no known drug allergies. In terms of surgical interventions, he has had open heart surgery with a three vessel coronary artery bypass graft 12 years ago and has had five stents with the most recent one being a year ago in the left anterior descending descending artery. He is not amenable to further surgical intervention. His mother passed due to breast cancer and his father is currently in a medical facility for Alzheimer's disease. In terms of social history, um Mr. Palmer does not partake in illicit drugs or alcohol. He does have one cup of coffee each morning with breakfast and um does have a one 30-pack year history of tobacco use. He works as an elementary school teacher and claims to have a balanced diet. He also walks regularly, though recently he has found this difficult due to his symptoms. Upon physical examination, Mr. Palmer was found to have jugular venous distension, um tachycardia with a split S2, laterally displaced PMI, and was positive for a gallop. Lung auscultation reveals wheezing and brails. He had pitting edema in the lower extremities, but the bilateral radial and dorsalis pedis pulses were strong. Pertinent vital signs include a heart rate of 90, a blood pressure of 80 over 50, respiratory rate of 22, and O2 stat of 86%. After review of labs, imaging, and history, they suggested  i suggested an ischemic dilated cardiomyopathy. All of the patient's medications were terminated except for clopidogrel and warfarin. We started him on dobutamine and admitted him to the ICU where he will be put on an insulin sliding scale and will be on a BiPAP machine. He was referred to Interventional interventional Cardiology for AICD placement and CRTD placement. Um he was also consulted about social supports and financial supports before being dismissed. Thank you so much.

113.

On the patient I just saw in the ED, I saw a 60-year-old female who presented to the emergency room today with complaints of shortness of breath and fatigue. The onset of the shortness of breath and fatigue began um over the last six months and has been gradually worsening. The patient states that she is even short of breath at rest and symptoms are worsening with any and all physical activity. The patient states that she has been sleeping in a chair in her recliner at night and is unable to walk with her friends anymore due to her symptoms. Uh patient's medical history includes hypertension, hyperlipidemia, diabetes, and paroxysmal atrial fibrillation. Her social history includes that she is a one-pack-per-day smoker for the past 30 years. include lisinopril, 10 milligrams, metoprolol succinate, 50 milligrams, atorvastatin, 10 milligrams, uh Metformin, 500 milligrams, Furosemide, 20 milligrams, Clopidogrel, 75 milligrams, Warfarin, 2.5 milligrams. She has no known drug allergies. Mother died of breast cancer and father currently has Alzheimer's and is living in a nursing facility. Patient's surgical history includes a CABG and stents. Through the review of systems and the physical exam findings, um patient was fatigued and recently gained weight, eight pounds within the last two weeks. Skin testing was negative. HEENT was positive for JVD. Her cardio revealed uh tachycardia with a split S2, a displaced PMI but no murmurs, gallops, or frictional rubs. Pulmonary testing revealed bi- bilateral rails, orthopnea, dyspnea with exertion and wheezing. MSK uh revealed lower extremity edema, negative for all neurological testing. Her labs, her vitals included a heart rate of 90, a low blood pressure of 80 over 50, and an SpO2 level of 86, very low. Her troponin level came back slightly elevated at 0.4. Her BNP was also elevated at 4,000. So the diagnosis for this patient is ischemic dilated cardiomyopathy, which would be due to her medical history, particularly her hyperlipidemia and her smoking history contributing. Plan is to admit to the ICU and diagnosis includes an NYHA functional classification of level four condition is serious. Allergies, no known. Vitals, Q2 hours. Activity, strict bed rest. Nursing instructions include strict intravenous, daily weights, DVT prophylaxis. Her diet is restricted to low sodium. IV fluids or KVO keep vein open. Medications where you're holding all existing medications except for clopidogrel 75 milligrams, her warfarin 2.5. We will be adding a dobutamine IV drip and replacing her metformin with an insulin sliding scale. Respiratory therapy includes BiPAP and for labs and imaging I'm doing uh serial troponin levels and a PT-INR for her warfarin. The specialists I'd like to consult are the interventional cardiologists for either a CRTD or AICD placement. And that is everything for the sixty-year-old patient who came into the ED today and presented with ischemic dilated cardiomyopathy. Thank you very much.

112. Today I'm presenting on Ms. Palmer, who is a 62-year-old female um who presented to the ED with complaints of some chest pain, fatigue, and shortness of breath. Um Ms. Palmer said that she saw her family physician a few days ago with similar symptoms, um unresolved, and its symptoms worsened to go to the ED. Ms. Palmer said a few weeks ago, she had flu-like symptoms with fever, cough, runny nose, and shortness of breath and fatigue. Most of those symptoms went away a few days ago, other than the shortness of breath and fatigue. Ms. Palmer said that she uses pillows to sleep so she's elevated and she has no tried no treatments and the only alleviating factor for shortness of breath is to sit upright. Um she continued to go into the gym after her flu-like symptoms but eventually had to stop due to symptoms worsening and she said that her symptoms get a lot worse with exercise and moderate activity, but day-to-day activities are mainly unaffected. um the patient presented with an increased heart rate at 110 and decreased oxygen saturation. uh surgical history includes a cardiac catheterization procedure about a year ago. uh the patient told me that there's no medical history, though they are on lisinopril, which leads me to believe that the patient does have hypertension. The patient has a balanced diet and does moderate exercise weekly, about two to three times a week. The mother has a history of breast cancer and passed away at 85 years old, and the father has dementia and is currently in a nursing home. Review of systems included a well-developed, well-nourished patient who is fatigued and in pain, and has gained eight pounds since two weeks ago. This may be due to her lower extremity edema and swelling, and myalgia, which was shown on the physical exam. The patient complained of heart fluttering and had heart palpitations and a laterally displaced PMI. uh the patient complained of wheezing and coughing and uhh dyspnea and orthopnea, with orthopnea being worse. The physical also showed JVD with no uh carotid bruits. um pertinent lab results showed an elevated troponin and BNP. Chest x-ray showed pulmonary edema and cardiomegaly. The 2D echo ultrasound showed dilated cardiomyopathy in the left ventricle with a reduced ejection fraction of 30% and EKG showed sinus tachycardia with the right bundle branch block. um so based on this information, I believe that the patient had myocarditis that caused dilated cardiomyopathy due to viral cause. The New York Heart Association stage is stage two with heart failure with reduced ejection fraction at 30%. My plan is to admit this patient to the telemetry unit and um keep their lisinopril, add acetaminophen and furosemide at 40 milligrams IV, acetaminophen at 625 milligrams orally. We're gonna consult interventional cardiology for a defibrillator and AICD placement, and also do a right ventricular biopsy. We want to consult an infectious disease for immunoglobulin or glucocorticoid treatment and get a radiologist contrast media enhanced MRI. um we want to do strict IOs, daily weights, DVT prophylaxis, O2 um , via nasal cannula to get the oxygen back up to above 96%. Other than that, we want to do a serial troponin again, up to above 96%. again and repeat the echo and also get CMP. Um the patient had no questions upon my consult  upon my consultation consultation and advising them after their treatment plan and physical findings.

111. 62-year-old male patient presented with shortness of breath and fatigue. He stated that the symptoms started around six months ago and um have progressively worsened. He noted that he went to his PCP three days ago and felt the need to come to the ER due to his extensive cardiovascular history. Um the patient has been diagnosed with hypertension, hyperlipidemia, diabetes, and atrial fibrillation, all of which have been treated with prescription medications thus far. He has had an open heart surgery, he said around 12 years ago, um with CABG and a stent each. So he's had, I'm sorry, he's had one stent for the past five years. And he also noted that he has been told that he has left axis deviation ejection fracture on fraction on ultrasound that he obtained last year regarding his family. His mother passed away at the age of 80 years old from breast cancer. His father is 82 years old and has Alzheimer's currently living in a nursing home. So the patient um, a little about him personally, he does not drink alcohol. He um has smoked a pack of cigarettes every day for the past 30 years, and notes that he is not ready to quit when asked. And he does not use illicit drugs drugs, and does not have a history of it either. He states that he eats a balanced diet, drinks one cup of coffee a day, and he used to walk with friends several times a week, but he has not been able to recently due to his shortness of breath. He is a fifth grade teacher and is married and lives with significant others other notes that he has a great support system. He also states that he stated that he does not have any allergies and takes up or medications daily, of which are atorvus, im sorry for my pronunciation, atorvastatin 10 milligrams  PO QD, clopidogrel 75 milligrams PO QD furosemide 20 milligrams PO BID um metoprolol succinate  50 milligrams PO  QD lisinopril 10 milligrams PO QD metformin 500 milligrams PO QD and warfarin 2.5 milligrams PO BID. Complains of complains of fatigue even at rest now an eight pound weight gain over the past two weeks, wheezing and shortness of breath. He notes that he does not have any skin changes. No, HEENT changes chest pain, palpitations, syncope, or neuro um complications either. So, that said, on exam, he was awake, oriented and fatigued. He does not have a fever, did not have a fever. He had a heart rate of 90 beats per minute, um his blood pressure was 80 over 50, and his oxygen was at 86 percent. He had a positive JVD, no bruits. He had wheezing and rales on lung auscultation, pedal edema, but no tenderness. And, um importantly, he had a displaced PMI laterally. X-rays showed pulmonary edema and cardiomegaly. Ultrasound showed decreased ejection fraction um and the EKG showed normal sinus rhythm, LVH, voltage criteria in a left bundle branch block. um labs had elevated troponin and a BNP of 4,000. um overall, I assessed that he was a New York Heart Association class four. um together, the patient and I discussed that he had ischemic dilated cardiomyopathy, and it's essentially just progression of his previous heart condition. um and we decided that we will admit him to the ICU due to his serious condition um and check his vitals every two hours. um he will be on bed rest and the nurse will be notified or has been notified that he will have strict IO, take daily weights and maintain DVT prophylaxis. He will have a low sodium diet, um KVO, IV fluids, and we discontinued all his medications like stuff like clopidogrel and the Warfarin. um we started him on Dobutamine, IV drip, and an insulin sliding scale for his diabetes. um we also started him on BiPAP, and we will check his INT and serial troponins um frequently.um um I'm sorry, not INT, what I'm talking about. INR, because he's um taking warfarin. Overall, we referred him to an interventional cardiologist for IACD or CRT placement. That's it, thank you.

110. Leslie Parker is a 62-year-old female who presented to the emergency department complaining of worsening shortness of breath and fatigue. She reports a recent illness about two weeks ago with fever, cough, and shortness of breath. Her fever and cough resolved about five days ago, but she's still experiencing dyspnea, worsened with exertion and lying flat. She has a past medical history of hypertension, which is treated with lisinopril 10 milligrams. She has no known drug allergies. In terms of her past family history, her mother passed from breast cancer and her father has Alzheimer's dementia. She eats a balanced diet, does not drink alcohol, and does not use tobacco. She exercises regularly and has moderate caffeine intake. In addition to her fatigue and dyspnea, she reports recent weight gain, muscle soreness, lower extremity swelling, a dull, constant chest pain, palpitations, orthopnea, and wheezing. Upon physical exam, I noted jugular venous dissension, but no carotid bruits. Her heart auscultation did not reveal any murmurs or gallops. Her PMI was laterally displaced, but she had no chest wall tenderness. Her lung auscultation revealed bibasilar rails and wheezing. Upon evaluation of her lower extremities, she had 1 plus pitting edema, however her dorsalis pedis and posterior tibialis pulses were full and equal and her calves were non-tender. Her labs and imaging revealed increased troponin and a BMP of 4,000. Her chest X-ray showed cardiomegaly and pulmonary edema and her echo showed a dilated left ventricle with decreased ejection fraction. Her EKG showed tachycardia with a right bundle branch block. Uh based on these findings and her clinical history and my physical exam, this patient most likely has myocarditis dilated cardiomyopathy. I would recommend admitting to telemetry. Activity as  tolerated with a low sodium diet. She should continue her Lisinopril. We should add furosemide 40 milligrams IV and acetaminophen 625 milligrams for pain. We should consult with the interventional cardiologist for an AICD and biopsy for definitive diagnosis. We should also consult with infectious disease for possible use of immunoglobulins or glucocorticoids, and we should consult with radiology for enhanced cardiac MRI to better view the inflammation in her heart.

109. I'm here today reporting about 62-year-old patient who came in complaining about shortness of breath, chest pain, and fatigue. That started about three days ago, and it has been constant level of discomfort since then. Patient mentioned she had flu-like symptoms about two weeks ago, but recovered fully. Patient states the discomfort level is mainly in the chest area, and she is unable to sleep in bed, so she has been sleeping in recliner. Patient also states she has uh shortness of breath at rest um. Patient, as well as patient, states the severity of discomfort as two out of 10. Patient has past medical history of hypertension and currently taking lisinopril to manage that and has no known drug allergy, as well as no past surgical history. Patient mom passed away of breast cancer and father is diagnosed with Alzheimer's and currently in nursing facility. Patient is an elementary school teacher and currently lives with her husband. Upon review  upon conducting review of system, patient mentioned to have fatigue, weight gain, about eight pound, lower extremity swelling, chest pain, palpitation, wheezing, dyspnea, and orthopnea. um patient's vitals were slightly elevated to a stage one hypertension and was tachycardic. Upon conducting full physical exam, I found patient to have JVD distention, carotid bruits, but no murmur, friction rub, or gallop. Patient also had wheezing and bilateral rails present upon um auscultating her lungs. Patient had pedal edema as well, but no chest wall tenderness. X-ray results showed cardiomegaly with pulmonary edema. 2D echo showed dilated cardiomyopathy with lab ventricle ejection fraction of 30%. EKG results showed sinus tachycardia with a right bundle branch block. Patient lab test also showed elevated troponin and BNP. Based on all these available tests and clinical examinations, our determined patient had myocarditis, dilated cardiomyopathy, and admitted her to telemetry. Based on patient information, I also sent her a class 4 heart failure. I'm also adding 625 mg acetaminophen and 40 mg ibuprofen to her medications along with continuations of 10 mg lisinopril. I'm also ordering serial troponin and CMP lab tests as well as repeat of 2D echo. I am setting her up to have consultation with interventional cardiology to discuss about potential placing any device placement as well as doing an endomyocardial biopsy. I'm also setting her up with infectious disease to go over about the immunoglobulin or glucocorticoid to better manage her condition right now. And radiology for MRI. I shared all of this information with the care team and discussed about necessity to recheck all her initial vitals as well as check vitals every two hours. I'm also advised low sodium diet for now. That's all I have for now. Thank you very much.

108. Leslie Walker, he's a 62 year old male that presents with a shortness of breath and fatigue. um he is a current smoker and he currently has hypertension, hyperlipidemia, diabetes, and um atrial fibrillation. Um i did a physical exam on him and he shows um  wheezing and bibasilar rails as well as some jugular venous distension and lower extremity edema. He also stated that he is having trouble laying down, so he's having trouble laying down breathing, so I believe he's got some orthopnea, some dyspnea going on as well. And he states that these symptoms are going on at rest. I looked at his um x-ray, his x-ray showed some pulmonary edema and cardiomegaly, and then I looked at his lab results and saw that his BNP is um severely elevated, showing some fluid buildup in the heart as well as an elevated troponin, which shows some damage to the heart that's going on. I believe what's going on is ischemic heart disease. I think the next best step in his treatment should be um to admit him to the ICU. I believe that we should have him follow up with the cardiologist for a possible AICD placement and or a CRTD placement. Um I would like to start, keep him on his clopidogrel and warfarin and add dopamine as an ionotrope to help his heart beat a little better. And um we can go in together and see him now. All right, thank you.

107. Okay, good afternoon. So we have a 60-year-old woman who's presenting with a chief complaint of shortness of breath and fatigue. The patient has experienced flu-like symptoms days prior to arrival. She states that her breathing is labored and sleeps in her recliner to alleviate the symptoms of shortness of breath. Her activity level has drastically decreased and her symptoms improve upon rest. She had a fever, cough, and runny nose, which has since subsided days prior. um patient also has chest pain, slight palpitations, dyspnea, and orthopnea. Patient denies syncope and abnormal skin rashes or lesions. On further review of symptoms, patient does complain of wheezing and swelling in her lower legs. The patient was previously diagnosed with hypertension in which she is currently taking lisinopril 10 milligrams by mouth daily. And the patient denies consuming alcohol, using illicit drugs, and smoking any tobacco products. Her vital signs that were within normal limits included the blood pressure, which was 130 over 90, and her temperature, which was 98.6 degrees Fahrenheit. Her elevated vital signs included the heart rate, which was 110, and respiratory rate, which was 20. Her oxygen saturation level was decreased. It read 91%. And on physical exam, pitting edema was shown in her lower extremities, and also rails and wheezing were noted during lung auscultation. Hypertension, actually, primary assessment is myocarditis dilated cardiomyopathy due to previous viral infraction. However, hypertension could be provided as a secondary assessment. And the plan to treat these symptoms would be to admit the patient to telemetry units just for monitoring. And we also want to begin nursing to have her on a strict IO to do daily weights, DVT prophylaxis, and to place the patient on the O2 nasal cannula to increase the oxygen saturation to 96%. And also we wanna give her medications with lisinopril, acetaminophen, and furosemide. Wanna do 10 milligrams by mouth of lisinopril, 625 milligrams by mouth every six hours of acetaminophen, and 40 milligrams of furosemide IV. And because she's on furosemide, we want to make sure we order a CMP because her troponin levels were also high and her BNP was also high. We want to make sure we order troponin levels to be monitored and to do a repeat echocardiogram. That's her chest x-ray and her echo showed, her chest x-ray showed pulmonary edema and cardiomegaly and the echo showed the left ventricular ejection fraction weight was below 30 percent. And we also want to have interventional cardiology follow her as well as infectious disease and radiology. She's going to get a contrast enhanced MRI of her heart, as well as be put on immunoglobulins or glucocorticoids because of the infection. And we would like to look at an endomyocardial biopsy, as well as CRTD and AICD, which is just the pacemaker and defibrillation, and we will have the patient continue to be monitored and checked every two hours while on the floor. Thank you.

106. and I'm presenting to you today the case that I saw in the emergency room. I saw a 62-year-old female. She came in with a chief complaint of shortness of breath and fatigue. Um he reports that the onset of this occurred around two weeks ago, which she reported to her family medicine practice. Uh they advised that she come in to be examined. She did report that she is experiencing and paroxysmal orthopnea, which uh her dyspnea is worsened by strenuous activity or being active, whereas her orthopnea is worsened by laying down. Um rest relieves her dyspnea and her orthopnea is relieved where she has to prop herself up on pillows, especially when she's sleeping. Um she also reports that during exertion, she does feel presyncopal episodes coming on, and as well as she has, she's significant for palpitations. Uh the patient was alert and coherent, however she was fatigued and pretty concerned about her current condition. Our review of systems yielded she was negative for chest pain. She, again, was positive for palpitations and syncope. She denied wheezing or coughing, just dyspnea and orthopnea was positive.  Her, she did report that she did experience edema, and pulmonary edema specifically. And her past medical history is significant for pulmonary sarcoidosis, which she takes prednisone 10 milligrams for. And she's also significant for hypertension, which she takes 10 milligrams of lisinopril for.Um she does report that she is consistent with her medication and she uses it as prescribed. Her mother is also, her family history yielded that her mother did die suddenly of an unexplained cause um at 40 years old and then her father did die at 59 years old from a uh from a ischemic cardiac event. She does report that she has known on drug allergies. Upon physical exam, it yielded that she was tachycardic. She had a heart rate of 110. Her O2, or her pulse ox was 91%. Her respiration was 20 breaths per minute. She was mildly hypertensive. She was 130 over 90. And, um you know, continuing with the physical exam. She, pulses were intact bilateral. There were no bruits present. And auscultation did yield a cardiac murmur. And there was bilateral rails as well as pitting edema present. Um uh chest x-ray did, you know, reviewing the chest x-ray, it did reveal pulmonary edema as well as mediastinal fullness and pulmonary infiltrates, uh which were detected, which were positive for a pawnbroker sign. Her echocardiogram did yield that there was uh thickening, and there was a preserved ejection fraction of the heart, and her EKG did demonstrate that there was non-sustained ventricular tachycardia. So regarding her labs, her BNP was also significantly elevated to 4,000. And this was discussed with the patient as far as clinical findings are concerned. So given this information, I would say her, she also reports that she is a non-smoker, non-drinker. She's fairly active, which is how she noticed that something was going on. So regarding this information, I do believe that she is suffering from sarcoidosis restrictive cardiomyopathy and I would classify her as New York Heart Association class three. She has secondary diagnosis of hypertension as well as pulmonary edema um and my plan for this patient is to admit to telemetry. I want to consult with uh interventional cardiology as well as radiology. So we can go ahead and see if there may be a need for a pacemaker or we could also get a FED PET. Additionally, um as far as orders are concerned, she can be activity as monitored activity or support. She's gonna be on nasal cannula and I like to start DVT prophylaxis, as well as strict IO and daily weights. Additionally, I would like to continue her with lisinopril. However, I would like to increase her prednisone to 60 milligrams. And then I would also like to start her on amiodarone 150, so it can improve her cardiac output, um and also for SVT. And as far as lifestyle modifications are concerned, um uh you know, as long as she maintains healthy way diet and weight reduction, she may be able to, you know when she meets with invention interventional cardiology and nuclear medicine, um she may be able to, you know, have a better or an improved outcome. Thank you so much, and I look forward to discussing this case with you. Bye.

105. case presentation on the patient that I just saw, Ms. Leslie. So she went to her PCP about three days ago, complaining of shortness of breath, tiredness, fluttering in her heart, as well as some feelings of about to pass out. She didn't actually pass out, so if racing can be feelings. Her PCP told us if any, told her if anything got worse to come see us, and he also ordered her x-ray, labs, echo, and EKG. So we're going to go over those with her. I went over them with her. Sorry. 3, 2, 1, go. Hi, Dr. Rawlins. I'm a student doctor Drew McCauley. I just want to give a case presentation on the patient I just saw, Ms. Leslie. So she went to her PCP about three days ago with complaints of shortness of breath, tiredness, flutterings in her heart, as well as presyncope feelings. went ahead and ordered labs, chest x-ray, echo, and EKG, and we're going to go over those results with the patient today, which is quite good. And she came to the ED as instructed by her doctor as her symptoms were getting worse. So this all began about two months ago, and she is no longer able to do really any activity without the pain, sorry not the pain, her symptoms getting worse. She likes to sit in her recliner as well as rest to help with her symptoms. She says that it gets worse when she's laying flat as well as being moving in any sort of activity. So her past medical history consists of high blood pressure and pulmonary sarcoidosis diagnosed 25 years ago. She had a cardiac cath one year ago. No complications, nothing significant from that. My family medical history for her mom was sudden death at 40 and her father died of a heart attack at 59. For social history, she does not use alcohol, not use tobacco, never uses drugs, never has before. She is currently employed as a fourth grade teacher. Cup of coffee. She used to exercise regularly five times a week with a walking group of her friends but due to her symptoms she is no longer able to do that. She is living with her husband. She currently takes a Centeprel 10 milligrams once a day as well as prednisone 10 milligrams once a day for sarcoidosis, lisinopril's for her high blood pressure. She has no drug allergies. She does have an unexplained weight gain of about eight pounds over the past two weeks. Her ROS for skin and HEENT were both negative. For her cardiovascular, we talk about her palpitation she's been experiencing and she also said the feelings of presyncope like we already talked about. For pulmonary, she has them having some wheezing as well as the dyspnea and orthopnea. For MSK, she's had the lower extremity edema and she's had some lightheadedness feeling. Today she presented awake, alert, and oriented. Her vital signs were as follows. Temperature was 98.6, heart rate 110, respiratory rate 20, blood pressure 136 over 90, SpO2 at 91%. She had no carotid bruits. She did have JVD bilaterally. She had a regular heart rate. She did have an S4 murmur when I was listening on the mitral valve and her PMI was normal. Bilaterally, she did have wheezing and rales upon auscultation of her lungs. No homann sign. For her imaging looking at her chest x-ray she had mediastinal fullness and pulmonary edema in a normal size heart. And looking at her echo they said that the diagnosis was restrictive cardiomyopathy with increased wall thickness, ejection fraction 55%. Looking at her EKG, it was normal sinus rhythm, but she did have some non-sustained Vtach. Her labs were normal for troponin and elevated for BMP at 4000. So given all the information of her history, physical exam, and the imaging and labs, I diagnosed her with sarcoidosis restrictive cardiomyopathy. She had a New York Heart Association functional classification of 3. And I told her we're going to admit her to telemetry for her serious condition and we're going to check her vitals every two hours and she can get out of bed with assistance. um strict IO, daily weight will be monitored, DVT prophylaxis, giving her some oxygen to help keep her sat, that's about 98% with the nursing interventions. Keep her on a low sodium diet and IV fluids, KVO. No pain medication. We were gonna start on amiodarone to help with her non-sustained vtach. The lisinopril's fine to keep taking for her high blood pressure. And then her prednisone we're are going to increase to help with sarcoidosis in her heart and lungs. We also are gonna add furosemide to help with the edema she's experiencing. And then we're going to consult interventional cardiologists, talk about an ACDI placement, and a radiologist to do a FDG PET scan to look at her heart better. And that's it.

104. I'm presenting to you today a 62-year-old female patient, Leslie Palmer, who showed up today to the ER with um chief complaints of fatigue, shortness of breath, and palpitations that started two months ago, which has been getting worse. Patient stated to have visited her family and medicine provider three days ago, but since then um her symptoms haven't gotten any better, and I would classify her as a NYHA classification of three. Um patient said that she had fatigue and gained eight pounds since the start of her symptoms. Patient also stated that she had wheezing, orthopnea and dyspnea with exertion. For her cardiovascular symptoms, uh she stated that she had palpitations, presyncope, but no chest pain. Her musculoskeletal symptoms were all negative except for swelling in her lower extremities. Otherwise, everything else was insignificant for her ROS. The patient has hypertension and pulmonary sarcoidosis that was diagnosed 25 years ago. The patient had a cardiac cath done a year ago with no significant results, otherwise no other hospitalizations. The patient has no known allergies . um she's not taking any illicit drugs, no tobacco or alcohol. Um she drinks a cup of coffee every day and is an elementary school teacher. She's also married and has someone to take care of her throughout her medical care, and um she has insurance. Uh her patient died suddenly at the age of 40, and her father died of a heart attack at the age of 59. Um for her physical exam, I noted a positive jugular venous distension, but no carotid bruits, no rashes, no petechiae, no purpura. Um she had bi-basilar rails and wheezing. Point of maximum impulse was normal, with no chest wall tenderness. She had a uh positive one pitting lower extremity edema and had a full and equal posterior tibial um pulses. Her calf was non-tender, her heart was regular with a systolic murmur of S4, no pericardial friction rub, um but positive for gallops. She had a heart rate of 110, up 120, blood pressure of 136 over 99, pulse was 108, and her temperature was 98.6 degrees Fahrenheit. For her lab, she only had elevated BMP levels, chest X-ray showed infiltration in her lungs, a widened mediastinum, and a normal-sized heart. The echo results showed restrictive cardiomyopathy with an ejection fraction of 55%. Her EKG showed normal sinus and access with a non-sustained ventricular tachycardia. Um so so the patient was diagnosed with sarcoidosis restrictive cardiomyopathy and she'll be admitted to the hospital. Patient will be continuing her lisinopril, 10 milligrams. I increased her prednisone to 60 milligrams and then I added amiodarone, 150 milligrams IV and furosemide 40 milligrams IV. Um I'll be ordering CMP labs for her and I will also be consulting interventional cardiology for an AICD placement and radiology for a FDG PET scan. Um patient will also be given oxygen via the nasal cannula to maintain her oxygen saturation above 96%. And I counseled the patient on maintaining a low sodium diet and not getting out of bed without assistance. Thank you.

103. for our patient Leslie. She is a 62-year-old female, Leslie Palmer. She came in to the emergency room complaining of shortness of breath and fatigue. She stated this started about two weeks ago when she first had flu-like symptoms and they seemed to go away around five days ago, but ever since that moment, she has been quite tired and fatigued. Um especially, she said, when she goes to the gym, she's not able to do any strenuous activity. So, having some exertion with dyspnea. She also states that she seems to have a dull, constant pain on her chest and uh the only way to make it feel better, especially during the night, is to put some pillows and sit on the recliner. So it seems like she's got some orthopnea going along with the dyspnea. Then she didn't take any medications in the past uh what the only thing that makes it feel better is just resting. I do want to see, I do want to go over also her past medical history. She does seem to have a history of hypertension. She was taking lisinopril, 10 milligrams. She stated she had no allergies, but she has had some prior procedures before. She had a cardiac cath about a year ago due to some abnormal EKGs, but everything came up okay, she stated. Other pertinent history, her mom, she died of breast cancer, and her dad currently is 90 years old with dementia. And in addition to that, social factors, she usually exercises two to three days a week, so she is active and eats a balanced, well diet, so it is a little on the stranger side that she has, she's had shortness of breath while trying to exercise. She is a teacher and is married and sexually active as well. When I did the review of systems, I did get some pertinent information when it came to general. She complained of fatigue, some gain of weight. She did have a fever and chills in the past but not currently. Then skin was normal, HEENT was normal. Then in cardiac ROS, she did have palpitations and chest pain. And with lungs, she said she complained of shortness of breath, orthopnea, dyspnea, and some wheezing as well. She did that she had fluid in her extremities. And other than that, the her vitals, they were 130 over 90, heart rate was 110, temperature was 98.6, respiration rate was 20, oxygen saturation was 91%, Uh when it comes to the physical exam itself, we have right here, let's see. She did have a jugular vein distension. In regards to cardiovascular problems, she did have her PMI was displaced laterally, uh no murmurs, friction rub, or gallops. There did seem to be some rails present as well, the wheezes, and in regards to her edema, she did have some pedal edema. She also had her pulses and her dorsalis pedis were equal bilateral. Her x-ray did show cardiomegaly and pulmonary edema, which was explained to her. It did show some dilated cardiomyopathy with a reduced ejection fraction as well. And her EKG showed some sinus tachy with left ventricular hypertrophy um and some probably a right bundle branch block. Troponin was elevated. BMP was 4,000. As a whole, she was diagnosed with myocarditis dilated cardiomyopathy due to the prior history. And with congestive heart failure, as her New York Heart Association score, it was a three due to, I'm sorry, was it two, as she had limitation only with strenuous physical activity. She was admitted for telemetry. This is a serious case. We wanted to keep vitals every two hours. Activity as tolerated. Uh nursing interventions included daily weights, O2 spats of 96% and DVT prophylaxis, strict intake and output. We wanted to keep the vein open. In regards to medication, we are allowing for a sat of 96, 625 milligrams every six hours as needed. Then we have metoprolol and lisinopril, which were prescribed. So, lisinopril 10 milligrams every day, and then the 50 milligrams by mouth every day of metoprolol along with furosemide 40 milligrams IV every 12 hours. Additional labs included serial troponins and then also repeat 2D echo to take a look at the heart and monitor progress. She was referred to interventional cardiology, infectious diseases, and radiology for possible AICD placement, CRTD placement, endomyocardial biopsy, media-enhanced MRI, and immunoglobulin or glucocorticoids, possibly. But that will be something the specialists will be taking care of. Thank you.

102. left the emergency department after seeing Ms. Leslie Palmer. She is a 62-year-old female who's presenting with symptoms of progressive worsening of shortness of breath and fatigue over the last two months. She said she saw her family doctor about three days ago where she received a diagnostic workup, but did not get to review the labs and diagnostic findings with her PCP. Um she said she presents today because her symptoms have worsened. She says that she has significant decreases in her activity levels, no longer able to complete her normal activity. Um the patient has a history of hypertension and pulmonary sarcoidosis for which she reports compliance with her medications of lisinopril and prednisone, reports a maternal history of sudden death of her mother around 40 years, and her paternal history of death at 59 following a MI. She has no known drug allergies, reports an outpatient cath procedure about one year ago, no complications from that. Her associated symptoms that she's experiencing with today is about eight pounds weight gain two weeks. Fatigue as I said. She notes some presyncope as well as palpitations, no chest pain though. Associated wheezing and orthopnea where she says she's now having to lay in her chair to sleep. Notes of edema to her ankles bilaterally. Um on my exam she was awake alert and oriented. Her vitals, she  she was a little low on her O2 stats with 91%. BP was a little elevated, 136 over 99. She was afebrile at 98.6 and was a little tachy at 110, a respiratory rate of 20. um on my exam, I didn't hear any carotid bruits. JVD was present bilaterally. I heard an S4 systolic murmur with no rubs or gallops. PMI was not displaced. Wheezes were present and rails were present. She had no tenderness, was not in acute respiratory distress though. Homanns was negative, no, non tender calves. She did have pedal edema, one plus. Her pulses were all present. I'm looking at her x-rays, she had mediastinal fullness, pulmonary edema, as well as a normal heart size. I discussed this all with the patient as well as going over her ECHO, which was read as restrictive cardiomyopathy with preserved ejection fraction at 95 or 55 percent, excuse me. Her EKG, it seemed normal, maybe an occurrence of some left ventricular hypertrophy was a little elevated in the V5, V6 leads. I told her it could have been maybe something we want to repeat on the EKG at a later time. On the monitor though, I did note a period of non-sustained V-tachs. We talked about that as well with the patient. Her troponin, as well as her CBC and CMP were within normal limits, non-diagnostic, but she did have an elevated BNP at 4,000. So I discussed with the patient that I believe that her pulmonary sarcoidosis history, that was about 25 years ago, has likely spread to her heart and is causing her symptom presentation. Currently, I would put the patient on the plan to get admitted to telemetry and where we'll get consults for interventional cardiology as well as radiology to further um evaluate and work up this patient. She told her about potential for getting a pacemaker placed as well as to get further imaging um with the radiologist um. Went through the plans and how she'll be admitted. Um she says she has insurance and good social support locally. So she felt good about that plan to get her admitted and have people who would support her. Um we talked about how she's gonna get some medication to support her symptoms, try to help alleviate them. So I'm gonna go ahead and diagnose her with, or prescribe her some amiodarone with a non-sustaining vtach as well as lisinopril. And I'm gonna up her prednisone dosage um since the pulmonary sarcoidosis has seemingly spread to her heart. I'm also gonna get some furosemide to help the pulmonary edema that she's experiencing. Um and I'm gonna do a repeat CMP just to make sure that nothing has changed from that. just to make sure that nothing has changed from that.

101. doing a case presentation on Leslie Palmer. The patient is Leslie Palmer, who is a 62-year-old male. He presents to the office with shortness of breath and fatigue. He states that he saw his GP three days ago and was referred to the ER today. Patient states his symptoms started two weeks ago with heart palpitations that worsen with exercise and improve with rest. He also states near syncope. He denies fevers, chills, and changes in weight. He denies joint pain, muscle pain, and back pain. He also denies skin changes. He denies vision changes and hearing loss and neck stiffness. He notes some dizziness with the heart palpitations when he's exercising. Past medical history includes hypertension and is taking lisinopril 10 milligrams daily. He denies a surgical history except for a cardiac catheterization that was normal. Family history includes his mother who passed away suddenly decades ago and his father also passed away at age 59 due to MI. He has no known drug allergies. For his social history, he states that he eats a well-balanced diet and walks daily. He denies the use of illicit drugs, alcohol, and tobacco. He drinks a cup of coffee every morning and is an elementary school teacher for fifth grade. He's also sexually active. Vital signs showed a heart rate of 110, which is slightly elevated, a blood pressure of 130 over 90, which is also slightly elevated, but he is taking lisinopril, a respiratory rate of 16, temperature was 98.6 and his O2 sat was 96%. Physical exam showed negative JVD and bruits There was an S4 murmur and gallop and a laterally displaced PMI. Lungs were equal to auscultation and bilaterally. no lower extremity edema or calf tenderness, and pulses were present, equal, and bilateral. Lab showed troponin and BMP within normal limits. A chest x-ray showed cardiomegaly. Echo showed LVH voltage criteria and tall R waves, in septal leads. Patient was diagnosed with familial hypertrophic cardiomyopathy due to genetics. The treatment plan for this patient is to admit two telemetry, maintain activity as tolerated, strict IO, daily weight, DVT, prophylaxis, and O2 nasal cannula to maintain the O2 sat at 96%. You can have a regular diet and we'll do a saline lock or KVO. The patient is to discontinue the lisinopril and start disopyramide, 100 milligrams BID. No further labs and imaging needed. We will consult with the interventional cardiologist for an AICD placement, and we'll consult with a cardiothoracic surgeon for a future septal myomectomy or alcohol injection to reduce the LVOT. Patient to lose weight or maintain healthy weight and not do strenuous activity until released by a physician. Thank you for your time.

100. after a family med consult. Uh her family doctor ordered some tests because she was concerned about her six month duration uh dyspnea. Um the patient noted that the dyspnea gets better only when she lays in the recliner. She hasn't tried anything to make it better and nothing that she tried made it better. She rated the breathing that she would experience a 9 out of 10 on the worst exertion. As far as her medical history is concerned, she had high blood pressure, high cholesterol, she was diabetic and five years ago she was diagnosed with AFib. Uh on her father's side, uh he is in a nursing home currently, 89 years old. Her mother's side, breast cancer. Um she has no allergies to medications. She had a stent put in last June. Aside from that, she had five stents put in total and she had a triple bypass done. No hospitalizations. She had a list of medications that I inputted into the EMR. She has a balanced diet, exercises daily, doesn't take any drugs or alcohol, still smokes. I counseled the patient about quitting the smoking because she does one pack a day. She drinks one cup of coffee a day. She's currently still an elementary school teacher, and she has a partner that was sitting in the waiting room who she's married to for 30 years with no kids. As far as her vitals are concerned, um her heart rate was 90, her blood pressure was 80 over 50, respiratory rate 22, pulse 90, temperature 98.6. EKG showed normal sinus rhythm, left bundle branch block, and left axis deviation. Uh her lab results showed elevated troponin and BMP, indicative of cardiac muscle cell death and heart failure, or what I said to the patient was heart dysfunction um. As far as review of systems is concerned, she had orthopnea, she had difficulty breathing at rest, so that puts her at an NYHA score of She had fatigue, wheezing, every other ROS for MSK and neuro GI was negative or otherwise noted in the EMR. I didn't have a chance to copy it over onto my sheet. She is immunized or up to date on all her immunizations. I gave her a consult as far as her needing to be admitted to the ICU. The nurses will receive instructions regarding vitals to be checked every two hours, uh strict bed rest, um also strict monitoring of intake, outtake, daily weights, uh DVT prophylaxis, low-sodium diet, IV, KVO. She would need BiPAP. We would discontinue all her medications, which I let her know, and add dobutamine for her blood pressure. I didn't let the patient know that we would need to put her on an insulin scale, but I think that's more necessary to know for the nursing staff. And she would continue taking Plavix and Warfarin. She would need to get repeat labs for troponins and PT and INR because she's currently taking warfarin. Um s far as consult, I let the patient know that she would need a consult to interventional cardiology for CRT and AICD, specifically because of the left bundle branch blocking need to reestablish some normal rhythm in her left bundle branch blocking need to reestablish some normal rhythm in her heart. Um that's it.

99. Mr. Leslie Palmer is a 62-year-old male who presents to the clinic today with, to the emergency room, a chief complaint of shortness of breath, fatigue, palpitations, and near syncope. The patient states that he began his symptoms about two weeks ago and he went to his family medicine doctor because he was a little concerned. And his family medicine doctor ordered some tests, but he did not, but the patient did not get any of his tests back. However, yesterday, the patient noticed that his, uh the patient noticed that his symptoms were worsening, so he decided to come to the ER. Upon presentation, the patient states that he has trouble with some physical activity. He has some trouble with physical activity and he also states that he, these symptoms do get better upon rest. The patient states that he, in terms of severity, he states that while he's sitting, his severity is zero, but with any brief, okay, I'm gonna start over. All right, so I'm gonna start over. Hi, Dr. Rawlins, this is student Dr. Akshata Sastry and I'll be presenting the case for Mr. Leslie Palmer who is a  62-year-old male, and he presents with shortness of breath, palpitations, fatigue, and near syncope. The patient states that he visited his family medicine doctor about two weeks ago, about a few days ago, concerned about his symptoms. And the PCP decided to run some tests, but the patient has not received those back yet. Uh the patient notes that he had an uh increase in symptoms yesterday, and that's why he decided to come to the ER. The patient states that his uh his symptoms began about two weeks ago. He states that they are better at rest, so he does not have any severity or any symptoms when he is at zero. However, he says that with some physical activity, he does have his symptoms do not radiate anywhere and he did not treat with any medication because he did not know any of them. Um his medical history states that he's the patient, Mr. Palmer states that he had a cardiac cath about a year ago and his medical history for hypertension. The patient states he also did not have any allergies. In terms of his social history, the patient eats a very balanced diet, and is a very active elementary school teacher. He is sexually active with his wife. Upon the ROS, the patient denies all symptoms except for his fatigue, his shortness of breath, some wheezing, and um and some palpitations, and of course, his presyncopal episodes. And I decided to start the physical exam at that point. I did not note any carotid bruise. I decided to listen to his and I did not notice any chest tenderness. When I listened to his heart, I did notice an S3, S4 murmur as well as a gallop. I listened to his lungs and uh they were clear to bilaterally to auscultation. Um i decided to also check for any abdominal bruits and abdominal masses and that was negative. He did not have any peripheral edema. He did not have any calf asymmetry, no homan signs. Yeah, and his pulses were very strong. I decided to get, look at his vitals and his vitals did look a little bit high. His heart rate was at 110 and his saturation was about 96%, which was okay. His respiration rate was about 16 breaths per minute and his blood pressure was 130 over 90. Um upon looking at his labs, I noticed his CMP, his troponin and his BNP were all normal within normal values. His chest X-ray showed cardiomegaly and his ECHO showed a left ventricular ejection fraction of less than 60%. And his EKG demonstrated tall R waves in all the septal Leads, some left ventricular hypertrophy, and but other than that, normal sinus rhythm and normal axis. For admission, I decided to diagnose him with familial hypertrophic cardiomyopathy because uh he did say that his family, oh, he also told me that he, in terms of his family, his mother passed away suddenly at the age of 40 and his father passed away from a myocardial infarction. So due to his history, I decided, and along with his physical exam, I decided that he has a diagnosis. I decided that he takes for his hypertension and instead we put on a disopyramide and then I would like to admit him to the hospital to telemetry. I would like the nurses to be watching it for ins and outs, DVT prophylaxis. I would like to have his daily weight watched and I'd like to put him on a nasal cannula at two liters and keep them above 96% because of his complaint on shortness of breath. In terms of people I would like to, the doctors I'd like to consult with him, I would like an interventional cardiologist to come see him for his AICD and I'd also like a  cardio- cardiothoracic surgeon to come see him for evaluation if he needs a septal myectomy or alcohol injection. And that is the conclusion of my case presentation. Thank you.

98. Mr. Palmer is a 62-year-old male in room 2. He arrived at the emergency room complaining of shortness of breath and fatigue, just constant fatigue. Um he said these symptoms gradually got worse over the past six months. Um and he made an appointment with his primary care physician about three days ago, and the physicians recommended him to check himself in at the emergency room. He did not complain of any chest pain. He did mention that his legs have been swollen, likely due to lower extremity edema. Mr. Palmer also said that he gained about eight pounds recently, and that he's been getting wheezes and shortness of breath while sleeping. He has a past medical history of um uh  hypertension, hyperlipidemia, type two diabetes, and atrial fibrillation. He's also had um triple bypass and a uh lower sorry lower left ascending artery stent put in about a year ago. Uh Mr Plamer has no pertinent family uh history related to his present illness. Mr. Palmer used to walk with his friends often, but now due to his fatigue over the last six months, he's been unable to walk at all. He does smoke one pack a day, and I have talked to him about quitting smoking, and he has interest in seeking help. And I was gonna refer him to a specialist who can help with that, help him quit. As of right now, he's currently taking the following medications. He's taking Warfarin, metformin, lisinopril, atorvastatin, clopidogrel, uh furosemide, and uh metoprolol succinate. And he has no known drug allergies. His vital signs are as follows. His blood pressure is 80 over 50, which is a little hypertensive. Temperature is normal at 98.6. His SpO2 is 86, which is also low. And his heart rate is normal at 90 beats per minute. Upon physical exam, Mr. Palmer had JVD, heart gallop, lung wheezes, and rails were also present. He also had pulmonary edema in his lower extremities, like he mentioned before, and uh he did not have any chest wall tenderness upon palpation. Um after the physical exam, I told him he most likely has ischemic cardiomyopathy, and as well as a secondary diagnosis of hypertension, type 2 diabetes, and hyperlipidemia. For admission, we'll have to admit him to the ICU upon serious conditions. We'll have to take his vitals every two hours, and he'll have tp be on strict bed rest with no, little to no physical activity. The nurses will intervene with strict IOs, daily weights, DVT prophylaxis, as well as BiPAP. We'll put him on a low sodium diet since he has no food allergies as well. I will order troponin and PT-INR for labs. We have to make sure his IV stays open and refer him to an interventional cardiologist for a AICD. And we'll have him continue as Warfarin and Clopidogrel, but as well we'll add on an insulin sliding scale continue as Warfarin and Clopidogrel, but as well we'll add on an insulin sliding scale and WME and IV drip. Thanks so much.

97. Today I'm presenting patient Ms. Palmer, who is a pleasant but somewhat fatigued appearing 62-year-old female patient with a chief complaint of fatigue, shortness of breath, and dull chest pain which began about two weeks ago. She states she just had some fever, cough, and runny nose when her symptoms began and believed that she just had a cold. She continued to exercise, believing she just had the common cold, but noticed she was unable to complete her exercises due to shortness of breath and fatigue, which was unusual for her. Ms. Palmer states her symptoms have been constant since her onset and nothing has made it better, but notices that exercise can make it worse. She has tried nothing medically for her symptoms and rates their severity as a 2 out of 10 today. Regarding her medical history, she did have a cardiac cath about a year ago and does have a history of hypertension. She has no allergies. She exercises about 2-3 times a week before her symptoms began and was unable to do so since. She does not use any drugs, tobacco, or alcohol. She does drink about one cup of coffee per day. She currently does work as an elementary school teacher and lives comfortably at home with her husband. She has no prior history of hospitalizations. She mentions no family history when inquired. She is currently taking Lisinopril, 10 milligrams peri-orally daily for her hypertension. Her general review of systems revealed no fever or chills today, although they did occur two weeks ago when her symptoms began. She does have fatigue today as well as an 8 pound weight gain. Her skin ROS is negative. Her head, eye, ears, nose, and throat ROS is also negative. Her cardio ROS reveals some dull chest pain today accompanied by palpitations but no presyncope. Pulmonary ROS does have shortness of breath, wheezing, and has been sleeping on a recliner due to her orthopnea. Her MSK ROS reveals some mild muscle aches in her lower legs as well as noticeable swelling in her lower extremities. Her neuro ROS is negative. She is otherwise well-developed and well-nourished, albeit with some fatigue and is alert and oriented today. She is not in any pain when asked. A thorough physical examination was performed and notably there was some JVD in her neck area. She also did have some bilateral rails and wheezing on auscultation of the lungs. However, regarding a cardiac examination, she revealed no murmurs, rubs, or gallops, but did have a laterally displaced PMI. Her lower extremity did reveal 1 plus pitting edema. However, the calves were symmetric and negative Homann's sign and eluded no concern for PE at this time. Her abdomen was also soft and non-tender and there were no TART changes noticed. Her vitals were normal except for a mild tachycardia of 110 and her respiratory rate of 20, a blood pressure of 130 over 90, and O2 sat of 91 today. Her labs including chest x-ray which reveals some pulmonary edema and cardiomegaly, her EKG which reveals some right bundle branch block and sinus tachycardia and her 2D echo, which revealed 30% ejection fracture and dilated cardiomyopathy. Her blood work revealed troponin slightly elevated and BMP of 4,000 and slightly elevated. This will be reviewed with the patient and a primary diagnosis of myocarditis, dilated cardiomyopathy, NYHA class two was made given her presentation. We plan to admit her to med with telemetry. Her condition is currently serious. Vitals are to be taken every two hours and her activity levels can be managed as tolerated. Nursing was instructed to manage strict input-output, daily weight changes, DVT prophylaxis, as well as O2 via nasal cannula, and her O2 saturation is to be maintained above 96%. She is also recommended to have a low-sodium diet, and perioral fluid restriction is recommended at this time. IV fluids are to be locked, and the veins are to be kept open. She has no allergies. Acetaminophen 625 milligrams peri-orally every six hours is recommended to help with her inflammation and she is to continue her lisinopril as previously prescribed of 10 milligrams every day. We are to add furosemide 40 milligrams IV every 12 hours to help reduce the swelling. We will repeat serial troponin and get a CMP as she is now on furosemide. She was referred to interventional cardiology for AICD placement as well as CRTD and a right ventricular endomyocardial biopsy. Infectious disease was also consulted for referral for immune globulin as well as glucocorticoids to further reduce the swelling. Radiology consult for contrast media enhanced MRI was also recommended to detect for further myocardial inflammation. She was recommended to maintain a healthy weight and to reduce her weight, and no strenuous physical activity is to be recommended at this time. Patient had no further questions and was satisfied with her diagnosis and treatment plan.

96. So, Mrs. Palmer is a 62-year-old female with a past medical history of hypertension on 10 milligrams of lisinopril daily, and she's presenting to the emergency department today with a chief complaint of shortness of breath, chest pain, and fatigue. She states that two weeks ago, she had a cough, a fever, and a runny nose, along with her current symptoms, and she says that those all subsided about five days ago, but the ones that are currently presenting are still persisting through. Her chest pain is described as being substernal, constant, and dull, and it doesn't radiate anywhere else. Um nothing seems to specifically aggravate it, but she has also not tried any medications, but she does note that reclining back makes her symptoms a little better. Um h er current pain level is a 2 out of 10, and she feels that her chest pain is at rest, which would classify her as an NYHA of four. Her only surgical history is a cardiac catheterization about a year ago that showed no obstructive coronary artery disease, and she has no known drug allergies. She doesn't smoke, drink, or do any illicit substances at all. She works as an elementary school teacher, and her family history is positive for a mom who passed away from breast cancer at the age of 80. And her current father is 89, and he's in the nursing home for Alzheimer's right now. She states she eats a well-balanced diet, and she was exercising two times a week for about an hour at a time, but she hasn't been able to given her current symptoms. She drinks a cup of coffee a day, and she's currently married and lives in a stable household with her husband of 30 years, and she's still sexually active with just her husband and only her husband. Her vitals at the consultation were a heart rate of 110, a blood pressure of 130 over 90, and an oxygen saturation of 91%. Her respiratory rate was a 20, and her temperature was at 98.6 degrees Fahrenheit. On the review of systems, she was positive for fatigue and recent weight gain of eight pounds. She noted palpitations and chest pain with no syncope. Um she also noted wheezing, dyspnea, and orthopnea, and some lower extremity edema. Um her physical exam showed jugular vein distension with no carotid bruits. Her heart rate was regular with no murmur, friction rubs, or any gallops. On palpitation of her PMI, it was noted to be laterally displaced, and her lungs were positive for bibasilar rails and wheezing. She also had 1 plus pitting edema in her lower extremity, but she also had a negative Homann sign, and pulses were full and equal bilaterally as well. On the imaging that was done upon entering the ER today, her chest x-ray showed that she had cardiomegaly and pulmonary edema. Her echo was interpreted by the radiologist and was found to have a dilated left ventricle, an ejection fraction of 30%. Um her EKG showed that she had sinus tachycardia with about 100 beats per minute on that and a right bundle branch block. And there were also a few captured preventricular contractions as well. Her lab showed a troponin of 0.1 and a BNP of 4,000. And given all her history, physical exam, and diagnostic exams that were done, a diagnosis of myocarditis, dilated cardiomyopathy was made. The treatment plan for Mrs. Palmer was to admit her to telemetry, take vitals every 2 hours and have the nurses monitor her ins and outs, daily weights, DVT, prophylaxis, and bring her oxygen up with an O2 nasal cannula, trying to get her sats over 96%. Um we should keep her on a diet low in sodium and have her restricted on oral fluid intake. She will also be on an IV fluid saline lock, KVO. She was instructed to continue taking her lisinopril while in the hospital and thereafter, and we'll also add on some acetaminophen, 625, every six hours by mouth, and furosemide, 40 milligrams IV, and also a beta-blocker, metoprolol succinate, 50 milligrams by mouth while she's in the hospital. Additionally, we're gonna get repeat labs with serial troponins and a 2D echo during her stay here. We also have consulted interventional cardiology for a CRTD and potential AICD placement, and also a right ventricular endomyocardial biopsy. Infectious disease was also consulted as well, just for potential immunoglobulin and glucocorticoid treatment if they deem it necessary. And then lastly, the radiologist was consulted for a potential media-enhanced MRI if they also deem that necessary. Overall, Mrs. Palmer expressed no concerns with being admitted to the hospital or to the treatment plan moving forward.

95. The 62-year-old female patient presents to ED with a chief complaint of shortness of breath. patient reports gradual worsening of shortness of breath, palpitations, and feeling like passing out over the past two months. She visited her primary care physician three weeks ago where tests were conducted, but her symptoms continued to worsen. Symptoms improved with rest but worsened with physical activity. The patient mentions sleeping on a chair at night to alleviate the symptoms. The patient has a history of pulmonary sarco- sarcoidosis and hypertension. She currently takes lisinopril 10 milligrams and prednisone 10 milligrams. She does not have any known allergies, and she does not use any substances such as tobacco, alcohol, illicit drugs. She does consume one cup of coffee per day. The patient reports a balanced diet, exercise regularly, but much less since her symptoms started. She works as an elementary school teacher, is in a monogamous relationship, and has insurance and also support at home. On physical examination, the patient appeared well-developed, well-nourished, fatigued, awake, and orient. Um notable findings include elevated jugular vein distention, a systolic murmur, rales, and one plus pitting edema of the lower extremities. BNP was elevated at 400 4,000. Chest X-ray showed pulmonary edema and mediastinal fullness. Echo showed, restrictive cardiomyopathy with a 50%, 55% ejection fraction. The EKG was suggested of a non-sustained VTach with normal sinus rhythm. And overall, the 60-terial male, female with a history of pulmonary sarcoidosis and hypertension presenting worsening shortness of breath, palpitations, near fainting episodes, demonstrating signs of volume overload and restrictive cardiomyopathy. So for her plan, we decided to admit her for telemetry with a diagnosis of sarcoidosis, restrictive cardiomyopathy, and a three on the NYHA scale. Considering the seriousness of her condition. There was no known drug allergies to be noted and vitals were to be closely monitored at two hours. The patient will be encouraged to engage in mobility with assistance. Nursing instructions are strict intake-outtake monitoring, daily weight measurements, DVT prophylaxis, and the use of oxygen via nasal cannula to maintain oxygen saturation over 96%. The patient will be placed on a low sodium diet to manage fluid retention. IV fluids will be administered via saline lock to keep vein open rate. Medications will be continued as previously described, including lisinopril, 10 milligrams Q QD, and additional medication will be initiated, such as amiodarone, 150 milligrams IV, and an increase in prednisone to 16 milligrams QD, and furosemide IV, 40 milligrams. A comprehensive metabolic panel will be ordered, overall organ function. Consultation with interventional cardiology will be made for consideration of an AICD placement. And a consultation with nuclear medicine radiology will be arranged for a FGE PET scan. To further evaluate the sarcoid, the patient will be advised to maintain a healthy diet, work towards weight reduction, and avoid strenuous physical activity until released by the physician. Cut.

94. All right. Leslie Palmer is a 62-year-old male with past medical history of hypertension who presents at the referral of his primary care provider for approximately two weeks of dyspnea on exertion with accompanying fatigue and wheezing. He states that his symptoms only present with exercise and are relieved by rest. He explicitly states that his shortness of breath improves with lying down. Leslie also mentions a presyncopal sensation with exercise and heart palpitations. He denies experiencing a syncopal episode, um  only feeling like he may pass out. He describes his palpitations as a fluttering and speeding up of his heart. He denies any chest pain, any lower extremity edema, or any recent changes in his weight. He says he's compliant with his lisinopril 10 milligrams daily. He notes a cardiac cath approximately one year ago, which was normal. He says his father died of a heart attack at the age of 59, and his mother died suddenly at the age of 40. He has no known drug allergies, and he denies tobacco and alcohol use. He also denies illicit drug use. He says he drinks about one cup of coffee a day and has a balanced diet with minimal salt intake, or addition of salt, I should say. He is employed as a teacher and lives at home with his wife. He says before his symptoms uh begin, he was walking a few days per week, but is unable to exercise with his symptoms now. On physical exam, he does have a systolic murmur with an S4 and gallop. He has no chest wall tenderness, no JVD, no carotid bruits, no abdominal bruits. His PMI is laterally displaced. His lungs are cleared of auscultation bilaterally. His calves are non-tender, no pedal edema, negative Homann sign. He has strong and equal DP and PT pulses. Uh chest X-ray was significant for cardiomegaly, but otherwise normal. His echo showed interventricular hypertrophy with an ejection fraction of 60%. His EKG showed uh left ventricular hypertrophy and tall R waves in the septal leads. Troponin was uh negative and BNP was within normal limits. I told him that he most likely has hypertrophic cardiomyopathy and that we'd like to admit him to the hospital. I said he'd be started on disopyramide for arrhythmia control, and that we'd also like to consult interventional cardiology for possible placement of an AICD. And we'd also talk to cardiothoracic surgery about a possible septal myomectomy or alcohol injection. He seemed to understand the plan um he noted he does have insurance to help cover the cost of his hospital stay.

93. All right. Leslie Palmer is a 62 year old woman who presents to the ER today complaining of dyspnea ongoing for six months, six months and worsening the last few days. She has orthopnea and is a NYHA class 4 she has a medical history of atrial fibrillation, hypertension, diabetes, hyperlipidemia, coronary artery disease. He meds are atorvastatin clopidogrel, furosemide, metoprolol succinate, lisinopril metformin, and warfarin. She has no drug allergies. She has a surgical history of multiple cardiac stents, coronary artery bypass graft. Her vital signs were heart rate of 90, blood pressure 80 over 50, her SpO2 is 86, and her temperature was 98. She has a maternal family history of Alzheimer's. Her physical exam reveals rails, wheezing, plus one pitting edema, splitting of the S2, Laterally disp- laterally displaced PMI, splitting S2, jugular venous distension, no calf tenderness and equal pulses. Her chest X-ray reveals uh cardiomegaly and pulmonary edema. Her EKG reveals normal sinus rhythm with a left bundle branch block. She has lost ventricular hypertrophic criteria on her EKG. Her 2D echo reveals dilated cardiomyopathy with an ejection fraction of less than 30. She has elevated troponin and elevated BMP. I diagnosed her with ischemic dilated cardiomyopathy and I admitted her to the ICU and placed her on a BiPAP. I ordered an IV to keep the veins open. I continued her on clopidogrel and warfarin for deep vein thrombosis prophylaxis. I kept her on furosemide, however I should have placed her on dobutamine. She's on strict bed rest. I ordered bulb labs of the PT / PTT INR and serial troponins. I consulted an interventional cardiologist for AICD the PT / PTT INR and serial troponins. I consulted an interventional cardiologist for AICD cardiologist for AICD and CRTD placement.

92. Presenting Mr. Leslie Palmer's case. Mr. Leslie Palmer was a patient in room 11 at our emergency room today. Mr. Palmer presented to the emergency department as a 62-year-old male who came to the ED due to feeling short of breath for the last six months. Mr. Palmer stated that he felt sore all over and couldn't participate in any exercise without feeling short of breath or feeling tired in general. Mr. Palmer also stated that he had a lower extremity edema bilaterally, as well as only feels comfort at rest in the semi-fowler position. Mr. Palmer, his past medical history consists of diabetes, hypertension, hyperlipidemia, and paroxysmal atrial fibrillation. His past surgical history includes a stent placed five years ago and a CABG, coronary artery bypass graft, placed 12 years prior to the visit today. Mr. Palmer has no known allergies and takes numerous medications such as atorvastatin, clopidogrel, furosemide, metoprolol succinate, lisinopril, metformin, and warfarin. Mr. Palmer lives at home, he's married, he currently lives with his wife. Upon physical exam, Mr. Palmer displayed JVD, laterally displaced PMI, rails, pedal edema, as well as cardiomegaly and pulmonary edema on checked x-ray. Mr. Palmer's EKG consists of normal sinus rhythm at 90 beats per minute. Mr. Palmer also had a left bundle branch block, as well as met left ventricular hypertrophy voltage criteria. He also, his lab work displayed elevated troponin, as well as BNP. With this said, Mr. Palmer was diagnosed with ischemic dilated cardiomyopathy. His echo also showed this and supported this with a dilated ventricle as well as thin septum. He was admitted to the ICU for monitoring and evaluation by interventional cardiology. Mr. Palmer's diagnosis warranted vitals every two hours, a strict bed rest, nursing interventions, as well as a low-sodium diet, KVO, clopidogrel, warfarin, and dobutamine administration, as well as an insulin sliding scale. This concludes Mr. Palmer's case presentation. Thank you.

91. So the patient, Ms. Leslie Palmer, is a female patient who is 62 with chief complaint of dyspnea and fatigue. The patient mentioned that it has been going on for two weeks with cough, runny nose, shortness of breath, and chest pain. She also mentioned orthopnea. Five days ago, the cough went away while the shortness of breath and fatigue remained. She mentioned a past fever. The patient has no surgical history or hospitalization or allergies. She mentioned hypertension is taking less than a pill, a 10-milligram orally for that. She mentioned a balanced diet with exercise two times a week. However, due to her symptoms, she isn't able to exercise currently. She mentions no drug, alcohol, or tobacco use. And she mentions drinking coffee about a cup a day. She's an elementary school teacher and sexually active with her husband. Patient's up to date with immunization and she reports other symptoms such as arrhythmia, wheezing, swelling, and says she's sleeping on a recliner indicating orthopnea. So physical exam was performed. So lung and heart auscultations were performed and OMM was performed as well with the focus of chart changes, spinal examination and tissue tenderness. Homann test was also performed. There was a jugular venous distension, no bruits, regular heart rate, no chest wall tenderness. There were rales and wheezing present during physical exam and there was pitting edema as well. The heart rate was 110, oxygen was 91, blood pressure was 130 over 90, and respiratory rate was 20. The chest x-ray showed pulmonary edema and cardiomegaly and the left ventricular ejection fracture of less than 30%. Um the troponin the lab showed troponin was high at .1 and BNP was high at 4,000. And on EKG, it showed a right bundle branch block with sinus tach and left axis deviation. All the labs and images were explained individually to the patient. Um the diagnosis made was myocarditis with dilated cardiomyopathy. And this was explained to the patient. For orders, patient will be admitted to telemetry for serious condition, and vitals will be taken every two hours. Uh strict IO, daily weight, and DVT prophylaxis with O2 nasal cannula and O2 stat greater than 96% will be recommended. A low-sodium diet will be recommended. Um also the uh lisinopril will be continued at 10 milligram. Acetaminophen will be added at 625 milligram orally and furosemide IV at 40 milligram will also be added. A repeat of ECHO will be ordered as well as a repeat of troponin and CMP. Um, there will be referral to interventional cardiology for AID and CRTD, and infectious disease for immune globulin and also radiology for a media-enhanced MRI. And all these were explained, the diagnosis, imaging, and next steps were explained to the patient. And that concludes my presentation, thank you. Bye.

90. Ms. Palmer, a 62-year-old woman, came into the office. She was complaining of fatigue and shortness of breath. She is awake and alert and just seems fatigued. Um she says that she had a cold about two weeks ago, during which she experienced chills, fever, coughing, and wheezing. She can't tolerate any physical activity, but however the symptoms are better whenever she sleeps in her recliner. Okay. Past medical history, she has hypertension. She takes the 10 milligrams of lisinopril for that. She's had no surgeries in the past. Um her mother passed away of breast cancer at the age of 80, and her dad has Alzheimer's. Um socially, she eats a well-balanced diet aside from the fatigue that she's starting to feel. Recently, she exercises twice a week and um she does not smoke any tobacco. She does not do any illicit drugs. She does not drink alcohol. She does drink caffeine. She's an elementary school teacher, and she lives with her husband. For her review of systems, two weeks ago she complained that she had she admitted to having fever. She does not have any chills. She said that she had gained weight and she feels fatigued. Her skin assessments were negative um skin assessments were negative, but she complains of chest pains and palpitation and has no syncope. She also complains of wheezing and coughing and having to sleep in her chair. her neuro exam was unimpressive but she complained of myalgia  Her vital signs for her vital signs , she had a heart rate of 110, blood pressure of 130 over 90 and an O2 of 91 on room air pulse of 110, and the respiration of 20 for her vital signs with her, I went ahead and took the physical exam. The physical exam showed distended  internal jugular vein distention,  She had bibasilar rales, on auscultation of her lungs. She also had pulmonary edema. There were no palpitations or irregular heartbeats upon auscultation of her heart. And her pulse were also present um. Her dorsalis pedis pulse was present, and they were strong. After the physical exam, we went ahead and reviewed her imaging. Her x-ray showed cardiomegaly. It also showed effusion in the lungs, pulmonary edema. Her echoes showed uh enlarged left ventricle with a reduced ejection fraction. Her KEG her EKG showed left axis, she had tachycardia, premature ventricular contractions, and also showed a right bundle branch block. So for her diagnosis, I went ahead and diagnosed her with myocarditis dilated myocarditis um I told her that the condition was serious and that we're going to admit her to telemetry. We are going to continue her on lisinopril, um put her on furosemide, and then acetaminophen for her chest pain. Um she, we're going to consult cardiology, interventional cardiology. We're also going to contact infectious diseases and then radiology as well. Um I ordered an ICD and a group of corticoids together with that as well. I asked if she had insurance, she confirmed to have insurance and she had family support that was going to help her through this time. So that's my case presentation on Ms. Palmer. Thank you, Doc.

89. Mr. Palmer walked into the ED today with a chief complaint of chest palpitations and difficulties when exercising. Mr. Palmer is currently being treated for hypertension with an ACE inhibitor, lisinopril, and his symptoms were onset during a bout of exercise. And Mr. Palmer states that he has no trouble when lying down, uh no trouble breathing when lying down. Some background history on Mr. Palmer is that he um tries to walk every day until his symptoms um and he has a balanced diet. He drinks one cup of coffee a day. And some relevant past family medical history include a myocardial infarction on his father's side and a sudden death from his uh mother who died at a premature age of 40. And Mr. Palmer had mentioned that he had initially gone to his PCP to get some work done and that his PCP told him to come to the ED to have his symptoms further evaluated. He has been hospitalized in the past for a cath procedure which came back okay as he stated and as he also had an EKG at that time. And Mr. Palmer presented tired, fatigued, and weak but he had no chest pain, only the palpitations. And he said that he almost had felt like as if he was gonna faint sometimes, leading me to think it was presyncope. And in addition to that, during the review of systems, relevant findings on the pulmonary side included dyspnea. And during the physical exam, there was no pedal edema noted or pitting. And his PMI was displaced laterally. And during counseling, I went over all of his labs and his labs included an x-ray showing cardiomegaly and a 2D echo showing septal growth in the myocardium of the heart and an EKG indicating um familial cardio- familial hypertrophic cardiomyopathy due to the growth in the septal waves. And for treatment, I counseled Mr. Palmer on discontinuing his lisinopril and I think it's best to plan and administer a dosage of disopyramide for him to help with his palpitations. And I would like to admit Mr. Palmer to telemetry for monitoring and ultimately have him consulted by interventional cardiology in order to get an AICD placed and cardiothoracic surgery to consult him on a potential septal myectomy and um alcohol alcohol injection and that essentially it concludes my notes on this patient encounter today and relevant vitals Encounter included an elevated heart rate and an elevated blood pressure as well. And that concludes my patient.

88. to the ER today complaining of fatigue and shortness of breath for the last week or so. She notes that the fatigue and shortness of breath is much worse upon any type of exertion or just regular moving around. Is also she also notes some orthopnea that is improved when she sits up and she actually prefers to sit in her recliner. Um patient notes that approximately 2 and 1⁄2 weeks ago, she had a cold, runny nose, fever, and some shortness of breath with a cough, um and uh also some fatigue. A patient has no significant history other than hypertension. Her surgical procedural history, she had a cardiac cath last year. Family history, her mom died of breast cancer, her dad is living with Alzheimer's. Social, she eats a balanced diet, she exercises two times a week, but ever since these symptoms began she has not been able to exercise without significant shortness of breath. She does not use drugs, tobacco, alcohol. She does drink a cup of coffee every day and she lives with her husband right now. Medications. She takes lisinopril 10 milligrams for the hypertension and she has no known allergies. A review of symptoms, besides the fatigue, um she denied today any fever, chills, uh weight loss or weight gain. Um she had no rashes, skin discoloration, lesions, or bruising. Musculoskeletal, patient noted some leg swelling but denied any muscle aches, joint pain, back pain. Um cardiovascular, she did have, she noted some chest pain and some palpitations, but denies any syncopal episodes. Um she  pulmonary, she did have some orthopnea and she noted some wheezing and obviously she had the dyspnea. Neuro, patient had no complaints. She denied up gait disturbances, dizziness, or confusion. HEENT, she denied any neck stiffness, difficulty swallowing, vision changes, hearing loss. And then upon presentation today, her vital sign, her blood pressure was 130 over 90, temperature 98.6. Uh she was tachycardic at 110 and her O2 set was 91. Upon physical exam, she had jugular vein distension, cardio vascularly regular, no murmurs, no friction rub, no gallops. She did have a displaced PMI laterally. Lungs, onto auscultation, I noted bibasilar rails and wheezing, MSK 1 plus pitting edema bilaterally in Neurological exam was normal. So today we ordered troponin, BMP, EKG, chest x-ray, echo. Troponin was 0.1, which is mildly elevated. BMP was elevated at 4,000. EKG, she was sinus tachycardic at 100. There was a right bundle branch block, RSR, in the right leads. She had left axis deviation and premature ventricular contractions in AVR, AVL, AVF. On chest x-ray, there was pulmonary edema and cardiomegaly. Echo showed a dilated left ventricle with reduced ejection fraction, less than 30%. So I discussed this lab work and the imaging with the patient. I diagnosed her with myocarditis, dilated cardiomyopathy, and I discussed that it's probably related to the viral illness she had a few weeks ago. So we're going to admit her to telemetry. She's gonna see interventional radiology for AICD placement and CRT. They might even wanna do an endomyocardial biopsy. We'll also consult with infectious disease for immunoglobulin glucocorticoids, as well as radiology for contrast MRI. So we're going to keep around lisinopril, add acetaminophen for the pain, and we're going to get her on a furosemide 40 milligrams IV to get that fluid off. And then I discussed all the findings, I discussed the plan with the patient. We discussed the cause of the uh myocarditis um and I discussed the treatment options for her and told her that she's gonna be in great hands.

87. you a case presentation on a new patient. Ms. Palmers is a 62 year old female presenting with the chief complaint of orthopnea and fatigue that started two months ago but has gotten worse the past three days. She has a history of hypertension and pulmonary sarcoidosis which she takes lisinopril 10 milligrams and prednisone 10 milligrams for. She has no allergies. She has gained eight pounds in the past two weeks, has dyspnea, palpitations, and sometimes has feelings of presyncope. She also mentioned swelling in her ankle. She had a cardiac catheter put in one year ago. Regarding her social history, she has a balanced diet, no alcohol, illicit drug, or tobacco use. She drinks one cup of coffee a day. She is currently sexually active and lives with her husband. She is generally active and walks with her friends regularly, but she has not been able to do that recently. Currently she is NYHA uh  class 3 with marked limitations of physical activity. Regarding her family, her mother is deceased and passed away from sudden death and her father died at 59 due to myocardial infarction. Now in regards to her vitals, temperature was 98.6, heart rate was 110, respiratory rate was 20, pulse was 108, blood pressure was 136 over 99, and oxygen level was 91%. Cardiopulmonary physical exam showed positive JVD, no carotid bruit, regular heart rate, murmur, presence of gallop, presence of murmur, rails, and wheezing. She had pedal edema, and DP PT pulses were full/equal. her pulses were her labs were elevated BNP at 4,000. X ray showed normal heart size pulmonary edema and mediastinal fullness. ECHO showed restrictive cardiomyopathy with increased wall thickness with an ejection fraction at 55%. And EKG showed non-sustained ventricular tachycardia. Homann's sign testing for DVT was negative. So at this point, sarcoidosis restrictive cardiomyopathy was suspected. So I spoke to her about the diagnosis and that the condition is serious. I also inquired about her social support and insurance. At this time, she will be admitted to telemetry. Vitals will be taken every two hours and activity instructions are out of bed with assistance. Nursing intervention includes strict I-O, daily weight, O2 2 liters per minute via nasal cannula, DVT prophylaxis, and maintaining her oxygen saturation about 96%. Diet is low, sodium and KVO for fluid IVs. Medication will include prednisone 60 milligrams PO. She will continue taking her lisinopril of 10 milligrams PO and we will add furosemide 40 mg via IV every 12 hours. CMP was ordered, should be consulted by interventional cardiologists and a radiologist for possible AICD placement and for FDG PET scan. Thank you so much.

86. Leslie Palmer is a 62-year-old female presenting with worsening shortness of breath. She had a cold two weeks ago that has improved, but since then she has continued to have non-radiating dull retrosternal chest pain and shortness of breath. Her activities have become limited due to her dyspnea, and she has gained eight pounds in the past two weeks. She has been sleeping in a recliner due to orthopnea. Um she has shortness of breath with any activity, including walking across the room, but her symptoms improve at rest. She has not had any fever for the past five days. Her past medical history includes hypertension that she takes lisinopril for, and she had a cardiac cath completed one year ago that was normal. Uh she was evaluated by her PCP recently, where she had a chest X-ray that showed cardiomegaly and pulmonary edema. She also had an echo that showed dilated cardiomyopathy with LVEF at less than 30 percent and an EKG that showed some sinus tachycardia with two beats of PVCs in the left bundle branch block. Um lab work had elevated troponin of 0.1 and elevated BMP of 4,000. On vitals, she had sinus tachycardia at a rate of 110 and a pulse ox 91. She has a slightly elevated blood pressure of 130 over 90 on physical and a JVD wails wheezes rails and pitting edema for diagnosis I think she has myocarditis dilated cardiomyopathy secondary to her illness that she had two weeks ago. The plan currently to admit to telemetry. Im gonna start her on O2 nasal cannula for her low pulse ox. We're also gonna order her lab work, serial troponin and CMP. Uh I'd like to get a repeat 2D echo as well. Um for her medications, I'll have her continue on her lisinopril, order furosemide 40 IV for her edema, and also acetaminophen 6.5 for her pain. Referrals, we're gonna refer her to interventional cardiology for evaluation of AICD, CRTD, and potential right ventricular biopsy. We're also going to consider to infectious disease for IVIG or glucocorticoids. And finally um radiology for an MRI of her chest with contrast.

85. I just got finished seeing patient Leslie Palmer. She prefers to go by Miss Palmer. She came in with a chief complaint of fatigue and shortness of breath. It started about two months ago. She's also having syncope, palpitations, dyspnea, orthopnea, and she also had an eight pound weight gain um in her legs, mainly from the edema that she's experiencing. Um It's worse with physical activities. So she's an NYHA class three, but better with rest. She is sleeping in her recliner due to the fact that um she is having orthopnea, not being able to breathe while she's laying down. Um she did have a cardiac catheterization 25 years ago, but they didn't find anything. Um her father died when he was 59 years old from myocardial infarction and her mom at 40 from sudden death without known cause. She has not been hospitalized other than the cath. Um in terms of her medical condition, she has hypertension and pulmonary sarcoidosis, for which she takes lisinopril 10 milligrams daily and prednisone 10 milligrams daily, um but she has no known drug allergies. In terms of her diet, she eats a balanced diet. She exercises daily, except she hasn't been able to for at least the past two months because of all of her current symptoms. Um she also does not use drugs, no tobacco, no alcohol, but does drink a cup of coffee daily. She's an elementary school teacher who's been married for 30 years and has a good support system with her spouse who she lives with. Um in terms of her vital signs, her temperature looked good. Her heart rate was elevated at 110, respirations were 22. Her blood pressure was 136 over 99 and her oxygen stats were 91%. Um so with that, I went ahead and admitted her um into telemetry and diagnosed her with sarcoidosis restrictive  um cardiomyopathy, a serious condition um where the nurse, I ordered for the nurses to check every two hours and um she could only come out of bed with assistance. Um in terms of instructions, strict I and O's, daily weights, uh nasal cannula, and also maintaining 96% and also DVT prophylaxis with a low sodium diet, KVO. Um in terms of her medications, I'm continuing lisinopril because her blood pressure is still elevated. In terms of her prednisone, I am increasing the dose to 60 milligrams since it's an acute exasperation. I also added on IV furosemide to help get rid of some of the edema. Um and also I added on um amiodarone since I noticed that she was having uh a non-sustained ventricular tachycardia on her EKG. In terms of lab work, I went ahead and ordered a CMP just since I put her on furosemide. And I've gone ahead and made consultations with an interventional cardiologist to come and look about AICD placement, as well as a radiologist, a nuclear radiologist for the FDG PET scan. Thank you.

84. shortness of breath and fatigue, which was progressively getting worse over the past six months. Um now he experiences these symptoms at rest when at the beginning he was just experiencing the symptoms during exercise uh and strenuous activity. Now his past medical history uh includes hypertension, hyperlipidemia, diabetes, atrial fibrillation. He has a past surgical history of three coronary artery bypass grafts and five drug-related stents. His pertinent review systems included a eight-pound weight gain in the past few weeks, as well as being positive for orthopnea and wheezing, and he showed uh one plus pitting edema in his lower extremities. For his active medical problems, uh we found that there was hypotension and hypoxia at 80 over 50 for the blood pressure and an SPO2 of 86 on room air. The remainder of his vitals were within normal limits. For his allergies and medications as well as substance use, he was shown to smoke one pack per day for the past 25 years at least. His meds include metoprolol succinate, 15 milligrams once a day, lisinopril 10 milligrams once a day, atorvastatin 10 milligrams once a day, metformin 500 milligrams twice a day, furosemide 20 milligrams twice a day, clopidogrel  75 milligrams once a day, warfarin 2.5 milligrams twice a day. For his pertinent social history, this revealed no abnormal behaviors other than the cigarette smoking um for one pack per day over the last 25 years. Relevant PE findings. Um a split S2 was noticed on the cardiac auscultation as well as a laterally displaced PMI. Lung sounds indicated pulmonary edema and one plus pitting edema of the legs was examined um when the calves were examined for swelling. For his diagnostic labs and procedures, the x-ray revealed cardiomegaly with uh pulmonary edema. Echo showed a dilated left ventricle and the EKG showed a normal sinus rhythm with a left bundle branch block. His labs were positive for an elevated troponin at 0.04 and an elevated BNP at 4,000. His likely diagnosis was ischemic dilated cardiomyopathy for which he will be treated in the following way. He'll be admitted to the ICU with a diagnosis of ischemic dilated cardiomyopathy with an NYHA score of four. His condition is considered serious. Uh allergies, no known drug allergies, as previously stated. Um his vitals will be checked at least every two hours. He will be confined to bed rest um during his stay. And nursing interventions will be including a strict input output, um daily weights. So they're gonna be checking his weight on daily, and DVT prophylaxis. His diet will be low sodium. Um his IV fluids will only have only be put at keep vein open to make sure that the IV remains in place. And the medications that he normally takes will be held aside from clopidogrel and warfarin, and dobutamine will be added to ensure his blood pressure is corrected. For means of respiratory therapy, he'll be put on BiPAP at 16 over 6 with an FiO2 of 50%. For repeat diagnostic labs and um and procedures what will be completed is only a serial troponin to see if that corrects with treatment. Um interventional cardiology will be consulted for possible uh AICD placement and possible um CRKD um placement as well. And he will be basically be advised of maintaining a healthy weight, um weight reduction, keeping away from strenuous physical activity, and he will also be advised to stop smoking cigarettes if possible. Alright.

83. Leslie Palmer is a 62-year-old woman who presented to the office today complaining of fatigue, presyncope, palpitations, and dyspnea. The patient states that her symptoms initially began approximately three months ago but have worsened over the past two weeks. The patient did see a family physician two weeks ago when the symptoms began to worsen, but decided to come to our office today since it's been two weeks without improvement. The patient has a history of pulmonary sarcoidosis and hypertension. the patient takes lisinopril for her hypertension 10 milligrams by mouth daily and she also takes prednisone. The patient's mother died suddenly at the age of 40 from unknown causes and the patient's father passed at the age of 59 from a myocardial infarction. With respect to the patient's review of symptoms, she complained of weight gain and orthopnea. The patient states that the orthopnea has gotten to a point where she needs to sleep in a recliner at night to feel comfortable. She complains that she is unable to exercise anymore due to the discomfort, but prior to that, she did exercise frequently. It seems that lying in an upright position does help to relieve some of the patient's symptoms. Physical exam found a jugular venous distension, lung auscultation found rails and wheezing, a systolic murmur with no S4 heart sound was heard upon cardiac auscultation, and lower extremity edema was also found bilaterally. The patient's chest x-ray showed mediastinum with a pawnbroker's sign and cardiomegaly. The patient's EKG demonstrated right bundle branch block and the patient's echo demonstrated restrictive cardiomyopathy. Based upon the patient's history and her diagnostic findings, and the patient also had an elevated BNP of 4000. Based upon the patient's history and her diagnostic findings,  the patient was diagnosed with sarcoidosis, most likely that had spread from her original pulmonary sarcoidosis. So she now has sarcoidosis of the heart. The patient was admitted to telemetry with serious condition. The patient is to continue taking their lisinopril. She is to increase the dose of her prednisone and she is also to start furosemide. The patient is going to consult with an interventional cardiologist for the potential placement of an AICD. And the patient is also going to consult with a radiologist for a PET scan. The patient has insurance and the patient is married with a spouse willing to help her during this time. The patient was in compliance and she had no further questions

82. 62-year-old patient Leslie presents to the emergency room for dyspnea and fatigue. Patient states that his symptoms began two weeks ago and he went to his primary care three days ago and was informed to go to the emergency room. He notes that his symptoms have worsened today. He states that his shortness of breath occurs when he is exercising but not at rest and his NYHA functional classification was a level 2. He has not taken anything for symptoms. Positive ROS symptoms included palpitations, presyncope, fatigue, wheezing, and dyspnea. All other ROS symptoms were negative. The patient has a past medical history of hypertension and is currently taking lisinopril 10 milligrams daily for it. He describes his diet as balanced and states he used to exercise daily with walking um until his symptoms started and he's no longer um because of the shortness of breath. He denies alcohol, tobacco, or illicit drug use. He's an elementary school teacher, and he's married and currently lives with his wife. He knows he has had a previous catheterization completed, which was normal, but denies any other hospitalizations or surgeries. Family history included his mother dying at the age of 40 due to sudden death, and his father dying at the age of 59 due to a heart attack. On the physical exam, it was noted that there was no JVD, no carotid bruits, a regular heart rate with a positive systolic murmur with an S4 sound, positive for gallops, but no friction rubs. There was no chest wall tenderness, calf was non-tender, lungs were clear to auscultation bilaterally, and it was negative for lower extremity edema. And his pulses were full bilaterally in his extremities um. The X-ray showed cardiomegaly and his echo showed left ventricular asymmetric hypertrophy with an ejection fraction of 60%. His EKG shows normal sinus rhythm with meeting the LVH criteria with tall R waves in the septal um waves. His vitals upon entering the room was a heart rate of 110, his blood pressure 130 over 90, oxygen stats of 96, respiratory rate of 16, and temperature of 98.6. Patient was admitted to telemetry and his medications upon admission were to discontinue lisinopril and to give disopyramide 100 milligrams. He was given a saline lock KVO and vitals will be taken every two hours with strict I and O input and output and daily weight, DVT prophylaxis, and oxygen via nasal- nasal cannula and maintaining O2 sat um over 96%. He will have a normal diet and activity as tolerated. Patient was also referred to cardiothoracic surgeon for surgical myomectomy and alcohol injection and as well as an interventional cardiologist for an AICD evaluation. Patient was diagnosed with familial hypertrophic cardiomyopathy.

81. Robin's service and I saw a patient named Leslie Palmer, which came in today for a chief complaint of fatigue and shortness of breath. Mr. Palmer is a 62 year old male that comes in complaining of these symptoms beginning about six months ago, progressively getting worse, especially within the last three days. Um he does not have any chest pain. However, at this point too, he must sleep in a recliner because he cannot um he cannot get down or lay down without having shortness of breath symptoms. Um overall, this limits his life to about a 10 out of 10. Past surgical history includes triple bypass surgery and five stents being placed. Overall, both surgeries were successful. He does have a support system at home in which he is married to his wife of 30 years. He works as a um elementary school teacher. His past medical history includes diabetes mellitus, hypertension, and hyperlipidemia. Overall, he has a good diet. In terms of exercise, he used to go on walks and no longer can due to the symptomology presence. Um the medications he's on is atorvastatin 10 milligrams, lisinopril 10 milligrams, clopidogrel 75, metformin 500 bi daily, furosemide 20 bi daily, warfarin 2.5 bi daily, and then metoprolol succinate 50. In terms of review of systems, he said that he did have weight gain of about eight pounds within the last couple of weeks, does complain of fatigue, has lower extremity edema, does have wheezing present, dyspnea, orthopnea, no heart palpitations though, and no chest pain associated. The patient overall seems like he's awake, alert oriented, but fatigued again. In terms of vital signs, his temp was 98.6, heart rate was 90, respiratory rate was 22, blood pressure, he was a bit hypotensive at 80 over 50, and his SpO2 was 86%. Upon physical exam findings, there were no carotid bruits. However, JVD was present. The patient was tachycardic. A murmur that was an S2 split was heard upon physical exam. PMI was displaced laterally to, um there were bibasilar rales associated in the lungs um based on labs that were found, the troponin was high at 0.04 and the BNP was about 4,000, indicating that um there was pulmonary edema associated and that the heart tissue was breaking down. Uh a left ventricular end diastolic volume was less than 30%. And also upon EKG rating, this patient did have a left bundle branch block. Overall, the patient did have a NYHA of a class four because any time that he got up from a resting position, he ended up having symptomology. Overall, the plan for this patient is to admit them to the ICU, um get vitals every two hours, uh start being only in bed rest for nursing interventions. Daily in and out should be taken, daily weights as well, DVT prophylaxis. They should be on a strict low Na+ diet that also corresponds with their diabetes diet as well. They need to keep their vein open, so KVO. In terms of medications, which of all the ones that they were on, they need to stop them, except for the Clopidogrel 75 milligrams, and the Warfarin 2.5 uh two times daily, because we do not want to throw a clot. We are also going to add dobutamine, IV drip, and an insulin sliding scale to its diabetes. Dobutamine will be used to allow for better contraction of the heart, since there was that pulmonary edema. Um lets see, so in terms of labs that need to be um  found or keep taken, we need to get serial troponins taken, taken,  to see if that heart tissue is breaking down more. And also we need to get an INR because of uh warfarin. And a consult for cardiologists was discussed with the patient. And this hopefully will be able to help them either be on a CRTD or an AICD placement. Thank you so much. Bye-bye.

80. I just met with a patient who I wanted to present to you about Mr palmer a 62 year old man cam into the ED complaining of shortness of breath and fatigue. He reported that he feels tired during exercise but denies feeling any pain. His vitals showed a heart rate of 110, oxygen saturation of 96%, respiratory rate of 16, temperature of 98.6 Fahrenheit, and blood pressure of 130 over  90. So this shows that his heart rate is a bit elevated, oxygen is normal, pulse is a little elevated, respiratory is normal, no present fever and a slightly high blood pressure. As for medical history he denies any past surgeries but has had cardiac catheter examination and a previous hospitalization. He reports a medical history of hypertension for which he takes lisinopril 10 milligram 1 tab per day. He is up to date on his immunizations, he has no known drug allergies. he reported that his father died of a heart attack many decades ago and his mother passed away suddenly at the age of 40. Mr Palmer states that he maintains a balanced diet and exercise routine and denies any illicit drug use, alcohol consumption, or tobacco use. He does have normal caffeine intake as he is an elementary school teacher and he is in a monog in a monogamous relationship with his wife with whom he'll be supported by today and they do have insurance. In a review of systems Mr Palmer reports that he has general fatigue with no pain, he doesn't recall any rash or skin condition he denies an neuro discomfort and denies getting dizzy or losing consciousness. he denies any heat issues, but he does report feeling flutter in his chest and feeling dyspnea. As for pulmonary, he reports wheezing upon dyspnea for MSK he denies any joint aches or pains and doesn't report any edema. afterwords i conducted a physical exam and JVD was negative no carotid bruits were heard. cardiac exam was positive for regular systolic murmur with pmi displaced laterally there was negative chest wall tenderness lungs were clear to auscultation bilaterally and there was no peripheral edema and pulses were normal the calf was non tender. after physical examination and examining past medical history i came to the diagnosis that mr palmer had hypertrophic cardiomyopathy or hocm the vitals were normal chest xray showed cardiomegaly the echo showed left ventricular asymmetric ejection fraction of 60% the ekg was normal sinus rhythm with tall r waves up the leads and left ventricular hypertrophy the patient was counseled and told his medications would change I suggested taking him off the lisinopril and administering disopyramide mr palmer was told that he would be admitted into the hospital telemetry to monitor his cardiac function and he would be given a consult with interventional cardiology with possible AICD placement and cardiothoracic surgeon for possible myomectomy or alcohol injection thank you

79. Um I have a patient, Leslie Palmer, a 62 year old female er 62 year old male that presents the emergency room today, uh complaining of syncopal episodes and shortness of breath happening gradually over the last two weeks. Uh this patient is comfortable at rest uh he says that physical activity with his friends, normally around three to five miles, uh has not been able to happen due to undue breathlessness. Um he also states that he's been having palpitations and has nearly passed out several other times. Uh he has a hypertension in his past medical history. He's had a cardiac catheterization about a year ago. Uh no evidence of obstructive coronary artery disease and um his past uh fa family history, his mother died from a sudden cardiac death and his mom his dad died from a uh cardiac myocardial infarction. Uh social history, he doesn't smoke, doesn't drink. Uh he's an elementary school teacher, has a balanced diet, and he takes lisinopril 10 milligram uh once a day. Uh this patient also presented with uh no headache or no fever, no chills, no general constitutional symptoms. Main symptoms were cardiovascular, he has palpitations, he has near-syncopal episodes, and but no chest pain. Lung-wise, he has no orthopnea, but he does have dysp dyspnea on exertion. He does have wheezing. Uh patient doesn't have any edema, and on physical exam, uh we did not notice any lower extremity edema. Uh no jugular vein distention. Um pupils were equal around and reacted to light. Um no issues with his uh labs, the troponin and the BNP were normal. Um the chest X-ray shows cardiomegaly and uh we got the echocardiogram as well and that showed left ventricular hypertrophy and a rejection ejection fraction of the left ventricle about 60%. EKG confirmed this. He had a normal sinus rhythm at 90 beats per minute. He had a left ventricle hypertrophy voltage criteria and he had a tall R wave in the septal leads. Um otherwise, this patient um uh was referred to uh cardiology and to the cardiothoracic surgeon for a potential septal myectomy uh or alcohol injection as well as an AICD uh placement. I started the patient on Dysopyramide and admitted him to nursing for vitals every two hours. Um activity as tolerated and stricts strict ins and outs. He's gonna get a daily weight, DVT prophylaxis and nasal cannula to keep his oxygen above 96%. Diet-wise, we'll keep him on a regular diet and uh we'll keep him in the telemetry unit until monitoring is over. Uh patient has NYHA class two familial hypertrophic cardiomyopathy and he's uh ready to be seen. Thank you, bye bye.

78. Good morning. My patient today is, uh was a 62, I believe, year old male. And um he came in complaining of tiredness and shortness of breath. And the first time he had um felt these symptoms was about two weeks before, while on a walk with friends and regular exercise. And these walks with friends is um a normal part of his lifestyle. And uh so he experienced that shortness of breath and tiredness precipitated by that walking exercise. And it continued to worsen every time he exercised, every time he went on a walk. So he visited his primary care provider, his family medicine doctor, about three days before presenting here at the emergency room. And um the family practice doctor ran several tests, ran an EKG, um everything came back negative. So he referred uh the patient to us at the ER. And as I mentioned, this patient, any activity that's ordinary physical activity, so exercise, resulted in this fatigue and shortness of breath. And when I'm going over his review of symptoms, um general, beyond the fatigue, excuse me, came back negative as well as the skin, the HEENT, and the musculoskeletal, but in the looking over cardio, in addition to the breathlessness, he also had palpitations and has nearly passed out several times, but has never fully passed out. So he experienced syncope there, or presyncope there, if I may correct myself. And he also experienced wheezing and dyspnea in his pulmonary. Um when going over his family history, uh the most pertinent information was he had a mother mother who suddenly died at the age of 40 with uh no medical explanation ever given, and a father who died of a heart attack at the age of 55. Um he has hypertension, and his past surgery surgical history was the cardiac cath that I believe he might have received at his family practice visit. Um but no, beyond that, healthy. Um he's on Lisinopril 10 milligrams for that hypertension. So when I went over my physical exam, um generally um I I when listening to his heart and lungs, uh several things came up mainly that being the palpitations, um there was a murmur present. Uh there was also a displaced point of mat maximal impulse laterally, and I heard that wheezing when listening to the lungs. but the lower extremity, osteopathic, um everything else about the physical exam came back normal. And when we got his labs back, everything was negative, um including troponin and um a denaturated peptide. His chest x-ray came back showing no pulmonary edema, but cardiomegaly. There's a large increased silhouette present and his echo came back with left ventricle asymmetric injection fraction of 60%. And in his EKG, there was clear tall R waves in the septal leads, normal sinus rhythm, and it fit the left ventriculo ventricular hypertrophy criteria. So this patient is diagnosed with familial hypertrophic cardiomyopathy, um a NYHA 2 classification, and this is secondary to his hypertension. So I admitted him to tele telemetry uhh his condition is serious. I ordered vitals to be taken every two hours. Um he has no known drug allergies, activity as tolerated. Um for his nursing instructions, uh strict input output, uh taking daily weight, TPT prophylaxis, O2 via a nasal cannula, and maintaining oxygen above 96 percent. Uh he could be put on a regular diet. I also ordered IV fluids via saline lock, um and importantly for medications, to discontinue his Lisinopril but initiate uh Dysopyramide 100 milligrams uh QID. Um no, I didn't order any diagnostics or imaging, but I did refer him to interventional cardiology for AICD placement. And I also referred him to cardi cardiothoracic surgery for a possible uh future septal myomectomy or alcohol injection to reduce that uh left ventricular obstruction. And his vitals, if I forgot to mention, were um 110 heart rate, um 96% oxygen, 130 over 90 and for um blood pressure, and 98.6 temperature. Thank you.

77. This patient has a 62 year old male presents to the emergency department um with a 6 month duration of shortness of breath. He states that for the past 30 days his shortness of breath of breath had increased and as a result he went to see his primary care physician today. Um the primary care physician went ahead and sent him over to the ER um for that shortness of breath and he now presents with um shortness of breath that is worse with lying down and exacerbated with any form of activity. Um he states that he has a previous history of diabetes, hypertension, cholesterol, and he previously had a cabbage operation 12 years ago um and 5 years ago he had a stent placement every year for the last 5 years. Um patient states that his mother died from breast cancer at the age of 80 and his father is currently alive. He has Alzheimer’s and is in a current care facility. Um patient states that he has gained 8 pounds in the last 2 weeks. He states that he has wheezing, um shortness of breath, fatigue, but he denies any syncope, chest pain, um syncope, chest pain, or um cough. He also states that um he has a good diet relatively health but minimum physical activity due to his symptoms. Um he also addresses that he is a um smoker. He has smoked one pack per day pack per day for the last 30 years. Um and he currently takes uh Lisinopril um 10 milligrams, Metoprolol Succ Succinate 50 mg, Atorvastatin 10 um milligrams, um Metformin 500 BID. He also takes Furosemide 20 mg as well as Clopidogrel 75 mg, Warfarin 2.5 mg twice a day. Um while I evaluated him, his labs showed that he had an elevated troponin and BNP. Um and that his chest xray showed cardiomegaly as well as um pulmonary bilateral pulmonary infiltrates. He also um had an echocardiogram that shows decreased um wall movement as well as dilated cardiomyopathy. Um based on these findings oh sorry the physical exam results have showed that he is oriented, fatigued, um oriented to time and place, oriented alert to time and place as well as fatigued. Um his um pulmonary exam revealed that he has bibasilar rales and wheezing um but no and a positive gallop but no rubs, no murmurs and also his PMI is displaced laterally. Um on examination, he also had bilateral pitting edema um and he had no neurological findings. Um his H um he had positive JVD and his skin findings were negative as well. Um based on these results, I went ahead and um diagnosed him with dilated ischemic dilated cardiomyopathy. He and um placed orders to admit him to the ICU. Um he has a NYHA scale of 4 um he has uh what vitals q 2 hours, strict bed rest, um and a strict I and O um daily weight with DVT pro prophylaxis. He’s been put on a low sodium diet um and um he all of his drugs have been held except for Clopidogrel 75 milligrams, Warfarin 2.5 milligrams, BID Dobutamine IV drip, and an insulin sliding scale. I’ve also gone ahead and put in orders for bipap 16 out of 6 on um FIO2 50 percent. Um diagnostics i am going to go ahead and order troponins, PT INR, and then go ahead and put in a consult with the interventional cardiologist for CRTD and AC AICD placement.

76. Patient was a 62 year old male named um Leslie Palmer. Uh Mr. Palmer was coming in for complaints of shortness of be breath and um fatigue. He said that it started about 6 months ago, but has been um increasing and then over the last 3 days, it has become significantly worse. Um he does he declined any um he denied any pain um and said he has been sleeping in his chair, his recliner, and not for relief. Um um he said that he does have symptoms at rest and that nothing has been making it better so I would say he was um he’s on the NYHA scale as a 4 but symptoms at rest. Um he has a significant past medical history um for hypertension, hyperlipidemia, diabetes, and um paroxysmal afib. His medications include um Metoprolol succinate 50 mg, Lisinopril 10 mg, Atorvastatin 10 mg, Metformin 500 mg, Furosemide 20 mg, um Clopidogrel 75 mg, and Warfarin 2 and a half milligrams. His surgical history includes a cabbage 12 years ago and then he also um has had 5 stents put in um over the past 5 years with the last one being a year ago. cardiology told him that he was no longer a candidate for anymore um so that was the last one he had. He has no known drug allergies um social history is significant for a 30 year history of smoking, one pack per day and um caffeine positive, he’s married. Denies any alcohol or drugs. Um he is an elementary school teacher second grade. Um um family history some notable things his mother died of breast cancer about 5 years ago at the age of 80. Um his father is still living but he is in a memory unit with Alzheimer’s disease. Um on review of systems, some signi significant findings was that he was um very fatigued, he has had a weight gain of around 8 pounds over the past 2 weeks. Um he did have lower limb edema um he had wheezing, he had dyspnea, and then he um was positive for orthopnea. Um on physical exam, his vital signs were as as um follows, his heart rate was 90, O2 sats on room air was 86 percent, BP was 80 over 50, temp was 98.6, and his respiration rate were 22. So um we were keeping uh s uh specially a close eye on the O2 O2 stat and the um his blood pressure. Um on actual physical exam, he did have pos, he did um test positive for JVd, um no carotid bruits were heard, um he was tachycardic with a split S2 on auscultation, his um PMI was displaced laterally, um he did he denied any chest tenderness but he did have the presence of wheezing and um bilateral ra rales on auscultation. Um going down his legs, he did have one plus pitting edema um and all pulses are peripheral peripheral pulses were good and equal. Um on his lab result, it showed that he did have an elevated troponin of 0.04 and his BNP was very elevated at um 4000. Um chest xray was significant for cardiomegaly and also um showed signs of pulmonary edema. Uh his 2D echo showed that he did have dilated cardiomyopathy with a left ventricular ejection fraction of less than 30 so very reduced. Um EKG um did have a normal sinus rhythm. There it looked to me like maybe some afib on the bottom which he did say he was diagnosed with and a um left bundle branch block. Um there was also on the EKG um criteria that met for left ventricular hypertrophy. So after I went over this with him, and talked to him uh stated that I though believe that he had um ischemic dilated cardiomyopathy um and that we were going to admit him to the ICU. Um his condition would be serious, he would be on strict bed rest, um some orders for the the nursing staff was to have strict ins and outs, daily weight, and uh DVT prophylaxis. Um for his oxygen, did order a Bipap um 16 6 of FIO2 of 55 percent to try to get his oxygen back up. Um we are going to keep him on a low sodium diet. Um IV fluids we none were indicated at the time so we were just going to keep him KVO. Um the meds were actually put on hold on everything except the um Clopidogrel 75 milligrams and his Warfarin 2 and a half milligrams but we are going to add Dobutamine IV drip and then have him on the insulin sliding scale. Um labs we are going to repeat the troponins to make sure they don’t continue to go up so we are going to do serial troponins and then we are also going to keep an eye on his his um PT PTT INR to make sure that his blood isn’t getting too thick and then for consults I told him that he would be meeting with the interventional radio uh cardiologist for um they would discuss possible implanting devices so the CRTD and the AICD um to help with dysrhythmias and to help his heart um do better. So um some lifestyle modifications that um I didn’t mention with him was that we can promote a healthy diet, we can talk to him about smoking cessation, and um i think just maintaining those things would be beneficial um so yeah i think that he will do well if we get him in and get him taken care of. Get a couple of maybe devices in to help with his heart um if we keep his afib under control and um maintain his other comorbidities i think that he will do well. So thank you.

75. He’s a 62 year old male, presenting for um light headiness, feeling faint, shortness of breath, feeling raspy, wheezing, and a flutter in his chest. These symptoms come with activity and have been um popping up for the past 2 weeks with activity onset. He says that this has disrupted majority of his daily activities and this is the first time this has ever happened to him. He does takes some \*\* does only get relieved with rest. Patient has a past medical history of hypertension diagnosed 10 years ago. He also had a catheterization 1 year ago due to abnormal EKG. Patient denies getting an ECHO done before in his life. The patient is prescribed Lisinopril 10 mg that he takes for his hypertension and also reports taking a multi vitamin. Patient has no known drug allergies um no previous surgeries, or hospitalizations. Immunizations up to date. Past medical uh family history is that his mother died of age at age 40 due to a sudden cardiac death and father died at age 69 due to an early MI. Patient denies any illicit drug use, tobacco, or alcohol use. Patient um reports that before symptom onset, would exercise 3 to 4 times a week for 45 to 60 minutes at a time. He has is sexually active because and he is married with one partner and they live together and he also is a school teacher for 7th grade. Patient is positive for fatigue, palpitations, presyncope, wheezing, dyspnea, and light headiness slash dizziness. Upon vital review, his vitals um showed a heart rate of 110, blood pressure of 130 over 90, and also O2 sat of 96. His physical exam revealed jugular venous distention, a laterally displaced PMI, wheezing, and plus 1 bilateral um lower extremity pitting edema. Labs revealed um troponin and BNP to be within normal limits along with the rest of the panels. The chest xray reveals cardiomegaly. An echo sh revealed an ejection fraction of 60 percent along with left ventricular asymmetry and the thickening of the septum and the EKG revealed a normal sinus rhythm with left ventricular hypertrophy and tall R waves in the septal leads. So Mr Palmer was diagnosed with hypertrophic cardiomyopathy with a new york a um scale of 3 due to his inability to maintain majority of his um normal activities. Patient was admitted to telemetry and activity as tolerated. Nurse intervention orders um were strict Is and Os, daily weights, DVT prophylaxis, O2 nasal cannula and to maintain oxygen sats above 96 percent. He was also ordered um a regular diet and for IV um to be KVO. He was discontinued on Lisinopril and is now been prescribed Dysopyramide 100 mg per oral. We sent referral to a cardio interventional cardiologist for AICD placement assessment as well as the cardiothoracic surgeon for a septal myectomy or alcohol injection. Patient reports having financial stability and insurance to proceed to the hospital for care and has a strong social and emotional support at home and we reported that upon uh discharge from the hospital to maintain healthy diet habits, physical activity, and to refrain from strenuous activity until physician clears and gives the okay.

74. Good morning, so the patient today is Mrs. Palmer. She is a 62 year old female who presented to the emergency department with a 6 month history of progressively worsening shortness of breath and fatigue. Um the fatigue is constant, its not brought about by exercise, it doesn’t go away with rest, um past medical history she has been diagnosed with atrial fibrillation, coronary artery disease, hypertension, hyperlipidemia, and diabetes. She’s had a triple bypass um and she’s also had 5 cardiac stents placed. Um she is an active smoker; one pack per day for about 30 years currently. She is employed as an elementary school teacher. Uh regular diet, caffeine uh is normal, no alcohol. Um she lives with her husband and she does walk daily. Uh she has noticed other than the gradual onset fatigue, she has had a weight gain of about 8 pounds uh which I believe is due to lower extremity edema. She did say that she has noticed some extra swelling in her legs. Um she also had noted wheezing and shortness of breath as well as um she needs to sleep in a recliner at night in order to get comfortable. Um upon presentation, she was hypotensive; her blood pressure was 80 over 50, her heart rate was 90 which is some it borderline tachycardic, um respiratory rate was 22 which was slightly low and her oxygen was 86 percent which was very low. Um on physical exam uh jugular venous distension was present, um she was tachycardic, her PMI was displaced laterally, on auscultation there was wheezes present as well as rales in her lungs. Cardiac auscultation, there was no murmur, no friction rub, no gallop. Um, there were positive findings for pedal edema on the physical exam. Chest xray showed cardiomegaly and pulmonary edema, um as well as the 2D echo showing dilated cardiomyopathy with a left ventricular ejection fraction of less than 30 percent. The EKG showed a normal sinus rhythm with a left bundle branch block, uh troponin was elevated, BNP was over 4000. Um overall the final diagnosis and assessment was ischemic dilated cardiomyopathy. Um she was continued on um she was continued on Clopidogrel Clopidogrel and Warfarin uh as well as added Dobutamine because she was hypotensive because we continued your Clopidogrel and her Warfarin we would we need to do a PT and PTT INR um as well as a consultation with the interventional cardiologist for an AICD placement and a CRTD placement. She will be admitted to the ICU with a new york heart association classification of 4. Given that she is on strict bed rest and serious condition, vitals every 2 hours, strict IO, daily weight, DVT prophylaxis, low sodium diet, as well as keeping the vein open for IV access. Uh she had no questions at this time, understood the plan, and where to go from there. Perfect. Thank you very much,

73. 62 year old male presented to the emergency department with a chief complaint of shortness of breath and fatigue. Um onset patient stated that he felt he’s been feeling this way for the last 6 months and its progressively gotten worse. Within the last 3 days, he has gotten really fatigued and he contacted his uh PCP who told him to come to the emergency department today. Um patient stated that he feels a general sense of fatigue. Um there isn’t a location or a character descriptor for his uh pain because its just fatigue. Um nothing seems to help make it better or worse and its been happening for for the last 6 months as I stated. It doesn’t go anywhere um for timing its the past 6 months. Um I asked the patient to rate it from a scale from 0 to 10. Patient stated that it was an 8 to 9 um his symptoms feel about 8 to 9 out of 10 and as far as surgical history, he patient stated that um 12 years ago he had a 3 f 3 vessel Cabbage um as well as 5 stents within the last 5 years one stent each year. Um he stated that his surgeon told him that he’s got 40 percent ejection fraction. For his medical history, patient got hypertension, hyperlipidemia, diabetes, and afib. Um he is not allergic to any medication. He is on a list of medications, he’s on Lisinopril, um he’s on metformin, he’s on uhhh I believe he was on Metoprolol. He was on Clopidogrel, he was on Warfarin, and um might be one or two more medications um for his uh for his uh past medical history. Um as far as hospital his hospitalization, patient stated that he was hospitalized once um and that was mainly during um his open heart surgery for the 3 vessel cabbage. Family history includes paternal Alzheimer’s, patients father is still alive but he has Alzheimer’s in a nursing facility. Um maternal side, patients mother is uh deceased uh due to breast cancer and um for social history, patient's food intake is adequate and he’s got a balanced diet. Exercise is not adequate uh patient stated that he gets fatigued um during any sort of physical activity for the last 6 months so he has not been keeping up with exercise. Um no use of drugs. Patient is a one pack per day smoker for the last 30 years, um no alcohol consumption um occupation patient is a school teacher and um living situation or living arrangement is um he’s uh he lives with he lives with his family. As far as ROS, um he has patient stated that he has fatigue, um as well as gaining 8 pounds within the last um 2 weeks, um no skin lesions, uh no abnormalities, no abnormal no abnormalities with any HENT um um problems. For cardia for cardiovascular no problems there too. For pulmonary patient stated that he has wheezing, hes also dy dyspneic um as well as orthopneic. Patient stated that he cannot lay flat and he usually has to sleep upright. Um for MSK, nothing to report. For neuro, nothing to report. Um physical examination revealed positive JVD, no carotid bruits, tachycardia with split S2 and no murmurs, but has gallops, um rales and wheezing. Um patient also had edema um pulse was full and equal and patient did not have a tender calf. Um as far as uh results showed, patients troponin and BNP were both elevated, um chest xray revealed cardiomegaly with uh pulmonary edema and um EKG showed left bundle branch block or changes from the past um changes from his past EKG. Um the the echo revealed a dilated cardiomyopathy with reduced ejection fraction. The ejection fraction right now is about 30 percent. Patient was counseled and diagnosed with ischemic uh um cardiomyopathy and um the results support that physical examination support that um the vitals were blood pressure 80 over 50, heart rate was 90, respiratory rate was 22, um temperature was 98.6, and uh the SPO2 i believe was 86 percent. Um so due to his um previous history of uh ischemic cardiomyopathy and his atherosclerosis, his stents, his uh cardiac disease, um we decided to admit him to the ICU. The treatments including uh discontinuing Clopidogrel and Warfarin and init initiating Dobutamine therapy to bump up the uh blood pressure and we are consulting with uh interventional uh cardiology as well as um having the patient um admitted to the ICU um try to elevate his blood pressure. So that was the plan um patient was immune uh has all immunizations in record and um thats about it for my case presentation. Thank you.

72. Hi Dr Rawlins, today Im here to talk to you about 62 year old Leslie Palmer who entered the ER with a chief complaint of shortness of breath, fatigue, and um chest pain while going on walks with his friends. Uh Mr. Palmer has a history of receiving a cardiac cath by recommendation from his previous PCP. His hypertension and he’s currently taking 10 mg of Lisinopril. Uh important family history his mother did die suddenly at the age of 40 uh from unknown causes and his father died from an MI at the age of 59. In terms of his social history, he has a balanced diet, he likes to regularly exercise before his symptoms started where he went on regular walks with friends. Um he has a cup of coffee about every morning and he has been happily married for his to his wife for about 30 years and they live together. Currently he is also still working as an elementary school teacher so in terms of his presentation like I said he presented with shortness of breath. He reported fatigue and wheezing and dyspnea. Uh he was experiencing palpitations and presyncope, however, he did not present with orthopnea. Um his vitals were pretty good. The only thing was that he was a little tachycardic um at 110, but his temperature and his O2 stats uh and everything seemed uh were also within normal range. In terms of his physical exam, uh no JVD, no bruits or anything like that. He had a regular heart rate. He did appear with a systolic murmur with an S4 and a gallop. His PMI was displaced laterally suggesting that he had cardiomegaly which became apparent when we looked at his chest xrays. His lungs were clear to auscultation so nothing to worry about there. No edema, full pulses, calf wasnt tender so that falls in line with no um edema as stated before. When looking at his lab work, his troponin and BNP was perfectly fine. His chest xray did show cardiomegaly. His echo showed um left ventricle asymmetric ejection fraction of 60 percent and his uh and an increased um thickness of his septum. His EKG was normal sinus rhythm, he did have signs of uh LVH, um voltage criteria and more importantly the not he did have tall R waves in his septal leads so this lead me to conclude along with his history that he has uh familial restrictive cardiomyopathy because of that, I told him that I would like to admit him into the hospital um and keep him on a monitor. I recommended that we discontinue his Lisinopril and started him on Dysopyramide 100 mg instead that way we can monitor for any um arrythmias or any other kind of problems in case that happens. I recommended a consult with interventional cardiology to look at the placement of an AICD as well as a consult to cardiothoracic surgery for um a septal myectomy or an alcohol ejection for him so thank you.

71. She is a for, she is a 62 year old female that comes in complaining of shortness of breath and chest discomfort uh started about uh 2 months ago, but discomfort and shortness of breath comes and goes but it gets worth worse with exertion and lying down uh thats why she says she sleeps in a recliner. She feels tired and says she feels flutters in her chest which I believe are palpitations. Past medical history uh she has hypertension and pulmonary sarcoid which she has been taking prednisone 10 mg daily for uh 25 years. She also takes Lisinopril 10 mg daily. She has uh no known drug allergies. Past surgical history she just had a cardiac cath uh 1 year ago. Vitals uh everything is uh fine except for heart rate which is now 110, blood pressure of 136 over 99, and a SPO2 at 91 which is a little bit low. Uh family history uh mother died of a sudden card sudden death at 40 years old and father died of a MI at 59. There is no pertinent social history but she does live with her husband which she uh wants us to get after we admitted her. A review of systems uh showed that there for uh general theres fatigue and uh weight gain uh for cvs um a review of systems theres chest discomfort and flutters which are uh chest uh uh which are cardiac palpitations and theres presycnope uh symptoms which uh she said were uh shortness of breath and tiredness so for cvs she had discomfort, palpitations, and presyncope symptoms. Uh pulmonary review of systems she had wheezing and dy uh dyspnea and also orthopnea. Uh physical exam showed overall she looked fatigued, uh no carotid bruits, but we did find JVD. Um there is a murmur present in the heart when I was doing a lung uh heart exam. Uh there was wheezing and rales during the lung eh lung exam as well. Pulses were equal but her leg did have edema. We went over the lab tests with her and uh chest uh xray showed there was some pulmonary edema and cardiomegaly. Uh but most noticeably there is a pawnbrokers sign which is indicative of sarcoidosis. Uh echo showed restrictive cardiomyopathy, it was increased wall thickness and also dilated atrium, ejection fraction was at uh 55 percent. Uh EKG showed nonsustained uh ventricular uh tachycardia. Troponin was within normal limits but the labs that were high were BNP at 4000. So after uh talking to the patient uh getting her history, review of systems, physical exam, and lab tests uh she uh she was diagnosed with sarcoidosis uh cardiac sarcoidosis so she had uh sarcoidosis restrictive cardiomyopathy of uh new york heart association criteria 3. Uh ive talked with um Mrs. Palmer and she was admitted to telemetry in serious condition. Uh orders for vitals every 2 hours, uh she wanted to get out of bed uh there was out of bed assistance, uh strict IO, uh daily weights, uh maintain O2 at 96 I know hers is at 91 right now uh there was an order for DVT prophylaxis uh keep veins open KVO and also uh just put her on a low sodium diet. Uh the meds that were ordered for her was to be kept on Lisinopril uh that she is already taking 10 mg uh once a day. Uh up the dose of Prednisone uh to 60 mg a day for her uh now cardiac uh sarcoidosis before it was the 10 mg for the pulmonary sarcoidosis, um so yeah um er so up the uh Prednisone dose to 60 mg and also add 150 mg of IV amiodarone for her uh arrythmia of the um nonsustained ventricular tachycardia and also 40 grams of um Furosemide IV was ordered for her. As a follow up uh to admit she was ordered to see cardiologist for a AICD and also um a radiologist for a FDG uh PET scan for her sarcoidosis.

70. Ultrasound Uh she complains of shortness of breath of 2 months duration and she states that um that is her chief complaint. She states that she visited her primary care physician 3 days ago as a result of her symptoms. Uh she also complains of fluttering chest. She states that this has an unknown character and has not been constant over the past 2 months. On top of this she states that uh this uh shortness of breath is worse when lying down indicative of orthopnea and on top of this uh she also really claims that she experiences dyspnea upon attempted physical activity. Um she rates her symptom severity as 0 out of 10 whenever she is in an upright position and not engaged in physical activity. Uh she also reports a weight gain of 8 pounds here recently and she also reports fatigue, palpitations, flutters, near syncope, um and lower extremity edema. Other review of systems were negative. She had a heart rate of 113 beats per minute, a blood pressure er a blood pressure of 136 over 99, and respiratory rate of 20. Her oxygen saturation was 91 and her temperature was 98.6 uh degrees Fahrenheit. Umm she had a prior history of hypertension and lung sarcoidosis. She has no known drug allergies. She has a prior surgical history of heart uh heart catheterization ummm she has never been hospitalized. Her father died of a heart attack, her mother died of sudden unknown death and she is currently placed on 10 mg Lisinopril and 2 mg of Prednisone. Um \*\* patient was diagnosed with sarcoidosis as a result of findings of um nonsustained ventricular tachycardia on EKG, um also findings of heart failure on chest xray and echocardiogram. Uh \*\* issue was diagnosed with sarcoidosis cardiac sarcoidosis with restrictive cardiomyopathy. She will be admitted to telemetry as a result of her diagnosis. Um her condition is serious, vitals will be obtained every 2 hours, um she will be permitted out of bed with assistance, um she will be on strict IO, daily weight monitoring, DVT prophylaxis, O2 nasal cannula, um we want to make sure that her oxygen saturation remains above 96 percent. Uh she will be on low low sodium diet. She will be given IV fluids saline, uh we will continue her on her Lisinopril. We will also prescribe amiodarone. Um and uh we will also refer her to interventional cardiologist for AICD placement uh to prevent irregular heart rhythm. Uh on top of this we will preside preserve Furosemide to help with her excess volume um and also increase her dose of Prednisone to help with uh blunting the hemo response to the cardiac sarcoidosis. Um, additionally she will be referred to radiologist for uh specific PET scan to monitor her condition and I believe that this is for this patient and will continue to follow up with her,

69. Just got finished meeting with Mrs. Leslie Palmer, a 62 year old female, elementary school teacher. She presented today with dyspnea, orthopnea, and fatigue. Um her vitals were 80 over 50, pulse 90, 86 percent oxygen, respiratory rate 22, and temperature of 98.6. She did not have a fever, she had an 8 pound weight gain, with lower extremity swelling. Uh she did not have syncope and she did complain of wheezing and dyspnea at rest. Um her immunizations are up to date. Her symptoms started 6 months ago and progressively got worse. She is not currently in any pain. Uh her medical history is significant for a triple bypass and 5 stents the most recent stent was 1 year ago for the uh left anterior descending artery. The cardiologist uh said that uh she has had the maximum number of stents at this point. Um and she currently has hypertension, hyperlipidemia, diabetes, and atrial fibrillation. Her family history is significant for breast cancer on the maternal side, her mother passed away at the age of 80, and her father is still alive at 89 years old with Alzheimer’s living in a facility. Excuse me. She is currently a smoker, uh 30 pack years. Balanced diet, she used to walk before her symptoms starting getting to her regularly um and she only has a cup of coffee everyday, no alcohol, no drugs, no tobacco uh no plenty of tobacco yeah sorry. Her current medications include Lisinopril, Atorvastatin, Clopidogrel, Metformin, Furosemide, Metoprolol Succinate, and Warfarin. Uh her lab values showed a elevated troponin, a elevated BNP. Her troponin was 0.04, her BNP was 4000. Um her chest xray showed cardiomegaly with pulmonary edema and her EKG showed a normal sinus rhythm with a left bundle branch block. Upon physical examination, I noticed that she does have jugular venous distention, no bruits, um she did have tachycardia with a split S2, and uh her PMI was displaced laterally, um wheezing was present and ral as well as rales and um a plus one peripheral edema was present and her pulses were were present bilaterally. Um so what we sent her to the ICU, we kept her on her clopidogrel and her Warfarin. Put her on an insulin sliding scale and Dobutamine and we consulted an interventional cardiologist for an AICD and a CRTD.

68. Im going to present about Mr Leslie Palmer who prevent presents with a chief complaint of shortness of breath at rest and fatigue that has been gradually worsening over the past 6 months. He has a history of cardiovascular problems including CABG and cardiac stent. He has experienced an intentional weight gain of 8 pounds over the last few weeks. He has lower extremity edema and he experiences wheezing, dyspnea, and orthopnea. He has his other current medical problems include diabetes, hypertension, hyperlipidemia, and afib. For medication, the patient takes Metformin 500 mg BID, Furosemide 20 mg BID, Clopidogrel 75 mg QD, Warfarin 2.5 mg BID, Atorvastatin 10 mg QD, Metoprolol Succinate 50 mg QD, Lisinopril 10 mg QD. Patient is a current one pack per day smoker and has been for the past 30 years. On physical exam, jugular venous distention was noted along with wheezing, bibasilar rales, and lower extremity edema. Patient had tachycardia with a split S2 and displaced PMI laterally. Troponin and BNP are elevated. Chest xray showed cardiomegaly cardiomegaly with pulmonary edema. Echo showed cardiomyopathy with left ventricular ejection fraction of 30 percent. EKG showed nor normal sinumet normal sinus rhythm, left bundle branch block, and left ventricular hypertrophy. Heart rate is 90, blood pressure is 80 over 50, and oxygen is at 86 percent. Based on the physical exam and the history, patient has ischemic dilated cardiomyopathy. Patient is to be admitted to the ICU with with interventional cardiology consult for CRTD and AICD placement. All meds to be discontinued except for the patient's Warfarin and the Clopidogrel and Dobutamine IV drip drip will be added as well as the insulin sliding scale. Patient will be given BiPap oxygen and nursing interventions will be given as well. Labs to be ordered include serial troponins and PT INR. Thank you.

67. Alright um Im here to give the case presentation on the patient I just saw. Patient presents with shortness of breath and fatigue starting 2 months ago. Patient states that it gets worse with activity and gets better with rest but the patient cannot lay flat or else she gets uh she gets short of breath. She needs to sleep in her recliner at night. The patient's past medical history is hypertension and pulmonary sarcoidosis and for the hypertension she is on Lisinopril and she is also on Prednisone. Patient stated that she had a heart cath a year ago. The patient does not take does not drink any alcohol, does not smoke tobacco products, or take illicit drugs. The patient states that she has palpitations and she feels like she is gonna pass out. The patient admits to fatigue and 8 pound weight gain in the past 2 weeks, wheezing, dyspnea, orthopnea, and leg edema. the patient had had an xray, blood work, echo done recently and we went over that with the patient. Based on the findings and past medical history of the patient, I would like to admit the patient to telemetry and while admitted I would like to put in consults to interventional cardiology and radiology. I would like to see if they would want to do an AICD and I would like to do get another PET scan on her. Additionally, I would like to put her on IV Furosemide and because of that we you should get another CMP on her just to make sure her blood work is fine. Um my diagnosis is sarcoidosis restrictive cardiomyopathy. Thank you.

66. Mr Palmer is a 62 year old male that presented to us today with a chief complaint of fatigue and uh palpitations that has been going on for the past 2 weeks. Um as far as his um history goes um the only additional thing is that he has also been experiencing experiencing near syncope with the with the um palpitations and fatigue. He says that this is this only occurs as he um uh performing activity like his his walks that he takes everyday. His only past medical history that is pertinent is the history of hypertension, however he does have a history of sudden death in the family. His mother died at 40 um of unknown cause. Dad died of a MI 59. Uh only medication that he is taking is 10 mg of Lisinopril PO uh daily. No allergies uh and no substance use. He does drink one cup of coffee a day. In addition to that um, as far as his activity, its its great. He says that he hikes almost 3 to 4 miles daily with a group of friends um and this issue has been keeping him from doing that. Um as far as physical exam goes, uh he uh did not have any JVD or peripheral edema but he did have a systolic murmur um with S4 um and a laterally displaced PMI. Uh overall this patients major presenting problem is fatigue um a differential diagnosis includes concentric left ventricular hypertrophy, sarcoidosis, myocarditis, and familial hypertrophic cardiomyopathy. I think given this patients uh family history and uh his immediate past medical history, as well as the tests that we ordered um the echo, the EKG, uh the chest xray uh and the uh labwork are all um are all in line with with HOKUM being the leading diagnosis. As far as a plan for this patient, I think that um we should start him on um uh Dysopyramide, discontinue his Lisinopril, and consult interventional cardiology for defibrillator placement and cardiothoracic surgery for either myectomy or a septal myectomy or an alcohol ablation.

65. And today I saw 62 year old male, Leslie Palmer, who came to the office today with a 2 week history of fatigue and shortness of breath. He stated noticing these um during exercise he said um the shortness of breath came on during some exercise exercise and that resting made him feel better as well as laying down helped him feel better. His vitals when I came in today, he had a temperature of 98.6, a heart rate of 110, a blood pressure of 130 over 90, respiratory rate of 16, and O2 stats of 96 percent. While gathering his history on him, I realized he had a past medical history of hypertension, no surgical history, his mother died of sudden cardiac death when she was about 40 years old and his dad er dad died at 59 years old of a heart attack. For the medication that he was on for his hypertension, was Lisinopril and any unknown history of any allergies. After gathering more information on his social history, he described his diet as being balanced, he exercised once a day before he started experiencing these shortness of breath symptoms, he had no history of any drug, alcohol, or tobacco use. He consumes one cup of coffee a day, he is a school teacher, 5th grade, he is insured, he has a great support system. Um he lives with his wife and his immunizations are up to date. After that, I continued on with his review of systems, in which he described feeling fatigued, having chest palpitations, feeling like he was going to pass out, having dyspnea, and wheezing, as well as feeling dizzy. Upon presentation, patient seemed to be awake, alert, oriented, and fatigued. From there, I continued on with physical exam in which I found no um JVD or carotid bruits. He had a regular heart rate with a systolic murmur with an S4 sound. He had no chest wall tenderness and his PMI was displaced laterally. His lungs were clear to auscultation bilaterally and he had no edema or swelling in his lower extremities. His pulses were equal and bilateral and his calves were non tender. After looking through his results, um his xrays showed um cardiomegaly, his echo had some assymetric um hypertrophy of the interventricular septum with an ejection fraction of 60 percent. His EKG had a normal sinud sinus rhythm with tall R waves in the septal waves and um left ventricular hypertrophy. His troponin and BNP were both within normal range. So I came up with the diagnosis of familiar familial hypertrophic cardiomyopathy due to his past history with his mom and his dad both having cardiac issues. Um I determined him to be a new york heart association class 2 um with limitations in sun some activity. I would like to admit him to telemetry and stop his Lisinopril. Start him on Dysopyramide and we would like to consult interventional cardiology to see if they would like to place an AICD device as well as consult cardiac thoracic surgery to see um if he would be a good candidate for an alcohol injection or septal myectomy. As far as his nursings, I would like his vitals to be done every 2 hours, his activity can be as tolerated, I want him on strict input outputs, daily weight, O2 nasal cannula for about 2 liters per minute and I would like to maintain his oxygen stats above 96 percent as well as DVT prophylactin prophylaxis. Patient um was feeling okay about his diagnosis and felt like he was in good hands and his wife was fine to come up with him and they were gonna get ready for him to be admitted. Thank you.

64. Hey Dr. Smith, so i just got finished seeing um Mrs Leslie Palmer. She is a 62 year old female with a past medical history of sarcoidosis and hypertension who presents to the emergency department today due to worsening fatigue, um shortness of breath, and palpitations. She said that this has been going on for the past 2 months. Initially called her PCP 3 days ago because her symptoms were worsening. They did some labs and um she said her symptoms got so bad today that she called her PCP again and he referred her to the emergency department. She also reports associated weight gain of approximately 8 pounds over the past 2 weeks, some wheezing, um and some other symptoms such as um lower extremity swelling bilaterally, some light headiness, some orthopnea which requires for her to sit in a recliner when she goes to sleep at night, um and a few episodes of near syncope which she has described as not fully passing out but getting close to it um and light headiness as well. Um she has a past medical history as I said of hypertension and sarcoidosis and she said she recently had a um cardiac catheterization a few years ago because of a concerning EKG which came back normal. She has um past family history which is concerning for her mother who suddenly died at age of 40 um and her father died at 59 years old of a heart attack. She is currently taking Lisinopril 10 mg once a day and Prednisone of 20 mg uh 20 mg once a day. She has no known drug allergies um she lives a pretty healthy lifestyle. Shes uh active, walks about 5 days a week, 45 minutes and her diet is balanced and she has no uh alcohol, drugs, or tobacco use that She has um talked about. She currently works as an elementary school teacher and uh she is married to her husband who she lives with. Um I mentioned all of her pertinent review of systems, everything else was negative. As for her vital signs, she was tachycardic to 110, she was um not hypoxic but she was borderline with an SPO2 of 91 percent, um she had a respiratory rate of 20 making her tachypneic, and then she was mildly hypertensive at 136 over 99, um and afebrile. As per her vitals, as per her physical exam, she had uh JVD as well as 1 plus pitting edema, wheezing, and rales, but everything else was negative. For her labs, she had a negative troponin, she had a negative CBC and CMP, but she did have a bumped BNP at 4000. We also took a look at her EKG which showed um kind of borderline tachycardia and was right around 100, which she also had nonsustained SVT which was concerning. As for her echo, she had increased thickening with an EF of 55 percent and it showed a restrictive cardiomyopathy which is concerning for sarcoidosis. Um her chest xray showed sarcoid nodules and what I thought to be borderline cardiomegaly. Um as for the labs that I think we should go ahead and order, I think we should order another CMP and I think the plan is to admit her to telemetry with a diagnosis of sarcoidosis restrictive cardiomyopathy. Um I think the plan should be too continue her on Lisinopril but add Amiodarone as well as um adding Lasix for her volume overload in her lower extremities as well as um I think we should increase her Prednisone to 60 mg per day instead of the 20 mg per day. I also think we should consult interventional cardiology for a possible AICD as well as uh nuclear medicine or radiology for a uh FDG PET scan. Um I think we should place her on uh assistance with getting out of bed, uh vitals Q 2 s, um or every 2 hours and um yeah I mentioned getting a lab CBC, CMP, um I don’t think any other imaging is necessary except for that um PET scan. Alright thank you.

63. who presents to the emergency department complaining of shortness of breath and fatigue with onset around 2 weeks ago. Patient reports that his symptoms worsen when he exercises and get better with rest. Patient states that when he exercises, he also begins experiencing palpitations and presyncope. Due to these symptoms, patient reports that he has lost most of his ability to exercise, therefore, his New York Heart Association functional classification is a 3. Upon onset of systems symptoms, patient went to his primary care physician for initial evaluation. His primary care physician conducted multiple tests that have not yet resulted. Patient states that his symptoms suddenly worsened yesterday, so he called his PCP and was advised to come to the emergency department. Upon presentation, patient is awake, alert, and in no acute distress. His vital signs include a heart rate of 110, a blood pressure of 130 over 90, an O2 saturation of 96 percent, and a temperature of 98.6. Patient is also complaining of maybe wheezing. He states that he feels like he is wheezing but he doesn’t actually know for sure so he doesn’t know if he can say yes but he doesn’t feel comfortable saying no. Patient denies any recent illnesses. The remainder of the patients review of systems was negative. Patients past medical history includes hypertension for which he takes 1 10 mg tablet of Lisinopril daily. Patient is compliant with his medication. Patient's past surgical history includes a cardiac cath around a year ago which according to the patient, was normal at the time. Patient's mother suddenly passed away at age 40 and patient's father died at age 59 from a myocardial infarction. Patient reports that he eats a balanced diet, has 1 cup of coffee per day, and does not drink any alcohol. Patient does not use any tobacco products and denies any illicit drug use. Patient works as an elementary school teacher and he does have insurance. Patient is married and is sexually active with his partner. Patient has no known drug allergies. Physical exam demonstrated no jugular venous distention, no carotid bruits. Patients heart was a regular rhythm and he had a systolic murmur with a S4 heart sound. Patient had no rubs, but he did have gallops. Patients PMI was displaced laterally. He had no chest wall tenderness and his lungs were clear to auscultation bilaterally. He had no lower extremity idea edema. His DPPT pulses were full and equal bilaterally. He also had no calf tenderness. He had a negative Homans sign. Patients bloodwork demonstrated that his troponin and BNP levels were within normal limits. His chest xray showed cardiomegaly but no pulmonary edema or mediastina mediastinal fullness. His 2D echo demonstrated left ventricular asymmetric hypertrophy with an ejection fraction of 60 percent and increased interventricular septum. His EKG demonstrated normal sinus rhythm with LVH voltage criteria and tall R waves in the septal leads. Results demonstrate that the patient has familial hypertrophic cardiomyopathy secondary to his hypertension and his family history. This will require admission because his condition is serious. In the hospital, patient's activity will be as tolerated and he is able to eat a regular diet. Medication wise, patient will be given Dysopyramide 100 mg by mouth everyday. We will discontinue his Lisinopril. Patient will also require vitals Q 2 hours, keep vein open fluids, strict I and Os, daily weight, DVT prophylaxis, oxygen via nasal cannula at 2 liters per minute, and we want to maintain his O2 sats at greater than 96 percent. Consult to interventional cardiologist for an automatic implantable cardioverter defibrillator placement and cardiothoracic surgery for septal myectomy and alcohol injection will need to be placed. Patient's wife is in the waiting room and would like to go up with to would like to go up with the patient if possible. Thank you so much for your time.

62. Alright, so Leslie Palmer is a 62 year old woman that presents to the ER today complaining of chest pain and dyspnea. Patient stated that they were diagnosed with a viral illness approximately 2 weeks ago by their PCP. At the time of previous illness, the patient had pyrexia, fatigue, palpitations, cough, and wheezing. Um approximately 5 days ago, the pyrexia resolved but they started experiencing arthralgia, myalgia, progressive dyspnea, and chest pain. The chespnea the chest pain and dyspnea get better with rest and sitting but they get worse with moving around. NYHA class 2. The patients blood pressure and heart rate were slightly elevated at 130 over 90 and 110 respectively. The O2 sat was low at 91 percent. Temperature normal at 98.6. Uh her troponin was elevated at 0.1 and BNP was also elevated at 4000. Um patient's ROS was positive for fatigue, weight gain of 8 pounds over the past 2 weeks, arthralgia, myalgia, edema, chest pain, palpitations, cough, and wheezing. The patient had no relevant neuro, HENT, or skin issues. The patient has a past medical history of hypertension for which they take Lisinopril 10 mg once a day for. Um they have no known drug allergies. They had a previous heart cath approximately 1 year ago with no pertinent findings and the patient has not been hospitalized or had any other types of surgery. Um the patient's mother died of breast cancer approximately 5 years ago and her father is still alive with Alzheimer’s in a care facility. Um for social history, patient states she has a balanced diet and exercise prior to this viral illness approximately 2 weeks ago typically going to the gym 2 times a week. The patient reports no drug, tobacco, or alcohol use and moderate caffeine consumption. Um Mrs. Palmer is employed as a teacher but is currently on summer break. The physical exam showed jugular venous distention, bilateral rales, and wheezing. Exam of the lower extremity showed 1 plus pitting edema, no murmurs or bruits on physical exam and pulses were 2 plus bilaterally. Um I diagnosed her primarily with myocarditis dilated cardiomyopathy with an ejection fraction of less than 30 percent. Secondary diagnosis of hypertension. The plan is to admit this patient to telemetry under serious condition. Get nursing instructions to be vitals q 2 hours, activity as tolerated, strict I and O, daily weights, DVT prophylaxis, O2 nasal cannula to keep oxygen sats around 96 percent or above, low sodium diet, and to keep the veins open. Id like to continue the Lisinopril 10 mg orally and add Acetaminophen 625 mg q 6 hours. Id like the patient to be on a low sodium diet and I would like to start patient on Furosemide 40 mg IV. As far as labs and other tests go, I would like to obtain serial troponins, a CMP, and to repeat the echo. I would also like a biopsy and immunoglobulin testing. For referrals, I would like to see interventional cardiologist for a potential CRTD and AICD. Id also consider doing an infectious disease consult for myocarditis as well as consult radiology for a potential contrast media enhanced MRI. So again, this patient was Leslie Palmer, aged 62, primary diagnosis of myocarditis dilated cardiomyopathy secondary diagnosis hypertension. Thank you.

61. Um Im here to give a report for Mrs Palmer. So Mrs Palmer is a 62 year old woman with a history of hypertension who presents with a chief complaint of shortness of breath and fatigue. She said she was sick sick 2 weeks ago and experienced sniffling, congestion, fever, cough, and chest pain as well as shortness of breath. About 5 days ago, she said her symptoms began to get better but she continued to have dyspnea, chest pain, and fatigue. These symptoms are improved when she rests, but are worsened when she begins to exert herself. She is also experiencing orthopnea and is sleeping in a recliner at night. Her chest pain is dull and located in the middle of her chest. Other pertinent uh review of systems include lower extremity edema, 8 pound weight gain over the past 2 weeks, palpitations and wheezing. Her vitals were 98.6 degrees Fahrenheit, heart rate of 110, respiratory rate of 20, blood pressure a little elevated at 130 over 90, and her oxygen was at 91 percent. On physical exam, she had a jug she had jugular venous distention, displaced PMI laterally, no gallops, rubs, or murmurs were noted. Negative Homans sign, bibasilar rales, and wheezing were also prominent. 1 plus pitting edema of the lower extremities bilaterally with 2 plus pulses bilaterally. Her chest xray showed cardiomegaly and pulmonary edema with a 2D echo showing uh dilated cardiomyopathy with a left ventricular ejection fraction of less than 30 percent. The EKG showed sinus tachycardia, right bundle right bundle branch block, and left axis and uh premature ventricular contractions. She has um had an elevated troponin and um BNP of 4000. Given the information, I believe she has myocarditis dilated cardiomyopathy with a NYHA functional classification of 2. Id like to admit her to telemetry in serious condition. Id also like to get strict ins and outs, daily weights, and start a nasal cannula to maintain O2 sat at greater than neg 96 percent um as well as beginning DVT prophylaxis. She can continue her Lisinopril but will start Acetaminophen for the pain and Furosemide 40 mg IV. I also ordered repeat troponin and CMP. Um CMP is to monitor the Furosemide. She will be referred to interventional cardiology for an AICD or CRTD consult um radiology for immediate enhanced MRI and infectious disease as well. Thank you.

60. So I wanted to present a case to you. Her um the patients name is Leslie Palmer. She is 62 years old. She is uh presenting to the ED today with uh chief complaint of shortness of breath and fatigue. Um she said her symptoms of fever and cough started 2 weeks ago which stopped in the last um 5 days ago. But then her chest pain and shortness of breath and her fatigue began 5 days into that um and have worsened. um she notes having um palpitations as well and dyspnea dyspnea on exertion with slight activity. Um and then also said that nothing really helps and that she has orthopnea at night which causes her to sleep in a recliner. Um her fever and cold symptoms have subsided but uh noted that overall these newer symptoms of shortness of breath and fatigue um continued on and then worsened. She has a past medical history of hypertension as well as um taking Lisinopril 10 mg a day for. Um she is compliant with her medication and denies having any allergies to medications. She also had a cath 1 year ago um which was due to EKG changes but noted that uh the cath was negative and then she also has um no she denies smoking um drinking or using any drugs but also uh notes that she used to workout at least twice um twice a week in the gym and hasnt been able to lately due to her new symptoms of shortness of breath and fatigue. Um her overall vitals were um heart rate of 110, uh pulse ox was normal, her um O2 saturation was a little low at 91 on room air, her high blood pressure was at 130 over 90 and her respiratory rate was at 20. Um when I did her physical exam, um she did have lower extremity edema um she did not have a murmur um but she did have JVD, uh no bruits, and her PMI was displaced laterally. Um when auscultating her lungs, she did have bibasilar rales and wheezing um and then after looking at the labs, there was elevation in her troponin and BNP. Her troponin was a 0.1 and her BNP was 4000. Um through the echo, um we saw an ejection fraction of less than 30 percent um and her cardiac xray showed pulmonary edema and cardiomegaly. Um and with her EKG there was um a right bundle branch block as well as left axis deviation and tachycardia um consistent with her vitals. Um she notes that she did not take any medications for this and none of that has helped nothing else has helped uh and with these results I diagnosed her with myocarditis myocarditis dilated cardiomyopathy um and then let her know that I would like to admit her to telemetry um and to see an interventional cardiologist uh to potentially get an endocard endocardial biopsy done as well as potentially an AICD um and then to also see an infectious disease specialist because her myocarditis could be a continuation on from that infection 2 weeks ago. Um so having the infectious disease specialist check on her immunoglobulins would be helpful. and then also to see a radiologist for a more in depth MRI um on her heart. Um she was agreeable to all this. Um and to also change her medications um to continue her Lisinopril but also add on Furosemide uh for the diuretic uh to get rid of that extra fluid in her and then also Acetaminophen uh for her pain. Um so overall uh she was very agreeable to this to this plan and um I did diagnose her with myocarditis dilated cardiomyopathy.

59. ED earlier. She was a 62 year old female, Mrs. Palmer. She presented with a dull, constant chest pain and she noticed she also noted that she was significantly tired and was short of breath. Um and she said this short of breathless, this lack of breath was more noticeable when walking. She reported a prior illness with fever, cough, and um shortness of breath about 2 weeks ago. She said it subsided about 5 days ago however the chest pain remained and she went to her family care doctor who referred her here. Her past medical history is um positive for hypertension. Her past surgical history was a cardiac uh catheterization with no findings. Her mother died of breast cancer in her fifties. Her father is living in a nursing home with Alzheimer’s. For her social history, she reports never using alcohol, tobacco, or illicit drugs. She is employed school teacher. Her diet she reported was balanced. She has one cup of coffee a day and she exercises at the gym twice a week. Her living situation is that she is with her husband and they are sexually active. Her current medications are 10 mg PO Lisinopril and she has no known drug allergies. Her review of systems revealed positive fatigue, weight gain, no fever in the office today however she again claimed that she had one prior. There were no skin changes present. No rash, no brushing bruising, no lesions. She had no headache, no hearing loss, no neck stiffness, no vision changes, no difficulty swallowing. Her review of systems for her cardiovascular system revealed uh chest pain um that was dull and constant. She was positive for dyspnea, orthopnea, and wheezing. Her musculoskeletal system examination revealed lower extremity edema. She was negative for any neurological deficits. The patient appeared fatigued. Um but outside of that no other distress. Her vital signs were 98.6 degrees Fahrenheit for temperature, heart rate of 110, respiratory rate of 20, pulse uh a blood pressure of 130 over 90, and her pulse ox was 91 percent. further examination revealed no carotid bruits, JVD was president was present, her heart was slightly tachycardic, her pulse rate that is. Her respiratory examination revealed wheezing, bibasilar rales, and no chest wall tenderness. Examination of her extremities, yielded non tender calves, bilateral pulses full and equal, and pedal edema. Her imaging the uh chest xray demonstrated cardiomegaly and pulmonary edema. ECHO 2D revealed dilated cardiomyopathy with left ventricular ejection fraction less than 30 percent. EKG findings were sinus tachycardia with preventricular contractions. And her troponin was elevated. Additionally, her BNP was measured at 4000 and her overall diagnosis was myocarditis dilated cardiomyopathy with pulmonary edema secondary to hypertension. I gave her a New York Heart Association scale of 2. I admitted her to telemetry her condit with condition serious, vitals Q 2hours. She was given out of bed with assistance for activity and her nursing interven interventions were to maintain oxygen saturation at 96 percent O2 um 2 Liters, stricts ins and outs, with daily weights. I gave put her on a low sodium diet with orders to keep the vein open. Acetam, I gave her Acetaminophen 625 mg PO for pain and I continued her Lisinopril at 10 mg PO. Additionally, I gave her metoprolol succinate 50 mg um for the heart failure and Furosemide 40 mg via IV for the pulmonary edema and heart failure. I gave sub prescribed no endocrine medications, no respiratory therapy. I ordered repeat serial troponins and a repeat 2D echo. Referred her to the interventional interventional cardiologist, infectious disease, and radiologist for potential consult of an AICD pacemaker er pacemaker and endomyocardial biopsy. And in lastly her EKG revealed a heart rate of 114 again with PVCs and left axis deviations. That is all I have for you today. Thank you for your time.

58. Pleasure of meeting with Leslie Palmer today. He is a 62 year old, male patient presenting with shortness of breath and fatigue. He states his symptoms started about 2 weeks ago while exercising. Uh in addition to his dyspnea and fatigue, he relays he also was experiencing uh heart palpitations and presyncope with exercise. He denies any chest pain. Uh he states that his symptoms were exacerbated with exercise but relieved with rest. He at first saw his primary care physician uh after his symptoms began and had some baseline tests performed but was unsure what those results were. He states that over the last day or so, his symptoms got worse and was advised by primary care physician to head to the emergency room. He has history of controlled hypertension for the last 10 years uh treated successfully with Lisinopril 10 mg um he had a cardiac catheterization about a year ago which uh was unremarkable. He states that he had it performed due to an abnormal EKG had his yearly uh yearly checkup. Um his family history uh shows that mother passed away at age 40 from a sudden cardiac event and his father passed away at 59 from a myocardial infarction. He also states that he’s was experiencing some wheezing but no history of asthma. Um he’s fatigued but denies any fever, chills, or unexplained weight loss or weight gain. All his other review of systems were negative nonremarkable. His vitals today were 130 over 90, his heart rate was one at about 110, his respiratory rate was at 16, and his O2 saturation was at 96 percent. For his physical exam, he presented with no jugular venous distention or bruits over the cardiac over his carotid arteries or his aortic abdominal artery. He had regular heart rate with a systolic murmur that had a S4 component. Uh no friction rub was was present but he had a gallop. His PMI was displaced laterally. He had no chest wall tenderness and the rest of his musculoskeletal exam was normal. His lungs were clear to all auscultation bilaterally and his osteopathic screening was normal as well. All his labs were normal. Theres no evidence of elevated troponin or uh BNP. His chest xray showed minutes of infiltrate infiltrative effusion but evidence of cardiomegaly. His 2D echo showed left ventricular asymm asymmetry left ventricle asymmetric hypertrophy and left atrial enlargement with preserved ejection fraction at 60 percent. His EKG showed sinus rhythm, normal axis, left ventricular hypertrophy criteria and tall waves and is uh tall R waves in the septal leads. Uh the patient was admitted to telemetry. His uh Lisinopril was discontinued and he was started on Dysopyramide 100 mg 4 times a day. Uh he I discussed with him saying a consult with cardiology to discuss um pacemaker placement and automated implanted cardioverter defibrillator and also discussed I was able didnt discuss in the room but went back and put in his note consult for CT surgery to discuss possible future septal myomectomy myomectomy and alcohol injections to review reduce left ventricular outflow tract obstruction. Uh patient was patient was compliant with instructions and processed everything seemed to process everything well. He was alert and oriented um his wife was there um at the ER with him and he is insured uh hes been married for the past 39 35 years. Has no kids. Um yes so that is my case presentation. Um let me know if you have any other questions. Thank you.

57. I just finished seeing the patient in room 1. Patient is a 62 year old female who came into the emergency department due to worsening heart palpitations and shortness of breath breath this morning. Uh the patient has had a history of these symptoms for the past 2 months um and it worsens when she is laying down and upon physical exertion. um it does get better um when she rests and when she sits up. The patient also complains of fatigue so i took her history. The patient has a history of hypertension and sarcoidosis. Um patient is up to date on all her immunizations. She is currently on Lisinopril 10 mg everyday and Prednisone 10 mg everyday with no known allergies. Um patient has a history of uh cardiac catheter catheterization 1 year ago um which did not show any coronary artery disease. Um mom passed away at 40 years of age um and it was a sudden death. Dad had passed away at 59 years of age due to a myocardial infarction. Um patient has uh regular and balanced diet, um and exercises by walking with her friends; however, due to these symptoms recently she has been unable to do that. Uh caffeine around 1 cup a day. No illicit drugs, no tobacco usage, no alcohol usage. Um she works as an elementary school teacher um and lives with her husband of 30 years um has insurance um and then I conducted a review of systems um patient has had unexplained weight gain and fatigue. Um uh review of the skin was uh showed no abnormalities. Um looking at the uh musculoskeletal system there was lower extremity edem edema. Um patient has felt uh dizzy at times um HEENT review of systems was neg negative with no abnormalities. Um patient had uh chest palpitations and presyncope um was also uh she reported symptoms of wheezing, dyspnea, and orthopnea. Um I looked at the vital signs; the temperature was in normal limits was 98.6 degrees Fahrenheit and was within normal limits. Heart rate was 110 slightly elevated, respiratory rate 20 slightly elevated. BP uh 136 over 99 slightly elevated uh depending on what you look at. O2 was 91 percent um slightly lower than what we want it to be. Um so then I conducted my physical exam. Um she patient was positive for uh jugular venous distention, um patient had a regular heart rate with a systolic murmur and there there was signs of gallops. The PMI was nondisplaced. Uh i heard uh bibasilar rales, there was wheezing, uh i confirmed the pitting edema in the lower extremities. Um then I looked at the diagnostic findings. Uh troponin levels were within normal limits and with everything else except for the BNP uhh that was uh at 4000 uh so that was elevated. Chest xray when i looked at it just showed some lymphedema lymphadenopathy. um while looking at the 2D echo, uh the ventricle the chambers were nondilated um there was some evidence of left ventricular hypertrophy. Oh i meant no left ventricular hypertrophy but the walls were rigid. I apologize for that. Uh the EKG findings showed uh normal sinus rhythm and normal axis. Um and nonsustained ventricular tachycardia. Uh so that lead me to believe that she had uh sarcoidosis restrictive cardiomyopathy. And so because of that I admitted her to the hospital so that we can uh monitor her. Uh we want to get vitals every 2 hours. I said strict ins and outs, checked the daily weights, uh DVT prophylaxis um because of the 91 percent oxygen saturation and um I set up a nasal cannula and uh for O2 and want to keep that above 96 percent. Uh for diet i have her as a low sodium, uh want to keep the veins open, uh Lisino Im going to keep her on the Lisinopril 10 mg uh I want to bump up her Prednisone to uh oh keep the Lisinopril at 10 mg everyday. I want to bump up the prednisone to 60 mg everyday. I wanna add on Amiodarone 150 mg by IV and Furosemide 40 mg by IV. Um I also wanted to get a consult uh wanna get an interventional cardiologist to come in, talk about maybe some ACID placement. I also wanna get a radiologist in to do a FDT-PET scan and uh just to uh further evaluate the patient and the possible treatments. Um so let me know what you think um this is the patient in room 1 and thank you.

56. Mrs. Palmer is a 62 year old female that presented today uh pleasant, awake, alert, oriented, um little bit of fatigue, mildly in pain and with a mildly elevated blood pressure, heart rate, and respiratory rate. Um she stated that she had a 2 week history of cold like symptoms that evolved in the last 5 days; the chest pain um and limitation of activity like going upstairs and shes worried that something is wrong with her heart. Um she states that the chest pain is 2 out of 10, dull, constant, non radiating, and is better when she leans forward, worse when laying down. Review of systems revealed fatigue, a recent 8 pound weight gain, wheezing, um jugular venous distention, heart palpitations, and lower extremity edema. Patient has a history of hypertension that is well controlled by 10 mg of Lisinopril daily, um she had a cardiac catheterization 1 year ago um that was normal. Patient's father is 80 years old and has Alzheimers and patient's mother died of breast cancer at 79 5 years ago. She claims that a balanced diet, exercised 2 days per week before um her onset of symptoms. Uh no history of drugs, alcohol, or tobacco. Uh has one cup of coffee every morning, is a second grade teacher and is still sexually active with her husband. Um no known drug allergies. Physical exam revealed a laterally displaced point of maximum impulse, bibasilar reels rales, and wheezing. Um lower extremity edema, but non tender calves. Negative Homans test. Um OMM um exam revealed no TART changes. Her labs showed high troponin and BNP levels. Xray showed cardiomegaly and pulmonary edema. Echocardiogram showed dilated cardiomyopathy with left ventricular ejection fraction of less than 30 percent. EKG showed sinus tachycardia with a right bundle branch block and some premature ventricular contractions. Um leading diagnosis is um myocarditis dilated cardiomyopathy um which its uh suggested to be taken care of with Acetaminophen and Furosemide, staying with her Lisinopril to control her hypertension. Um sent to telemetry to be checked on by cardiology for potential CRTD or AICD placement um as well as an endo endomyocardial biopsy. Also consider um consulting infectious disease.

55. Alright so um today I saw 62 year old female patient uh Leslie Palmer uh. She was presenting after uh a follow up from her primary care three days ago with uh chief complaint of dyspnea um and this has been going on for about 2 months uh with mostly any activity. Uh she currently is sleeping in a recliner um at night to alleviate her symptoms. Uh she presented with fatigue um, an 8 pound weight gain in 2 weeks, um she has presyncope uh as well as palpitations and some wheezing was noted. Um entering into the room, her vitals uh were a little uh a little out of the ordinary range but not too bad uh her heart rate was 100, respiration rate was about 20, her blood pressure was 136 over 99 and her O2 sat was 91 percent. Um so she presented with a history of a heart catheterization a year ago. Um she has hypertension and diagnosed with sarcoidosis for about 25 years. Um on her maternal side there was a history of sudden death um but she presents with no allergies and um her current medication is 10 mg once daily of Prednisone and 10 mg once daily of Lisinopril. Um so as I was uh going through my physical exam, uh there were a few pertinent details. She was positive for JVD, but she didnt have any carotid bruits. Um her heart rate was regular uh but there was a S4 murmur that was noted. There was no regurge um the PMI was normal placement and there was no tenderness on the chest wall. Uh doing a pulmonary exam, there were bilateral rales and wheezing noted um and there was 1+ pitting edema um in her lower extremities. But uh the pulse was equal and calves were non tender and there was negative Homans sign. Um for her labs, BNP was 4000 and um there was restricted cardiomyopathy with a 55 percent ejection fraction noted on the echo those ordered on admission. Um for EKG there was normal rhythm um so there was normal sinus rhythm, normal axis, but uh there was a nonsustained ventricular tachycardia noted in leads uh V1 through 3. Um so following uh her admission into the hospital, Id like to admit her for uh for telemetry um followed up every 2 hours, um id like to place her on a low sodium diet uh with a saline lock as well so we have IV access. Um Id like to cont continue her Lisinopril but add um 150 um IV of Amiodarone and increase her her uh Prednisone um to 60 mg um as well as put her on Furosemide um 40 mg IV. Um and uh Id like to have her on a nasal cannula uh with the O2 sat greater than 96 uh doing that with 2 liters of oxygen per minute. Um once she is all set up with uh telemetry, then Id like to get a CMP on her and then refer out to interventional cardiology for um an AICD placement as well as radiology for a FDG-PET scan.

54. I had the pleasure of seeing um Mrs. Palmer in the emergency department. Um Mrs. Palmer is a 62 year old female, um um presenting in the emergency department with a chief complaint of shortness of breath and um chest pain. Her vitals um demonstrated elevated heart rate at 110 and low O2 saturation at 91 percent. Um she states that she has had trouble breathing over the past 3 days and she also reports that she had a cold 2 weeks ago including um a fever, sniffle, and some sneezing. She states that her um current symptoms are better when she is in her recliner so she has been sleeping in her recliner um at night to help with these symptoms. When she lays flat, her symptoms are worse and um her symptoms also worsen with um some daily activities which would put her at a NYHA classification of class 2. Um her other pertinent medical history includes a 10 year history of hypertension which is well managed on Lisinopril. Um 10 mg by mouth daily. She has no allergies to medications and no history of illicit drug use, no history of alcohol use, and no history of tobacco use. She eats a balanced diet and before her symptoms began, she was exercising about 2 times a week um at the gym and she states that she does have a support system at home and her insurance through work as an elementary school teacher. Her father is 89 and is living in a nursing home due to his dementia and her mother passed away at 80 due to breast cancer. Her pertinent review of systems um included fatigue and unexpected weight gain of 8 pounds over the past 2 weeks. Um she has been having chest pain and palpitations but no presyncope. Um she has also been experiencing wheezing, orthopnea, and dyspnea and she has lower extremity she reports that she has lower extremity edema. Her pertinent physical exam findings included um JVD jugular venous distention, um bibasilar rales, a displaced PMI laterally, plus 1 pitting edema in her lower extremities and normal lower extremity pulses at 2 plus. Um her labs demonstrated elevated troponin and BNP and her chest xray chest xray demonstrated pulmonary edema and cardiomegaly. Her cardiac echo showed that she had diabetic er dilated cardiomyopathy with um a left ventricular ejection fraction of less than 30 percent and her EKG indicated that she had sinus tachycardia, um at 100 beats per minute and a right bundle branch block. Um based on her history, exam findings, and diagnostic workup, I believe that Mrs. Palmer um has myocarditis dilated cardiomyopathy um due to her um recent illness. Um this is a serious condition so i think that the best plan of action for her would include admission to the telemetry floor um to monitor her vitals every 2 hours. She can proceed with activity as tolerated, um and she should be monitored by nursing for strict ins and outs, daily weight, DVT prophylaxis and she should receive a nasal cannula to maintain her O2 saturation above 96 percent. A 2D echo should be repeated and um she should continue her Lisinopril 10 mg daily and she should also be prescribed Furosemide 40 mg IV over 12 hours, and Acetaminophen um 625 mg every 6 hours. Um a CMP and serial troponin should be ordered and I would like to consult with interventional cardiology, radiology, and infectious disease so that she can have an ACID and CRTD placed um and endomyo endomyocardial biopsy can be performed um she can have immediate enhanced MRI completed and um she can have her immune globulins and glucocorticoids evaluated. Um if you have any questions dont hesitate to ask. Thank you. I hope that she feels better soon.

53. I just saw 62 year old male, Leslie Palmer, with a chief complaint of 6 months of fatigue and shortness of breath that has gotten worse in the past 2 weeks which prompted a visit to his primary care provider. Um he explains that he has been sleeping in a recliner due to increased shortness of breath while lying down and that he has these symptoms with all physical activity. Past medical history includes afib, hypertension, hyperlipidemia, and diabetes; surgical history of CABG and bio cardiac stents to which his cardiologist had recommended no further intervention. \*\*\* He is a one pack per day \*\*\*. Current medications include Atorvastatin, Clopidogrel, Furosemide, Metoprolol succinate, Lisinopril, Metformin, and Warfarin with no known drug allergies. Upon review of systems, significant findings include fatigue, weight gain of 8 pounds in the last 2 weeks for an unknown cause, um wheezing, dyspnea, orthopnea, lower extremity edema. Vitals uh temp was normal, heart rate was normal, and respiratory rate was normal but the patient was hypotensive with a BP of 80 over 50 and SPO2 of 86 percent. Upon physical exam, JVD was present, gallop was present with split S2, and tachycardia as well as PMI displaced laterally. There was no respiration distress or chest wall tenderness but rales and wheezing were present. Extremities um the calves were non tender but pedal edema was present. Up uhh upon imaging, chest xray showed cardiomegaly and pulmonary edema. ECHO showed dilated cardiomyopathy with a left ventricular ejection fraction less than 30 percent. EKG showed normal sinus rhythm, a left bundle branch block, and LVH criteria. Troponin and BNP were elevated. Our primary primary diagnosis is ischemic dilated cardiomyopathy with a NYHA functional classification of 4. Id like to admit this patient to the ICU with serious condition. Vitals checked every 2 hours with strict bed rest, strict IO, daily weights, and DVT prophylaxis as well as a low sodium diet and KVO fluids. Medications i would like to hold his medications except for Clopidogrel and Warfarin and I'd like to add dobutamine IV and insulin sliding scale. Also like to put him on Bipap which would raise that O2 and order PT INR and serial troponins. Id also consult interventional cardiologist for possible AICD placement and CRTD placement.

52. Um Mr. Palmer today, so Mr. Palmer presented with um complaint of shortness of breath and fatigue that had been ongoing for the past 6 months. Um he said that this was um kind of just mild for 6 months and then over the last 3 days. it started progressively worsening. So he went to his primary care physician who ordered a few tests which he was not sure of the name of. Um however when his symptoms significantly worsened today, he called his PCP again who referred him to the emergency department. Patient stated that his shortness of breath is worse with laying flat um and with any type of exertion at all such as just walking around. Um and he feels a little bit better when he lays back on an incline. Um when i walked in the room, his vitals showed a blood pressure of 80 over 50 with an SPO2 of 86, and a heart rate of um 90 beats per minute. His past medical history was significant for hyperlipidemia, hypertension, diabetes, atrial fibrillation, and coronary artery disease with a coronary bar coronary artery bypass graft times 3 12 years ago with an additional stent placed um more recently. He remembers having an ECHO done that showed an EF of about 40 percent a few years ago. He is currently smoking um one pack per day and lives at home with his wife. Um on exam he had positive jugular venous distention, he was tachycardic with a split S2, and had no murmurs, rubs, or gallops. His PMI was displaced laterally and he had 1 plus lower extremity edema, with no associated calf tenderness. Um after reviewing his results, we discussed that his chest xray showed pulmonary edema with cardiomegaly. His EKG showed a normal sinus rhythm, with a left axis deviation, and a left bundle branch block and his labs showed elevated troponin and a BNP significantly elevated at 4000. His most recent ECHO that he had done with us showed an ejection fraction of 30 percent and a dilated left ventricle. Given this, I diagnosed Mr Palmer with ischemic dilated cardiomyopathy with a plan to admit him to the ICU, reorder his PT INR and serial troponins and i kept him on Clopidogrel, Warfarin, Lisinopril, and started him on Dobutamine as a positive ionotropic agent. Um i also told him that the interventional cardiologist would be coming by to consult and um discuss AICD CRT placement to also assess with increasing the heart's pumping power. Um and to consider that as a potential medical device. Um to conclude, patient had no questions for me and was agreeable with the plan. Thank you.

51. Mrs. Palmer is a 62 year old woman who presented to the emergency department today with shortness of breath and fatigue. She was in her normal state of good health until about 2 weeks ago when she developed a cough, chest pain, rhinorrhea, and fever which she described as a cold. 5 days ago she noticed that while all of her other symptoms had resolved, her chest pain, fatigue, and shortness of breath had actually gotten worse. So 3 days ago she saw her family medicine doctor who recommended today that she come to the emergency department as the chest pain had continued to worsen. She has hypertension for which shes been taking Lisinopril 10 mg for 10 years and a cardiac catheter one year ago following an abnormal EKG showed no coronary artery disease. Her review of symptoms reveals fatigue, 8 pound weight gain in 2 weeks, palpitations, chest pain, wheezing, orthopnea, dyspnea, and lower leg myalgia and edema. Vitals show a temperature of 98.6, a heart rate of 110, a blood pressure of 130 over 90, a respiratory rate of 20, and a SPO2 of 91 percent on room air. She was previously able to go to the gym twice a week which she is now unable to do without symptoms which points me to um NYHA class 2. Physical exam showed JVD, laterally displaced PMI, bibasilar rales, and wheezing as well as point one plus one lower extremity edema with equal dorsalis pedis pulses and non tender calves. She had no cardiac bruits. The labs showed troponin elevated at point 1 and BNP elevated at 4000. Chest xray showed cardiomegaly and pulmonary edema. A 2D echo showed ventricular dilation with an ejection fraction less than 30 and a EKG showed a right bundle branch block and sinus tachycardia. My leading differential diagnosis is myocarditis with dilated cardiomyopathy in New york heart association class 2 heart association class 2. I think it is best if we admit her to telemetry and consult interventional cardiology for an AICD or CRTD, infectious disease for immunoglobulin, and endomyocardial biopsy and radiology for immediate enhanced MRI. I would like to start her on IV Furosemide 40, 625 Acetaminophen PO, and continue the 10 mg Lisinopril as well as put her on a nasal cannula for O2 to get those sats above 96 percent. This patient would benefit from a low sodium diet with oral restrictions, strict intake outtake, daily weight, DVT prophylaxis, and vitals every 2 hours. Um I walked this patient through these results and our plan and she had no further questions.

50. Reported to the ED this morning. She is a 62 year old female with a chief complaint of shortness of breath, fatigue, and dull chest pain. She presented to her family menace medicine physician 3 days ago to be evaluated. She says that she had a cold 2 weeks ago consisting of fever, cough, rhinorrhea, dyspnea, and fatigue. The symptoms went away 5 days ago but returned and now she feels worse than before. She continued to go to the gym while she was sick but stopped when her symptoms came back. She notices that she sleeps in a chair at night because it helps her breathe better. She notes she is comfortable at rest but has dys dyspnea on exertion and with some exercise and orthopnea. This places her at a New York Heart Association classification of class 2. Her past medical history includes hypertension which she takes Lisinopril 10 mg daily for. She has no known drug allergies. Her past surgical history includes cardiac catheter 1 year ago that showed no obstructive abnormalities. Her mother passed away 5 years ago due to um breast cancer and her father is currently living with Alzheimers. She eats a healthy and well balanced diet and before symptoms started, she exercised 2 to 3 times a week. She denies any illicit drug use, alcohol, and any illicit drug use, use of tobacco products and um consumption of alcohol. She drinks one cup of coffee daily and shes a third grade teacher and she is updated on her immunization and having insurance. Her review of systems was positive for fatigue, weight gain of 8 pounds in the past 2 weeks, chest palpitations, dull aching chest pain, wheezing, myalgia, and lower extremity edema. Her physical exam revealed JVD, bibasilar rales, um PMI displaced laterally, 1 plus pitting edema in her lower extremities, and normal radial, dorsalis pedis, and posterior tibial pulses. Her labs demonstrated elevated troponin at point 10 and BNP at 4000. Her chest xray showed pulmonary edema and cardiomegaly. Her ECHO demonstrated dilated cardiomyopathy with a left ventricular ejection fraction of less than 30 percent. Her EKG indicated sinus tachycardia, right bundle branch block, left axis deviation, and preventricular contractions. Her vitals showed um temperature of 98.6, elevated heart rate of 110, elevated respiratory rate of 20, elevated blood pressure of 130 over 90, and her O2 was slightly decreased at 91 percent. So based on her history, exam findings, and diagnostic workup I believe that Ms Palmer has a myocarditis dilated cardiomyopathy new york heart association class 2 which is serious condition. I think the best plan of action would be to admit her to telemetry to monitor her vitals every 2 hours. She can proceed with activity as tolerated. Um and should be monitored by nursing for strict IO, daily weight, DVT prophylaxis, O2 nasal cannula to maintain O2 sats greater than 96 percent and her saline fluid should be KVO and her diet should be low sodium and \*\* injection. Um 2D I ordered a 2D echo should be repeated. She should continue her Lisinopril 10 mg daily and begin um or she should continue her Lisinopril 10 mg daily and begin furosemide 40 mg IV over 12 hours and acetaminophen 625 mg every 6 hours. Um a CMP and serial troponin should be ordered. Um a consult with interventional cardiology, infectious disease, and radiology should be conducted to place an AI AICD and CRTD um and endo endomyocardial biopsy should also be completed a media enhanced MRI should be completed and her immuno immunoglobulins and glucocorticoids should be evaluated and that is the end of my case presentation. Thank you for your time.

49. Ive been seeing um Mr. Leslie Palmer, a 62 year old male, who presents today with a complaint of uh dyspnea, fatigue, and intermittent intermittent palpitations that he has been experiencing for the past couple of weeks. He states that he has also been experiencing uh presyncope. Episodes that has not had any syncopatic episodes today. He states that he experiences these symptoms when he does moderate activities and is unable to do them to um to do them without experiencing dyspnea and he has to uh rest uh or especially laying down helps to alleve his symptoms. Hes history of hypertension which is controlled with Lisinopril 10 mg daily. He reports that he is tolerating the medication well. Um Mr Palmer had a uh positive um issues for cardiac sudden cardiac or sudden unexpected death his mother died at age 40 unexpectedly, his father died at age 59 to myocardial infarction. He states that he has never been in the hospital before but has had a uh cardiac catheterization one year ago because his PCP wanted to investigate an abnormal EKG findings and he was also the cardiac catheterization was normal though. He has no known drug allergies um he is currently an elementary school teacher. He would walk daily with his uh friends before experiencing uh symptoms for exercise he did not use any alcohol, tobacco, illicit drug use use and has a morning cup of coffee. Um his review of symptoms was positive for wheezing, um also obviously palpitations, presyncope, it was uh negative for any lower extremity edema, chest pain, uh any in the uh musculoskeletal, neurological, review of symptoms are unremarkable. His uh his vitals showed a blood pressure of 130 over 90, oxygen saturation at 96 percent, heart rate at 110, respiratory rate of 16 and the uh temperature was 98.6. His physical exam revealed no JVD, no carotid or um no carotid or abdominal bruits. There was uh positive systolic murmur and S4 as well as with a gallop. No friction rub. The PMI was displaced laterally. The patient had no chest tenderness and their lungs were clear to auscultation bilaterally. The distal uh the size the dig excuse me dorsalis pedis and tibialis posterior pulses were equal and intact. The calf was nontender and Homans sign was negative. No signs of lower extremity edema. Um yeah chest xray revealed cardiomegaly, BMP and troponin labs were um normal and unremarkable. 2D echo showed left ventricular hypertrophy. Usual atrial enlargement. Um the sorry the EKG revealed um left ventricular hypertrophic voltage criteria as well as tall R waves in the septal leads suggests um interventricular septal hypertrophy and left ventricular hypertrophy. sinus rhythm normal sinus rhythm that approximates 60 beats per minute but that was the EKG. Excuse me um the uh and so with all of this uh in mind, I believe Ms. Palmer has familial hypertrophic cardiomyopathy. I uh recommended that we should uh not also new york heart association stage 2. Uh i recommended the uh the hospital to telemetry. Umm so its condition serious, vitals every 2 hours. Strict IOs strict IOs, daily weight, um nasal cannula oxygen delivery to maintain oxygen saturation at 96 percent. That can be normal activity as tolerated. Dis Discontinue Lisinopril 10 mg daily and replaced him at Disopyramide 100 mg four times a day. Um we do um IV lock um saline lock keep the veins open and um no labs or other imaging is ordered at this point but due to er her consult with the cardiothoracic surgeon, her \*\* with the myectomy, as well or um alcohol injection to reduce the um obstructive um of the outflow obstruction of the outflow tract um and also to the interventional cardiologist to um for a possible AICD placement. With that with that I think um Mr Palmer is ready to see you. Hopefully that is it and um ya.

48. 62 female elementary school teacher who presented today with a 2 month history of shortness of breath and fatigue. She is also experiencing palpitations and pre syncope and was referred to us after visiting her primary care physician. Um her vital signs are heart rate of 110, a blood pressure of 136 over 99, respiratory rate of 20, um O2 saturation is 93 percent, and temperature is 98.6. She has a hip history of hypertension and sarcoidosis, uh which she’s taking 10 mg of Lisinopril and 10 mg of Prednisone. Um she has had a previous cardiac catheterization with no signs of obstructive coronary artery disease. Um her family history includes the sudden death of her mother at 40 years old and the death of her father, 59, um from myocardial infarction. Her diet is fairly balanced and she has she used to exercise regularly until she started experiencing the shortness of breath. Uh she does not use tobacco, alcohol, or any illicit drugs. On her caffeine intake, its one cup per day one cup of coffee. Um she has experienced an 8 pound weight gain over the past few weeks, along with orthopnea and swelling in her legs. Um I admitted her uh for continued cardiac monitoring with daily checks or daily weight checks um oxygen and uh that’s been maintained over a 96 percent saturation and DVT prophylaxis. Um I increased her dosage of Prednisone too and kept her um Lisinopril dosage the same. She will remain on a low sodium diet, and it allowed um activity or movement um with assistance um I added 150 mg of Amiodarone and 40 mg of Furosemide to help with the swelling and ordered a CMP to monitor her potassium levels. Um I have also gotten consultations to interventional cardiology um for an AICD placement as well as radiology for a FDG PET scan.

47. \*\* up with Ms Palmer, a 62 year old female, who presents today with shortness of breath and chest pain. Ms Palmer states that her primary care doctor sent her to the ER uh after he evaluated her for her symptoms. 2 weeks ago, Ms. Palmer had a fever and a cough and has had progressive symptoms since then. She states that her chest pain was currently 2 out of 10, her shortness of breath was worse with exertion and supine. Um the patient is alert and oriented, is not febrile today, and 98.6 is her temperature. Her blood pressure is slightly elevated at 130 over 90. She is tachycardic at 110 and her sats are at 91 percent on room air. Ms Palmer has uh hypertension as her medical history and she currently takes Lisinopril 10 mg everyday. She has had a cardiac cath done 1 year ago but has no noted obstructive coronary artery disease. She does not have any allergies and concerned with her lifestyle she is currently a second grade teacher and reports that she exercises twice a week when she feels well. She reports no alcohol, tobacco, or drug use. She has a father with Alzheimers, a mother who died at 80 from breast cancer. In reviewing her systems, Ms Palmer reported recent weight gain of 8 pounds, edema in her ankles, um she also noted palpitations, chest pain, and wheezing. Positive for dyspnea and orthopnea. On physical exam, Ms. Palmer noted JVD and pitting edema. I did note a left displaced PMI and no carotid or epigastric bruits or murmurs. Rales and wheezing were noted bilaterally on lung sounds. I ordered a chest xray, echo, labs, and an EKG. On chest xray, I noted cardiomegaly and diffuse bilateral pulmonary edema. Her echo indicated a reduced left ventricular ejection fraction under 30 percent and she had an elevated troponin and BNP. Her EKG indicated tachycardia, left axis deviation, PVCs, and a right bundle branch block. Because of her negative cath 1 year ago and lack of comorbidities, I ruled out coronary artery disease and ischemic heart disease. Her family history rules out sarcoidosis or other inflammatory cardiac conditions. Due to her recent fever, my primary diagnosis is myocarditis dilated cardiomyopathy with a NYHA class 2 heart failure. Her condition is serious and i will have her vitals monitored every 2 hours. I am going to admit her to telemetry and I will allow activity as tolerated with strict I and O, daily weights, DVT prophylaxis, and begin oxygen by nasal cannula and 96 until she gets to 96 immediately. I am going to keep her on low sodium and fluid restriction diets. I am going to get an IV but Ill hold fluids and I will reorder a trop and a CMP. I plan to continue her Lisinopril 10 mg, Acetaminophen at 625 for pain, Furosemide of 40 by IV, and I will consult interventional cardiology due to the possible need for CRT and AICD placement and endocardial biopsy, infectious disease, and also the radiologist for MRI to detect myocardial inflammation. Let me know if you need anything and thank you.

46. So Leslie my patient is Leslie Palmer who is a 62 year old female, whose chief complaint is shortness of breath and fatigue. Um the patients shortness of breath um began about 2 months ago and has been getting worse. Patient describes feeling fluttering in her chest and like she is going to pass out. Uh 3 days ago the patient presented to her primary care physician where they ordered tests and her primary care physician then recommended for her to go to the emergency room. Patient states that her symptoms get worse with activity and are better at rest. Patient is currently sleeping in a recliner at night because laying down makes her symptoms worse. On a scale of 0 to 10, patient describes the severity of her discomfort as a 7 or 8. As far as her social history goes, patient has a bat balanced diet and walks everyday prior to experiencing symptoms. She drinks a cup cup of coffee everyday and is an elementary school teacher who lives with her husband. As far as her past medical history goes, she was diagnosed with hypertension 15 years ago and pulmonary sarcoidosis 25 years ago. She is up to date on immunizations and has no hospitalizations and no allergies. As far as surgery go, she had a cardiac catheter 1 year ago and um it was found to have no obstructive coronary artery disease present. For her medications, she is currently on Lisinopril 10 milligrams once a day for hypertension and then her prednisone 10 milligrams once a day for pulmonary sarcoidosis. Patient states that she is compliant with these medications began the Lisinopril 15 years ago and the Prednisone 25 years ago. As far as her family history goes, patients mother passed away at the age of 40 due to sudden death and her father passed at age 59 due to a myocardial infarction. As far as uh pertinent review of system goes, patient it has experienced fatigue, weight gain of 8 pounds over 2 weeks, swelling in lower extremities, near syncope, palpations, wheezing, dyspnea with exertion and orthopnea. As far as pertinent physical exam, patient has a positive jugular venous attention and no carotid bruits. They showed a positive systolic murmur with S4 and a positive gallop. Um as far as when listening to her lungs, I heard bibasilar rales and wheezing. Um looking at her lower extremities, she did have edema in her lower extremities as well as a normal dorsalis pedis and posterior tibial pulse. She also does not have any epigastric bruits and no pulsatile masses. As far as her abnormal vitals go, she had a heart rate of 110, respiratory rate of 20, an oxygen saturation of 91 percent, and blood pressure of 136 over 99. Uh for her results of her lab and imaging, her labwork shows that she has an elevated BNP of 4000. Her chest xray shows cardiomegaly, mediastinal fullness, as well as pulmonary edema. Um her echo her echo shows restrictive cardiomyopathy with increased wall thickness and an ejection fraction of 55 percent. Her EKG shows normal sinus rhythm, normal axis, nonsustained ventricular uh nonsustained ventricular tachycardia. My leading differential diagnosis is sarcoidosis restrictive cardiomyopathy with a New York Heart Association uhh rat rating of 3. As far as the car cause goes, I explained the patient that most likely this is due to the pulmonary sarcoidosis that went to her heart and um resulted in arrythmia and congestive heart failure. As far as assessment and plan goes, I am admitting the patient to tele tele tele telemetry sorry condition is serious, allergy is none, vitals um two every two hours, um she can be out of bed with assistance. As far as nursing interventions go, this would include strict IO, daily weight, DVT prophylaxis, O2 via nasal cannula, as well as maintaining oxygen saturation greater than 96 percent. A diet of low sodium is also recommended as well as for IV fluids a saline lock, and keeping the vein open. As far as medications go, I recommend continuing Lisinopril Lisinopril 10 mg once daily and then starting Amiodarone 150 mg IV, increasing Prednisone to 60 mg once daily, and um adding Furosemide 40 mg IV. Diagnostic labs slash imaging would be um CMP labs. As far as specialists and consults, I recommended interventional cardiologist who discussed the possibility of an automatic implantable cardiac defibrillator as well as nuclear medicine and radiologist to discuss an FDG PET scan. As far as lifestyle modifications, I recommended to her focusing on a healthy diet, weight reduction, and physical activity when she is cleared by the physician. The patient had no further questions and um I went ahead and uh let her know that her husband could come up and I would explain the information to him. Thank you.

45. Presenting with complaints of shortness of breath and fatigue. Her symptoms began 6 months ago when she visited and she visited her PCP 3 days ago. She reports that she cannot catch her breath but states that there is no accompanying chest pain. She describes orthopnea in which reclining improves her symptoms and her symptoms worsen with activity. In terms of Leslie Palmer's past medical history, she has reported atrial fibrillation, hypertension, hyperlipidemia, diabetes, and her immunizations are up to date. In terms of past surgical history, she reports a previous cardiac stent, in fact there have been 5 cardiac stents, and she is no longer a candidate for any future ones and she has also undergone a um a bypass bypass graft or a CABG. In terms of her maternal family history, her mother has passed due to breast cancer and her father is alive but is suffering from Alzheimers. In terms of her social history, she reports no alcohol use, um tobacco use active about a pack per day and no illicit drug use. She is currently employed, her diet is regular and balanced, she reports one cup per day in terms of caffeine, she exercises regularly prior to having these symptoms. Now she can no longer exercise and uh she lives with her husband. In terms of medications, she takes Atorvastatin, Clopidogrel, Furosemide, Metoprolol, Lisinopril, Metformin, and Warfarin. And in terms of drug allergies, she has no known drug allergies. Uh when assessing her ROS, she does suffer from fatigue, she reports weight gain, there have been no skin um abnormalities, and when it comes to HEENT there are also no abnormalities. And when assessing her chest report no chest pain no palpitations. They were all negative when it comes to her lungs. Uh she reports wheezing again uh orthopnea as described and dyspnea. When it comes to muscular musculature she does have lower extremity edema. and in terms of her neurological examination, there was nothing er it was all negative. Uh her vital signs were a temperature of 98.6, a heart rate of 90, uh rather high respiratory rate at 22, a low blood pressure hypotension at 80 over 50, and her SPO2 was also at 86 which is low. Uh when assessing her neck, there was JVD present and when assessing her heart during physical exam, we noticed no murmur and her PMI was displaced and there was some tachycardia as well. Um when listening to her lung sounds, we found there was both wheezing and rales. In terms of her extremities, we found um pedal edema and decreased pulses and in terms of imaging she had cardiomegaly and pulmonary edema on the chest xray. Uh when we assessed her 2D echo we found that there was a left ventricular ejection fracture of less than 30 percent and in terms of imaging when it came to the EKG we found uh normal sinus rhythm at 90. Um there was a left bundle branch block and there was also uh criteria that met left ventricular hypertrophy. Her troponin levels were elevated and her BNP was at 4000. I came to the diagnosis of ischemic dilated cardiomyopathy based off of her lab values and her patient history. Her NYHA classification will put her at a uh level of 4 where she cannot carry on physical activity due to her symptoms and the plan that was uh the plan would be to admit her to the ICU because her serious her condition is serious. This would necessitate checking her vitals every 2 hours as well as strict bed rest. And when it comes to the nurse, it requires um a strict intake and out outflow monitoring as well as a daily weight monitoring and also DVT prophylaxis in case her symptoms cause um clot or embolus. In terms of her diet, we would prefer to be low sodium and IV fluids we should keep the vein open. In terms of medication, there is no necessity for pain meds. However for cardio vasculature, we should prescribe Clopidogrel, Warfarin, and Dobutamine. Uh there is no need for diuretics at this moment and because this is a diabetic patient, it would be best to put her on the insulin sliding scale. And again based off of her oxygen saturation and her increased respiratory rate, I decided to put her on BiPAP. In terms of diagnostic lab orders, uh PT and INR because of the Warfarin and Troponin to see if there is any change in her uh her heart status and then there is no need for any new imaging at this mo at this point. However in terms of consultations, I did recommend an interventional cardiologist. This would be for both in a AICD placement as well as a CRTD placement which could deliver a shock as needed. And that concludes my presentation.

44. Leslie presents today as a female patient for an evaluation for shortness of breath, feeling like she is going to pass out, and heart palpitations. She states that she cant do anything. She reports this began 2 months ago and has worsened over the past 3 days. She was referred here today by her family medicine doctor who saw her 3 days ago. She notes fatigue, an 8 pound weight gain over the past week, lower extremity edema, significant palpitations over the past 2 months, as well as wheezing and orthopnea over the past 2 months. Her past medical history includes hypertension and a diagnosis of pulmonary sarcoidosis 25 years ago. She currently takes Lisinopril for the hypertension and prednisone for her recent medical issues. Patient currently lives with her husband who she describes as her social support and she does have insurance. she currently works as an elementary school teacher. Prior to 2 months ago, she was an active walker. She states due to her symptoms she is not able to do that now. Patient reports a healthy diet. She reports tachycardia er on exam today she had tachycardia at a heart rate of 110, a SPO2 less than 95, hypertension at blood pressure 136 over 99 and a respiratory rate of 20. She was positive for jugular venous distension, negative for carotid bruits, systolic S4 present, gallop present, negative rubs, rales bilaterally, positive wheezing, plus 1 pitting edema, she had a bilateral lower extremity pulse and non tender calves. In summation, uh with the patients history of sarcoidosis with positive exam findings, as well as \*\* sign and pulmonary edema on anterior and posterior views on radiograph, an echocardiogram displaying restrictive cardiomyopathy with heart failure with preserved ejection fraction, normal sinus rhythm with non sustained ventricular tachycardia on electrocardiogram, negative troponin, and a brain natriuretic peptide of 4000. She has a diagnosis of sarcoidosis sarcoidosis restrictive cardiomyopathy. Today I stated that she was a New York Heart Association level 4 and this is a serious condition. So given these findings and her diagnosis, she will go to telemetry to be continued to be evaluated and I will consult with an interventional cardiologist as well as a nuclear medicine or radiologist for further work up. She will continue Lisinopril 10 mg everyday, Amiodarone 150 mg intravenously, Prednisone will be increased to uh 60 mg everyday, and furosemide 40 mg intravenously. Repeat vitals will be taken every 2 hours and if she decides to get out of bed she will need assistance and that is my case presentation for Leslie. Thank you.

43. Hello, uh Mr. Palmer is a 62 year old male who presented today with um dyspnea and fatigue after being referred to us by his family doctor. He noticed fatigue and dyspnea while walking 2 weeks ago um although he states that its better with rest and better with laying down. Um the dyspnea and fatigue became worse last night and he also reports a history of presyncope, palpitations, and wheezing. He has a medical history of hypertension for which he takes Lisinopril and he takes no other medications and he has no allergies. He had a cardiac cath years ago um which came back normal and he also has a family medical history of sudden death in his mother at 40. His father died of an MI in his fifties. Um he is an elementary school teacher who drinks one cup of coffee a day, no alcohol, no tobacco, he eats a balanced diet, and he enjoys going for walks everyday although he has been um unable to do this recently due to the dyspnea and fatigue. Um for his vitals, I noticed a heart rate of 110, um oxygen saturation of 96, blood pressure of 130 over 90, and a respiratory rate of 16 and a temperature of 98. On physical exam, I noticed a crescendo decrescendo murmur and a displaced PMI which i discussed with the patient. Um for his imaging, on the xray we saw a cardio uh myopathy, a cardiomegaly, um on the ECHO we saw hypertrophy of the septum, and um on the EKG showed septal hypertrophy with increased amplitude waves in the leads um V1, V2, and V3. So the um diagnosis which i think is most likely? for this case is familial hypertrophic um cardiomyopathy which i discussed with the patient and i prescribed disopyramide for him discontinued his Lisinopril. Also referred to him an interventional cardiologist um which i discussed with the patient and as well as a cardiovascular surgeon. Thank you.

42. So Ms. Leslie is a 62 year old female presenting with dyspnea, shortness of breath, orthopnea, and a history of progressively worsening symptoms of palpitations and \*\* troubles breathing. This has been going on for the past 2 months um when she went and finally decided to see her family doctor 3 days ago to address these symptoms. The family doctor sent her away and then she called the family doctor today and he told or they told her to go and visit the uh the emergency department. Ms Leslie has a history of hypertension and pulmonary sarcoidosis. Uh upon arriving her vitals were taken and she had a heart rate of 110, blood pressure of 136 over 99, and a SP of 2 of 91. Uh her familial history is significant for sudden death of her mother at 40 and uh father dying of heart attack at 59. what. Uh she has no known drug allergies uh She is currently on Lisinopril and Prednisone as well as uh having no uh substantial social history other than living with her husband and moderate caffeine usage. Uhh Ms Leslie used to exercise uhh fairly frequently until the past 2 months where she has been bed ridden. Ms Leslie sleeps in a chair now because of her orthopnea so its easier for her to breathe in a recliner so that’s where she sleeps and she has a NYHA uh scale of three uh of a heart rate of 3 as she has issues with any sort of non resting activity. Upon uh that upon systems of review and diagnostic findings we determined that Ms Leslie we believe she has pulmonary uh pulmonary sarcoidosis restrictive cardiomyopathy. Uh we saw that with an xray that had pathognomonic QR uh Lymph node findings as well as diffuse infiltrates within the lung and enlarged heart and yes. Ms Leslie will be admitted to the hospital in serious condition. she will receive 2 liters of O2 via nasal cannula as well as increasing her Prednisone, keeping her on Lisinopril, as well as adding Amiodarone and uh Furosemide to relieve edema that she has from a build up of water in her legs or build up of fluid in her legs. Furthermore, we consulted radiology for a FDG PET scan as well as interventional cardiology for a AICD automatic cardiac defibrillator in her heart. A uh Ms Leslie was put on a low salt diet with an IV to keep open as well as wait a during our physical exam Ms Leslie did have abnormal cardiac findings including a murmur and a gallop of S4. Uh bi bibasilar rales and that is it. So once again we admitted her to the hospital and we started treatment with Furosemide, Prednisone, uh continued Lisinopril and Amiodarone due to treat a paroxysmal ventricular tachycardia. With that.

41. 62 year old female um named uh Leslie Palmer. She reported to me today with a history of shortness of breath and fatigue um so the uh the shortness of breath um and the fatigue had been progressively worsening over the past 6 months and um uh at her visit today she had she had reported that the shortness of breath was occurring even at rest. so any sort of physical activity um even just walking down the hall she reported um uh shortness of breath. and um she is having to sleep in a chair for that reason at night um so she did have a positive orthopnea um and again at it is um it is at rest and with physical activity. Um so uh additionally she has been um in the past 2 weeks she has reported that she has gained about 8 pounds um and getting into some of her medical history um she does have a history of hypertension, uh hyperlipidemia, um diabetes, and atrial fibrillation. Uh surgically she has a history of um about 12 years ago she had a triple bypass surgery. Shes also had 5 uh stents placed uh in total and they did inform her that she is not a candidate for further stents. Um she was informed by um previous physicians that her ejection fraction um was about 40 percent. Um getting into some of her her medications um she provided me with a list she she was on a good number of medications um to name them she was on lisinopril, Metformin, uh Warfarin, Metoprolol succinate, um she was on uh Furosemide and um uhh so thats it for the medications. She did not have any drug allergies um. Some of her social history uh she has a good uh balanced diet. She did report that she is actually able to walk daily um even though she did state that she uh is experiencing shortness of breath with any physical activity um she is still was making the effort to walk everyday um which is very good and she does not report any uses of illicit medications or over the counter medications other than what is prescribed to her. She does have a 30 pack year history um sorry 30 year history of smoking um for which she has been smoking one pack per day. No alcohol consumption and um she has been drinking about one cup of coffee everyday. Uh as far as her sexual activity she is married um and it is a monotonous relationship and for her living situation she is living with her husband. Um so getting to some of her vitals um her blood pressure was significantly low at 80 over 50 um her pulse at about 90 and her oxygen also low at about 86. Um and her respiration rate was a little bit elevated at 22. Um and i did discuss that with her um and talk about um you know what was um standing out in in regards to her vitals as well. So um getting into her physical er or physical exam sorry she did have um positive jugular venous distension, um however she did not have any carotid bruit. Uh she did have some um swelling in her in her calves um so she was positive for lower extremity edema um however, her um her Homans sign was negative. So um getting into her lab work um so troponin and BNP were both elevated um INR was not elevated. Um Her echo was showing a reduced ejection fraction of about 30% so she had reported in the past that physician told her it was about 40 and today it was 30 so um uh it possibly could have could have gone down. um her EKG was showing a left bundle branch block um and so using those findings i i um my my diagnosis was ischemic dilated cardiomyopathy. Um and and for which i i decided to discontinue a lot of the medications that she is currently prescribed and I I however I did keep her on her blood thinners so I kept her on Warfarin and i kept her on the Clopidogrel. Um and I also added Dobutamine for her blood pressure as it is um quite low and I added um some insulin um because she is diabetic and she has not been taking insulin um so I added insulin as well. Um I also admitted her to the icu um because of her lab work and because of her her symptoms um I just wanted to make sure that she can be continuously monitored monitored taking uh taken good care of. Um so other than that would be my encounter. Thank you very much for listening. Bye.

40. Mr. Leslie Palmer, who is a 62 year old male, with a history of hypertension, and presented with a chief complaint of shortness of breath and a pre-syncope episode 2 weeks ago while walking. The um associated um episode was with dyspnea that was aggravated while walking and any kind of physical activity. But was relieved with rest therefore it falls under the New York Heart association classification of 2. The patient also described wheezing as well as rasping and fluttering that um last for a duration of any kind of exertion. Patient described there was no history of cough, chest pain, no weight loss, or fever, chills, or sweats. the patients risk factors for coronary artery disease include a positive family history of a MI on the fathers side that passed away at 69 years old and a maternal medical history of sudden cardiac death. Currently, patient is taking Lisinopril for their hypertension and has no known drug allergies. They did have surgical history of heart cath and as for their social history they have a balanced diet and were very active exercising but as of now they have shortness of breath while walking, moderate consumption use of uh caffeine, and no consumption of tobacco, alcohol, or drugs. They are uh elementary sorry they are middle school teacher that lives with their husband. So as for their vital signs, the um the patient has uh vitals of blood pressure of 130 over 90, uh temperature of 98.6, heart rate of 110, respiratory rate of 20, and uh saturation of oxygen of 91 percent and they appear to be awake alert and oriented. I performed a cardiac pulmonary physical exam that indicated no carotid bruits, and did have a jugular venous distension. Um they had a regular heart rate, no murmurs, friction rub or gallops present but a laterally displaced PMI. As for respiratory had no chest wall tenderness, uh but wheezes were present with no respiratory distress. In their extremities, their pulses were full and equal with uh non tender calves and no pedal edema. I reviewed uh imaging of a chest xray that indicated cardiomegaly as well as uh an echo that indicated left ventricular asymmetry uh with hypertrophy and an ejection fraction of 60 percent. And their EKG uhh read to be a normal sinus rhythm with a left ventricular hypertrophy criteria and tall R wave in the uh septal leads. Their um labs came back showing their troponin BNP levels as not elevated, therefore my assessment for this patient is a that they have familial hypertrophic cardiomyopathy secondary to their hypertension and uh this is because of the family history of sudden cardiac death and normal cardiovascular markers in their labs. Thats umm why I would like to admit this patient to telemetry for serious condition and checking their vitals every 2 hours. Um and indicated activity as tolerated with nursing interventions of daily weight, strict IOs, a nasal cannula oxygen maintaining their oxygen saturation above 96 percent and DVT prophylaxis keeping them on a low sodium diet and uh IV fluid orders for keeping the veins open. No uh pain medications but I would like to add disopyramide 100 mg per oral and discontinue the Lisinopril in order to manage any dysrhythmias that they are experiencing. Um no labs are needed to be ordered as well as no imaging but refer in for consult to interventional cardiologist for a AICD placement defibrillator as well as cardiothoracic surgery. Um consult for a septal myectomy for the inflammation and um management of the hypertrophy. Thank you.

39. Today, Mr. Palmer is a 62 year old man who presents to the office for the chief complaint of dyspnea with exertion and fatigue. Uh Mr. Palmer is an elementary school teacher with the wife of 30 years. He was in his usual state of excellent health until a week 2 weeks ago, prior to admission when he developed an acute onset of shortness of breath. He reports walking with his coworkers after work, when he felt the symptoms uh before admission. Uh he describes the symptoms to be generalized throughout his body with a constant duration during exertion. Um exercise seems to make it worse. He does not complain of any radiating pain. He rates his pain as a 5 out of 6 on a scale of 0 to 10. Mr. Palmer has a history of high blood pressure, which he was diagnosed with hyp- hypertension and is currently being treated for this with uh lisinopril 10 milligrams. Along with the lisinopril he does not report any over the counter herbal medications. Mr. Palmer does not report any allergies. His social history includes a balanced diet, regular exercise before onset before the onset of symptoms 2 weeks ago, no drug use, no tobacco use, no alcohol use, and regular regular caffeine consumption of 1.5 cups of coffee every morning. He works as an elementary school teacher and is sexually active with his wife. He has a positive surgical history of a cardiac cath performed 1 year ago and his yearly physical. Um he's had no hospitalizations. Family history is positive for his father, passing away at age 59 from an MI, and his mother passing away at age 40 from a sudden cardiac death. Today uh Mr. Palmer appears awake, alert, oriented and presents with no fatigue, fever, chills, weight loss or weight gain. Review of symptoms of his skin was negative with no rash, bruising lesions uh or color changes or warmth touch. Review of systems of his MSK was negative, no muscle back or joint pain. Review of pulmonary systems was positive for wheezing and dyspnea with exertion. Review of cardiovascular systems was positive for palpitations near syncope uh but no passing out no, no full syncope uh and S4 murmur and a laterally displaced PMI. His vital signs seemed abnormal, with an elevated BP of 130 / 90. Um other vital signs were normal, with a BPM of 110 and oxygen saturation of 96%. No carotid bruit or JVD were noted. No chest wall tenderness. Um auscultation and palpi- palpation of the epigastric area was a negative for no bruit or pulsatile mass. Uh lower extremity pulses were normal bilaterally. Lungs were clear to auscultation bilaterally. Homan’s sign was negative and calves were symmetrical. OMM examination of the thoracic spine was normal with known TART with no notable TART changes. Upon palpation, no lower lower extremity, no lower extremity edema was noted. Um review of labs uh ordered by the family med physician 3 days ago showed cardiomegaly on chest Xray troponin and BNP were within normal limits and a 2D echo uh performed showed an asymmetrical left ventricle with a enlargement enlarged intraven- interventricular septum and an ejection fraction of 60%. Um today Mr. Palmer was diagnosed with familial hypertrophic uh obstructive cardiomyopathy and is in serious condition. I counseled Mr. Palmer to be admitted to telemetry and to check vitals q2 hours. He was counseled for activity as tolerated and a regular diet. Uh lisinopril 10 milligrams was discontinued and diso- disopyramide 100 milligrams QID was instead started. Uh referrals to interventional cardiology for AICD placement and cardiothoracic surgery for possible septal myomectomy and alcohol injection were uh counseled. Thank you.

38. Patient I saw earlier in the ED, Ms. Foster, she presented with a 2 month history of chest palpi- uh chest flutters and dyspnea on exertion, uh she states that over the last 3 days it's gotten worse. She saw her doctor, who had ordered some lab tests, but when she called in and said things that gotten worse the last couple of days they were recommen- recommending that she uh go to the ED. So she presented today. Uh she states that she's having to be uh sleeping in a chair due to um orthopnea at night. Uh she has a history of pulmonary sarcoidosis. As far as her uh past medical history, she has history of hypertension, which she takes lisinopril for and she's also currently on 10 milligrams of prednisone for her sarcoidosis. Um past uh surgical history includes cardiac cath that she said went well uh last year, and her family history on her mother's side she said that her mother died at age 40 from a from sudden death they weren't exactly sure occurred and her father is also deceased at age 50 uh 9 from an MI. Uh as far as her social history, she does not drink alcohol, uh does not um use tobacco, does not use illicit drugs. She's a teacher for occupation, diet is well balanced. She does drink 1 cup cup of coffee a day. She states that she normally will exercise, like walking with her friends, but recently due to um her the the inability of the shortness of breath upon exertion she is no longer continued to walk with her friends. Uh lives, living situation is stable. She has support at home. Uh no known drug allergies as doing her review of systems she was uh she had some fatigue, uh but otherwise, and some recent uh 8 pound weight gain in the last couple of weeks that she's noticed. Um her skin no, uh nothing of noticeable there. All negative. Uh nothing uh regarding her head. No recent headaches, neck, neck stiffness, uh difficulty seeing her vision. Uh as far as her cardiac evaluation, uh she noted, some fluttering palpitations in her chest, along with um some near syncope events uh with exertion. Uh as far as her uh respiratory, we uh already discussed that she had had some uh dyspnea and uh orthopnea. Uh she had some lower extremity edema, but otherwise no muscle aches or pains. Uh neuro she had no confusion, dizziness or uh gait disturbances that she had noticed as as as far as I could tell, she was alert and oriented. She did have some fatigue. Uh vital signs were 136/99 heart rate of 110 and respirations of 20 uh SPO2 was at 91. Uh when I further did an evaluation um of the patient, she had a positive JVD uh with but no carotid bruit. Uh right her, her uh heart rate was regular but there was an S4 uh murmur noted. Uh that positive gallop, and no regurg. Uh she did have some peripheral edema. Uh lung sounds she had some bilateral rhonchi uh with wheezing. Um after the physical exam, um some Xrays and a echo along with an EKG were ordered. I interpreted uh at the patient's bedside those results. Uh her lab showed elevated uh BNP uh with normal troponin. Her EKG showed uh non sustained uh ventricular tachycardia with otherwise normal sinus rhythm. And her uh echocardiogram showed uh restriction uh in her cardiac it showed restricted cardiomyopathy with increased wall thickness but the ejection fraction was still uh 55%. Uh upon reading her um chart examining the patient and looking over her uh lab results and Xrays, I determined the patient most likely was uh having cardiomyopathy related uh to her sarcoidosis. Uh I advised that the patient be admitted to telemetry um vitals every couple of hours. Uh she can uh be on bed rest, but out of out of bed with with assistance. Put her on strict I- I- IO uh daily weight uh oxygen to bump up her stats and DVT prophylaxis. Um and I also recommended that we uh continue her lisinopril but up her prednisone to 60 milligrams, uh put her on uh IV furosemide, for her pulmonary edema. Um along with uh recommended that we get repeat CMP labs uh to check the furosemide. Uh and consulted radiology and interventional cardiology to look at place look at an I uh AICD placement along with a PET scan uh to further evaluate her sarcoidosis. And that's all I have.

37. Leslie Palmer is a 62 year old female who presents to the emergency department with complaints of palpitation, shortness of breath and feeling fatigue progressively for the past 2 months. She states that she's going to pass out um occasionally whenever she does any activity. She denies any feeling any symptoms like these in the past. Um her symptoms worsen with any activity. And especially when she she's trying to lay down, she denies any radiation of the pain or any of her symptoms, and she rates her symptoms 7 out of 10 in terms of severity. She states that she followed up with her primary care physician 3 days ago and had blood work and imaging done at the same time. Her past medical history is significant for hypertension and pulmonary sarcoidosis. She is currently on lisinopril, 10 milligrams daily, as well as prednisone, 10 milligrams daily. Her past surgical history, significant for cardiac catheterization, that she had about 1 year ago, which was reportedly normal. She denies any tobacco use alcohol use drug use and states that she has a balanced diet and tries to exercise every day. Her mother, her mother passed away from sudden cardiac death at the age of 40 and her father passed away from myocardial infarction at the age of 59. Her reviews of system was positive for feeling fatigued weight gain palpitation presyncope dyspnea with exertion orthopnea wheezing and lower extremity edema. Her vitals showed um blood pressure of 136 / 90 pulse of 110 respiration rate of 20, temperature of 98.6, uh oxygen saturation of 91 and heart rate of 110. Uh physical exam findings were significant for S4 murmur, jugular vein distension, bibasilar rails, wheezing and pedal edema. However, dorsalis pedis pulse was full and equal on both sides. PMI was noted to be normal and there were no carotid bruits noted. Labs showed BNP levels elevated at 4000. However, troponin levels were normal. Chest Xray findings showed normal cardiac silhouette sign. However, it was noted to have widened mediastinum as well as pulmonary edema. 2D echocardiogram showed that patient had restrictive cardiomyopathy with increased wall thickness as well as ejection fraction of 55%. EKG showed non sustained ventricular tachycardia and normal sinus rhythm. And patient was noted to have uh sarcoidosis restrictive cardiomyopathy based on all the labs and imaging findings and was advised to admit to telemetry. She was also started on amiodarone 150 milligrams IV, as well as furosemide 50 milligrams IV dosage. Her prednisone dose uh prednisone dose was increased from 10 milligrams to 60 to 60 milligrams daily and she was advised to continue rest of her medications. Ms.Palmer Ms.Palmer was also advised to consult with interventional cardiology for automatic implantable cardioven- cardioverter defibrillator as well as radiology for a PET scan. She was agreeable to all the um uh consultation and management plan that was given to her.

36. Hello Dr. Rawlins, I'd like to present the case of Mr. Leslie Palmer. He is a 62 year old male who presents today with shortness of breath and severe fatigue. Um this all started about 6 months ago, but has gotten worse in the last 3 days. He went to see his primary care physician and was instructed to come to the emergency department. He said he doesn't know any of the test results that he um took at the primary care physician. Um the shortness of breath occurs even at rest, and he's forced to sleep in his recliner due the symptoms worsening when lying down so um he really doesn't feel good today and like it's been bad around the clock pretty much. Um he is uh from my review of systems I see he's he said that he has fatigue, had an 8 pound um has gained 8 pounds in the last week. He's experiencing wheezing, dyspnea, orthopnea and lower extremity edema. Everything else was negative. His prior medical history he does have hypertension, high cholesterol, diabetes and recent afib. Um his past family history his mother died at the age of 80 from breast cancer his father is still alive, but in a nursing home with Alzheimer's. Um for some pertinent surgical history, he did have a CABG12 years ago. He's had 5 stents in the last 5 years, with the last one being in his LAD. Um his cardio, his cardiologist has told him he is not able to get any more stents after this. And his most recent Echo showed a 40% ejection fraction. Um for his medications he is treating his medical history. Um he does he is on lisinopril 10 mgs atorvastatin 10 mgs clopidogrel 75 mgs metformin 500 mgs furosemide 20 mgs metoprolol succinate for 50 mgs and warfarin 2.5 mgs. He does not have any known drug allergies. Um as for his social history he claims to eat a balanced diet. He used to go on walks daily, but due to his recent symptoms has not been able to. Um he has been smoking for the last 30 years about a pack a day. He consumes caffeine, just 1 cup of coffee a day. No tobacco or alcohol. Um he is an elementary school teacher teaching 5th grade and he is sexually active with his wife, who's also his social support system at home. His vital signs showed a temperature of 98.6 respiratory rate of 22, uh blood pressure of 80 / 50 and a SPO2 of 86% which is a little low. Um from my physical exam, some pertinent positives were uh JVD tachycardia with split S2 and a gallop. Um his PMI was displaced laterally. He did have bibasilar rales and wheezing, and 1+ pitting edema in his lower extremities. The negatives were there were no bruits, no regurgitations, no chest wall tenderness, no calf tenderness. And pulses were full, full and equal dorsalis pedis pulse. Uh my primary diagnosis is ischemic dilated cardiomyopathy with um NYHA class 4 due to the symptoms being present at rest. Uh my secondary diagnoses are hypertension, high cholesterol and diabetes. So my plan for this patient is to admit him to the ICU. Um his labs also showed elevated troponin and BNP, so I would like serial troponins taken. Um as for his um other lab results, he did show cardiomegaly and pulmonary hypertension on chest Xray. Um his EKG had a left bundle branch block and left axis, and his echo had a dilated left ventricular left ventricle with a decreased ejection fraction from his last one down to 30% this time. Um in the ICU, I would like him to be on strict bed rest, uh I and O's, daily weight, and DVT prophylaxis. Um I am going to put him on Bipap 16/6. A low sodium diet and um put in a IV just to keep the vein open. As for meds, I am going to keep him on his clopidogrel and warfarin of 75 and 2.5 mgs respectively. I am going to add in IV dobutamine and uh put him on an insulin sliding scale. Um for his labs, as I said, I would like serial troponins, but I'm also going to get a PT/INR and I am going to consult interventional radiology to put in a CRTD and AICD. I think all with all these combined you can really get Mr. Palmer where he needs to be. Thank you so much.

35. Mr. Leslie Palmer presented to the emergency department today with uh shortness of breath and fatigue. Uh claims it's been happening for the past 6 months, getting worse uh as the 6 months progressed. Saw his family medicine doctor uh 3 weeks ago or 3 days ago. Excuse me. And they were uh gave him some tests. Told him they were gonna talk about the test in a few days. It got worse. They called him he called him and said to come back to go to the ER. So he's here in the ER today uh says the symptoms have been like I said, getting worse. They're worse when he lays down the shortness of breath. So he's been sleeping in the chair the past few weeks, he says. Um there has been he has a history of multiple stents placed that have 5 in the past 5 years, I believe, and also a uh open heart surgery uh CABG um 12 years ago, 15 years. Uh he has a history of hypertension, hyperlipidemia, diabetes and was recently diagnosed with atrial fib. Uh no drug allergies. Pack a day smoker for the past 30 years. No alcohol or drug use. He is employed as an elementary school teacher uh has insurance through his work and a married family support system. Um no relevant uh family medical history. Currently medicated on lisinopril metoprolol, atorvastatin, metformin, furosemide, clopidogrel, and warfarin, all for the previous diagnosis said before. Uh presented uh well dressed, well nourished, uh oriented. He uh was very oriented, just fatigued, um did not seem to be seem to be in any apparent pain. Review systems shown uh he had uh a JVD present. Uh no carotid bruits. Uh he’s tachycardic with a split S2 heard on auscultation. Uh no heart murmurs or gallops or fric- friction rub. He had uh laterally displaced uh PMI on palpitation. Um listening to lung sounds, he had uh rales were present also, like you said orthopnea can't uh can't breathe while lying down short of breath dyspnea with exertion wheezing. He also says the fatigue and shortness of breath is even on rest. So go into a class 3 heart failure. Um on his labs he came back um PT/INR was elevated and as well as troponin and BNP. Uh 2D ECHO showed that uh he had a dilated cardiomyopathy with uh ejection fraction of 30%. EKG showed a normal sinus rhythm with a left axis, probably because of that cardiomegaly and that uh lateral PMI uh left bundle branch block and uh left ventricular hypertrophy hypertrophy voltage criteria was met. Uh chest Xray shows uh edema cardiomegaly. So we went ahead and diagnosed him with ischemic um excuse me ischemic dilated cardiomyopathy. Uh with uh reduced ejection fraction, 30%. Gonna administer him to the ICU. Uh it's a serious condition. We're gonna get his vitals checked every 2 hours. Uh strict Is and Os, daily weights, DVT prophylaxis. Uh gonna get him on a Bipap 16 over 6 50% uh saline with a KVO. Gonna pause all of his uh current meds right now, except for the warfarin and clopidogrel. Uh go ahead and add a dobutamine drip drip because of that low blood pressure and also his vital showed a low blood blood pressure of 80/60 80/50 excuse me with a heart rate of 90 oxygen sats 86%. So that's why we want to go and get them on the Bipap dobutamine for that low blood pressure. Uh also insulin keep track of those sugars, keep him stable. Uh go ahead and order more serial troponins to check how he's doing as well as PT/INR since he's on that warfarin. Uh with that afib we don't want any extra clotting to occur. From there going to go ahead and uh give him uh interventional cardiology consult potential for a uh CRTD and AICD uh placement. Other than that uh seemed present happy, just fatigue and troubled. So hope we'll get him taken care of. Alright. Thank you.

34. Good afternoon, Dr. Rawlins. Um I saw Ms. Leslie today. She is a 62 year old uh woman who presents to the office for a chief complaint of shortness of breath, fatigue, heart flutter and palpitations. Ms. Leslie was in her usual state of excellent health um until 2 months ago when she developed worsening um shortness of breath and palpitations. She reports um the symptoms being better at rest and when she's elevated and worse during physical activity. She does feel like um passing out at times. She does not complain of radiating pain. Um Ms. Leslie does have a history of sarcoidosis, which she was diagnosed um 25 years ago and is currently being treated um for hypertension with lisinopril along with the along with lisinopril, she reports taking prednisone as well. She has no known allergies. Her social history includes a balanced diet, limited exercise, no drug use, no tobacco use, um no alcohol use, and moderate caffeine use. Um she is an elementary school teacher. She is um sexually active and in a relationship. Her past surgical history includes a cardiac cath about 1 year ago, and she has no prior hospitalizations. Her father died of a heart attack at 59, and her mother had a sudden death at 40. She appears awake alert oriented fatigued and presents with weight gain of about 8 pounds and swollen ankles. Review of systems um of her skin was negative. Um review of systems of her um musculoskeletal component was negative and her blood pressure was elevated at 136/99, and her heart rate was also elevated at 110. Upon palpitation, um edema was noted in her ankles. Lower extremity pulses were normal bilaterally. She did present with rales bilaterally and wheezing. She was active, she was negative her um Homin’s test and had no TART or spinal abnormalities um during her osteopathic screening. Her chest Xray showed normal cardiac silhouette, um mediastinal fullness, and um pulmonary edema. Her BNP was elevated at 4000. Troponin was at normal levels. Her EKG demonstrated normal sinus rhythm with a non sustained left ventricle tachycardia. Her 2- 2D Echo showed um increased wall thickness with an ejection fraction of 50%. Um and she was up to date with her immunizations. She was diagnosed with sarcoidosis restrictive cardiomyopathy, and was admitted to telemetry. In terms of medication, amiodarone 150 mg and furosemide 40 mg IV was added, and um Prednisone was increased to 60 mg from 10 mg. She will be on a low sodium diet and will be receiving out of bed assistance. CMP was ordered and an interventional cardiology consult for a AIC um for AICD placement. Nuclear Med consult for um FDG PET was indicated. She will be continuing her lisinopril uh medication.

33. 64 year old female presents with shortness of breath, fatigue and chest pain. 2 weeks ago she had an infection associated with a cough, cold, and fever, but it has now resolved. Now she's feeling pain in her chest and it increases um her shortness of breath increases with exercise and the shortness of br- breath is release relieved by sitting. She's not been able to lay down because of her um shortness of breath and that pain. So she's been sleeping in the chair in the chair for the past few weeks. Um her review of systems shows that she has fatigue and gained 8 pounds in the past 2 weeks. She has palpitations and chest pain. She experiences wheezing, dyspnea and ortho orthopnea and she has swelling in her legs. She they are no pertinent findings in skin HEENT and neuro. So past medical history, she has been diagnosed with hypertension and is currently taking lisinopril 10 mg every day. She currently has no known drug allergies. Surgical history includes a cardiac cath a year ago. Um but other than that, no hospitalizations. Her family history shows her mother passed from breast cancer um a coup- 5 years ago and her father is currently living in a facility a nursing home because he is he has dementia. Social history shows she has a balanced diet, exercises 2 times a week, but hasn't been able to because of her shortness of breath, doesn't do any illicit drugs, tobacco or drinks alcohol. She drinks a cup of coffee a day. She is currently employed as an elementary school teacher. And has a partner for 30 years who is her support system. So after conducting the physical exam, I found a positive JVD sign. Her PMI was displaced laterally. Bibasilar rales pedal edema and with no chest wall tenderness and her um pulses in her extremities were um 2+. Her vitals show she had an elevated heart rate at around 110 beats per minute. Her O2 sat was at 91% and her BP was slightly elevated at 130/90. Her lab values showed she had elevated troponin and BNP levels. Her echo shows reduced ejection fraction with dilation of left ventricle. Her EKG shows a right bundle branch blo- block and sinus tachycardia. Chest Xray showed she had pulmonary edema and cardiomegaly. After looking at all these values and um conducting the physical exam and getting her history, I'm diagnosing her with myocarditis cardiomyopathy. A secondary diagnosis could be a dilated ischemic cardiomyopathy but given her recent recent um infection a couple weeks ago I am going to assume it is the myocarditis cardiomyopathy. So my plan for her right now is to admit her to telemetry and administer acetaminophen for the pain she's feeling acetaminophen 625 and IV furosemide for the swelling in her legs and keep her on that lisinopril. Nursing orders include strict IO, daily weight check, DVT prophylaxis, O2 nasal cannula, and maintain her O2 sat greater than 96%. I’m gonna talk to infectious disease the cardiologist and radiologist to come up with a plan for this patient. This includes CRTD and AICD placement, right ventricular endomyocardial biopsy, immunoglobulin or glucocorticoids and a medical medically enhanced MRI. Cause of her um myocarditis is because of her recent um infection that she's experienced 2 weeks ago. And her she currently does have insurance because of her job, and her husband will be meeting her at the hospital.

32. Leslie Palmer is a 62 year old man who presents with shortness of breath and fatigue. He has a history of hypertension, diabetes and afib. He had a CABG 12 years ago as well as stents more recently. He takes a lisinopril atorvastatin clopidogrel metformin furosemide metoprolol sulfate, and warfarin. He eats a balanced diet, walks for exercise, and smokes one pack per day. Has a family history his mother uh died of breast cancer. Father has Alzheimer's disease. He has no known drug allergies. He eats a balanced diet, walks for exercise and smokes 1 pack per day. He has like 1 cup of coffee. Has 0 drug allergies. Reports that sleeping in a recliner is helpful and alleviate symptoms. NYHA scale of 4 symptoms even at rest. Patient has good family support vital showed normal heart rate, respiratory rate, and temperature. But low oxygen sats at 86 and low blood pressure at 80/60 ROS is positive for fatigue weight gain orthopnea dyspnea wheezing edema of lower extremity. His troponin is elevated and his BNP is elevated at 4000. He is positive for JVD. The tachycardia with split S2 on physical exam. His PMI is displaced laterally. He has rales wheezing, lower extremity edema. Xray shows cardiomegaly and pulmonary edema. Echo shows dilated left ventricle ejection fraction of less than 30. EKG shows left bundle branch block is normal sinus rhythm. Patient diagnosis is ischemic dilated cardiomyopathy. He will be admitted to the ICU. We'll have um vitals checked every 2 hours. We're going to stop his current medications, but only do clopidogrel warfarin and dobutamine. He will get a consultation with the interventional cardiologist for AICD CRT. Um he was also negative for homin’s signs and has no signs of DVT.

31. So for today's case, we have a 62 year old male presenting with fatigue and shortness of breath. Patient reports symptoms begin about 6 months ago, but then 2 days ago they got worse. So he decided to come in and um see us. So he described a dyspnea and a fatigue that is constant even at rest, which in which I gave him a NYHA class 4. He feels quote unquote, generally tired, sitting up relieves the dyspnea activity worsens it. Um so he has orthopnea and sleeps upright at night because it feels better for him. He has not tried any self-medication, no self-treatment. He rates the fatigue as an 8.9 8 or 9 out of 10. So as vitals, he was hypotensive with 80/50. He's tachnep- tachypnea with fast heart rate um no fast breathing rate sorry, respiratory rate of 20. His low oxygen SPO2 was 86%. So in his review systems, he's positive for fatigue. He recently gained 8 pounds in the last 2 weeks, which suggests fluid buildup. He has wheezing, shortness of breath, and orthopnea. He has bilateral lower leg edema. Past medical condit- past medical history consists of hypertension, hyperlipidemia, diabetes for the last 10 years, atrial fibrillation, coronary artery disease of the left anterior descending coronary artery, and he's an active smoker. Medications, he takes atorvastatin clopidogrel furosemide metoprolol succinate lisinopril metformin and warfarin. He has no known drug allergies. So in the physical exam, the remarkable positives were he has tachycardia with a split S2, he has jugular venous distension, um his PMI is displaced laterally, he has rales wheezing, lower extremity edema. Um all the other findings for negatives were unremarkable. Chest Xray shows cardiomegaly and pulmonary edema. His echo shows normal sinus rhythm I mean sorry his EKG, my fault. His EKG shows normal sinus rhythm, left bundle branch block and left ventricular hypertrophic voltage criteria. On his labs, his troponin is elevated and his BNP is 4000. His echo shows dilated cardiomyopathy with left ventricular ejection fraction less than 30%. The primary diagnosis is ischemic dilated cardiomyopathy and the secondary diagnosis that I gave him were because of hypertension, hyperlipidemia and diabetes mellitus. Um so his actually his family history that's pertinent. Um so his mom is passed away at 80 from breast cancer and his father is still alive. He's 88. He has Alzheimer's. So that's the for the um so the pri- we're going to, so now for our treatment plans, I want to admit him to the ICU. His condition is serious. I want vitals done every 2 hours. I want to limit him to strict bed rest. Nurses are going to give him strict IO daily weight and DVT prophylaxis. For fluids, he's KVO. We're gonna give him a low sodium diet. We're gonna hold everything for his medications except the clopidogrel and warfarin, and I'm gonna add in a dobutamine IV drip. And yeah, dobutamine IV drip. We're gonna put him on a BiPAP, and we're gonna get P for lab we're gonna get PT/INR and serial troponins. We're transferring him to interventional cardiology for AICD and CRT um CRTD placement.

30. Good afternoon. I would like to present to you a patient I've just finished seeing at the emergency room. Uh Mrs. Palmer is a 62 year old female with a history of hypertension, who presents with a chief complaint of shortness of breath, fatigue with accompanying chest pain. Uh these symptoms have been occurring over 2 weeks and are worsening. Uh she describes the chest pain as sharp, central, non-radiating and a 2 out of 10 severity. Uh symptoms are worsened with uh some exertion and symptoms are alleviated by rest and sleeping in a sitting position. Uh no treatments have been tried at this time. Uh the patient also noticed that a recent illness consisting of fever, headache, coughing, and runny nose that dissipated 5 days ago uh most recently evaluated by her PCP 3 days ago. Ms. Palmer currently takes lisinopril 10 milligrams once a day uh for her hypertension and claims no known drug allergies. Social history significant for a cardiac catheter 1 year ago with no complications. Family history showed a living father with Alzheimer's and a deceased mother who passed of breast cancer 5 years ago. Uh Mrs. Palmer's social history is described as a regular diet with no tobacco, drug, or alcohol use with moderate caffeine intake and insufficient exercise. She is currently employed as an elementary school teacher and lives at home with her husband of 30 years. Uh review of systems demonstrated an alert oriented patient uh in pain. Uh there was a weight gain of 8 pounds over 2 weeks noted um as well as lower extremity edema. Uh cardiology noted heart palpitations, chest pain, and pulmonology assessment uh demonstrated orthopnea, wheezing, the shortness of breath. Uh dermatology, HEENT, and neurology review of systems were all non-contributory. A focused physical exam was assessed with uh negative Chapman's points and bilateral equal uh TART changes anteriorly and posteriorly in the thoracic area. Physical exam was significant for jugular vein distension, uh 1+ pitting edema, 2 + bilateral pulses bibasilar rales, regular heartbeats uh with no murmurs, rubs or gallops with the displaced PMI laterally. The homin’s sign was negative. Vitals were assessed and were significant for tachycardia at 110 BPM, uh elevated blood pressure at 130/90, tachypneic at 20 breaths per minute, and hypoxic at 91% oxygen saturation. And no fevers noted. Labs revealed elevated troponin at 0.10 and elevated BNP at 4000. Chest Xrays showed pulmonary edema and cardiomegaly, while ECHO showed enlarged left ventricle with a left ventricle ejection fraction of 30%. Uh EKG showed a left axis sinus tachycardia with premature ventric- ventricular contractions and a right bundle branch block. A diagnosis of myocarditis dilated cardiomyopathy with a New York Heart Association stage 2 was made uh with admission to telemetry. Patient will be placed on acetaminophen 625 milligrams by mouth every 6 hours um as well as furosemide 40 milligrams via IV uh while continuing her lisinopril. I will consult a interventional cardiologist for CRTD uh AICD placement, as well as endocardial endomyocardial biopsy. Uh infectious disease will be consulted for immunoglobulin or glucocorticoids, and uh radiologists will be consulted for immediate enhanced MRI. Uh diets will can change of consist of low sodium and oral fluid restriction. We'll be placing an IV fluid saline lock uh with strict IO daily weight DVT prophylaxis and O2 via nasal cannula maintaining the O2 saturation above 96%. Vitals will be taken every 2 hours and we will order a serial troponin and a repeat 2D echo. Thank you very much.

29. a 68 year old female. They came into the office today um with a chief complaint of shortness of breath and chest pain. Two weeks ago she presented to an office um due to her fever and cough and then 5 days ago she had to go back because of her chest pain and shortness of breath. 3 days ago she went to another doctor and they told her to come here due to her symptoms not improving. Uh she says the shortness of breath does not improve with um Tylenol or I'm sorry her physical activity causes her shortness of breath. Um she has a constant chest pain that is dull and is not alleviated by Tylenol. She said out of a scale of 10, her pain is 2. I give her a NYH score of 3 due to her um decrease in physical activity. And she has to sleep in a recliner. Uh when I did my physical exam um there was a positive JVD, as there were no cardiac bruits. There was some uh lower extremity edema. The neuro exam was negative. Uh pulmonary, she had rales, orthopnea, dyspnea, and wheezing. Um cardio her PMI was displaced, as well as experiencing palpitations and chest pain. Um and then just in general, she was oriented, but she was fatigued and had some slight weight gain, probably due to the edema. Her labs are CBC, uh PT/INR negative, troponin was slightly elevated, BNP elevated, uh chest Xray showed pulmodary- pulmonary edema and cardiomegaly. Our 2D echo showed uh dilated cardiomyopathy with a left ventricular ejection fraction of 30%. EKG showed sinus tachycardia with a right bundle branch block, as well as a left axis deviation. Um after speaking to the patient and doing the physical exam, um I decided that she had myocarditis dilated dilated cardiomyopathy. Uh so we are going to admit her to telemetry, uh condition serious. She has no known drug allergies, vitals every 2 hours, her activities as tolerated. Um she's gonna be on strict IO, daily weight, DVT prophylaxis. Um her O2 sats were lows at 91% so we're going to put her on O2 via nasal cannula and maintain an O2 sat of 96%. Put on a low sodium diet and fluid restriction. Put on a saline lock KVO. She is currently on lisinopril 10 milligrams so we're going to keep that, but we're also going to add uh 625 milligrams acetaminophen every 6 hours to help with the pain and then uh furosemide at 40 milligrams IV to try to get rid of some of that fluid. Um we're gonna keep uh an eye on her troponins. We are gonna repeat the echo and we are gonna do CMP. We will be consulting uh interventional cardiologists for a CRTD and AICD placement to help get her rhythm back to normal, um as well as a infectious disease to consider for glucocorticoids. And we're gonna do a right ventricular endomyo- carpe-cardial biopsy. We're also going to consult a radiologist to do a contrast media enhanced MRI. Uh patient does have a husband that is here at the hospital um who will be helping her and supporting her with that. And other than that, her vitals heart rate was elevated at 110. As I said, her O2 sats were low and she had a BP of 130/90.

28. Uh so Mrs. Palmer is a 62 year old female, um coming with a chief complaint of shortness of breath. Um so she had been seeing her uh PCP, and over the past 2 months, her symptoms of shortness of breath had worsened. And so her doctor told her to come into the emergency department. Um she presents today and has shortness of breath. Uh she also complains of palpitations uh presyncope. Um she says these symptoms have been worsening over the past 2 months, but she denies any sort of chest pain. Uh she says the shortness of breath is constant. She feels it even when she's at rest. Um in terms of her medical history, she has a history of hypertension, a history of uh sarcoidosis. Um she does not have any allergies. Um she actually says that she used to exercise once per day, but because of her symptoms, this is uh decreasing and she's no longer able to walk every day like she used to. Um she says that she has gained uh 8 pounds over the past 2 weeks. Um then on physical examination, I found a I found uh jugular venous distention, uh no carotid bruits. Listened to her heart it sounded regular I did hear a soft ejection murmur with an S4, no rales, but I did hear a gallop. Uh PMI was normal, there was no chest wall tenderness. Um when I was listening to her lung sounds, I heard bibasilar rails along with wheezing. Um when looking at her legs, I saw pitting edema on both legs. Uh her pulses were equal and her calves were non-tender. Um looking at her labs, her troponin was normal, her BNP was 4000. Um the Xray the heart size looked normal. I did see some like hilar consolidations. Um on echo, it showed restrictive cardiomyopathy with the increased wall thickness, but her ejection fraction was normal. EKG showed sinus tachycardia and right bundle branch block. So with all of this, I think what's going on is that she is having a uh sarcoidosis cardiomyopathy, um an exacerbation of her of her pulmonary sarcoidosis. Um so what I want to do is I want to admit her uh to the telemetry unit. Uh I'm going to consider or continue her lisinopril. I'm going to add on amiodarone and increase uh add on amiodarone and furosemide, and I'm also going to increase her prednisone dose. Uh I want to order another CMP so we monitor that BNP. Um I'm also going to consult the cardiologists and the radiologists so we can get some some more uh lab results in.

27. I saw Mr. Palmer today. Leslie is a 62 year old male who presents to the ER for the chief complaint of fatigue and shortness of breath. Mr. Palmer has been experiencing these symptoms for 6 months and saw a family medicine physician 3 days ago who ordered tests but did not go through them with him. The PCP referred him to the ER for which he is here today. He reports symptoms that have progressively been worsening and he needs elevation when sleeping using a recliner. The fatigue and shortness of breath have um been constant at rest and worsened with any and all physical activity. Mr. Palmer has a history of hypertension, hyperlipidemia, diabetes, and paroxysmal atrial fibrillation and is currently being treated with metoprolol succinate 50 mg, lisinopril 10 mg, atorvastatin 10 mg, metformin 500 mg, furosemide 20 mg, clopidogrel 75 mg, and warfarin 2.5 mg. His social history includes a balanced diet, moderate exercise with daily walks with friends from his neighborhood. But uh recently he reports having increased shortness of breath by walking. He has no drug or alcohol use and smokes a pack a day. He consumes 1 cup of coffee every morning and is sexually active in a monogamous relationship with his wife. His surgical history includes a triple bypass and a stent every year for the past 5 years. However, on his last visit, his surgeon informed him that he will no longer be getting any more stents due to his ejection fraction being below 40%. He is a school teacher and his family history includes his mother passing away from breast cancer and his father who is still alive in a nursing home with Alzheimer's. He is also up to date on all his current immunizations. He appears awake, alert, oriented, and fatigued and after a thorough review of systems pertinent positives include an 8 pound weight gain in the past 2 weeks fatigue, orthopnea, dyspnea on exertion and wheezing, as well as swelling in his legs. His vital signs showed normal temperature of 98.6, a heart rate of 90. He was tachypneic with a respiratory rate of 22, hypotensive with a blood pressure of 80/50, and a hypoxic and hypoxic with a pulse ox sat of 86%. Physical exam findings showed jugular venous distension, no carotid bruits, tachycardia with a split S2, and a displaced PMI laterally. His lungs on auscultation showed bibasilar rales and a pitting edema was also palpated in his lower extremities. Diagnostic lab work showed an elevation of troponin and a BNP of 4000. Chest Xray showed pulmonary edema and cardiomegaly. Echo showed dilated cardiomyopathy with the left ventricular ejection fraction of less than 30%. EKG was interpreted to show normal sinus rhythm and a left bundle branch block. This led me to my diagnosis to be ischemic dilated cardiomyopathy, um which is classified as class 4 heart failure by the New York Heart Association. The patient will now be adminis- admitted to the ICU on strict bed rest and will be needing um BiPAP as well to tackle the uh hypoxia. He will be administer- we will be administering his clopidogrel, warfarin, and dobutamine, as well as an insulin sliding scale. I will also be ordering troponin and PT/INR lab work. I will consult with an interventional cardiologist to discuss treatment with a CRTD or a possible AICD as well. Thank you.

26. Ms. Leslie Palmer presents as a 62 year old female patient for chief complaints of dyspnea and fatigue. She also complains of heart palpitations and presyncope. She first started noticing her symptoms about 2 months ago and went to her primary care doctor 3 days ago for these symptoms. Um they are running tests now and results are not known at this time. Symptoms have worsened in the past few days. So she was instructed by her primary care provider to come to the emergency room. She notes that symptoms improve when she lays in her chair and with rest um when she sleeps in her chairs and with rest and symptoms worsen when she lays flat and with most physical activity. Uh patient has a symptom uh a history of hypertension and pulmonary sarcoidosis 25 years ago. She takes lisinopril 10 milligrams daily and pred- prednisone 10 milligrams daily. She has no known drug allergies. She had a cardiac catheterization 1 year ago and reports that the results were normal. Her father passed away from myocardial infarction and her mother passed away from an unknown um cause. She follows a balanced diet. She used to walk regularly, but notes that she cannot exercise now due to her symptoms. Uh she drinks one cup of coffee a day and denies any tobacco, alcohol, or illicit drug use. Patient is an elementary school teacher and lives with her spouse. Um so patient in the review system, patient complains of fatigue, a weight gain of 8 pounds in the last 2 weeks, edema in her lower extremities palpitations, heart palpitations, presyncope, dyspnea, and orthopnea, patient denied having any other skin, musculoskeletal, neurological, or um head, ears, eyes, um neck and throat symptoms, nose and throat symptoms. Um her vitals were taken upon entry with a high respiratory rate of- on the higher end of normal of 20, and then high heart rate of 110, a higher blood pressure of 136/99 and a low O2 saturation of 91%. Uh patient was informed of their vitals and that we were going to continue to monitor them. Physical exam was then performed. Um we found jugular vein distension and no bruits. The heart had a regular rhythm, but a systolic S4 murmur with gallops and no regurgitation sounds. Point of maximal impulse was normal. Bibasilar rales and wheezing were appreciated. Patient had a +1 pitting pedal edema. Um the dorsalis pedis and posterior tibialis pulses were full and equal, um negative Homin’s sign, and osteopathic screening was done of her back, and no tart changes, and no Chapman's points were appreciated. Um the chest Xray showed pulmonary edema and mediastinal fullness. The echo showed restrictive cardiomyopathy with uh increased wall thickness and an ejec- ejection fracture fraction of 55%. The EKG showed normal sinus rhythm and nonsustain with periods of nonsustained ventricular tachycardia. Troponin levels were normal, but the BNP levels were elevated at 4000. Um patient was then counseled on the diagnosis of sarcoidosis restrictive cardiomyopathy um which is an and was classified as a NYHA class 3. She will be admitted to telemetry and serious condition and will, was told that she could get out of bed with assistance. Vitals will be taken every 2 hours and lows and she will adhere to a low sodium diet. Nursing interventions included strict IO, daily weights, um oxygen um delivered via nasal cannula at 2 liters per minute to maintain a saturation level over 96% and DVT prophylaxis. IV fluids are administered um KVO. Patient will in- continue her lisinopril 10 milligrams daily, increase her prednisone to 60 milligrams daily and add amiodarone 150 milligrams via IV um Q 10 minutes and furosemide uh 40 mil- milligrams IV every 12 hours. Patient will also have a complete metabolic panel um done as well to check her um potassium and she will see interventional cardiology to discuss um I- AICD placement and radiology to get an FDG PET scan. Umm patient has support from her spouse and no further questions at this time.

25. Reporting on Mrs. Leslie Palmer who presented today to the emergency department, complaining of fatigue, shortness of breath, and a dull achy chest pain that began about 2 weeks ago. She noted that about this time about 2 weeks ago, she was sick with flu like symptoms, but these symptoms resolved about 5  days ago these flu like symptoms specifically. However, her fatigue, shortness of breath and chest pain have only gotten worse over the past several days. Um she knows that she is unable to exercise to her normal limits without her- without these symptoms, and she's been sleeping in a chair at night due to pretty severe orthopnea. She denies taking anything to alleviate her symptoms, and she rates her symptoms at a 2 out of 10. She does have a past medical history of hypertension for what she is taking with lisinopril. She also has a surgical history of a cardiac catheterization. She is an overall pretty healthy patient who exercises regularly and has a balanced regular diet. She's also up to date on all of her immunizations. As for her ROS, she does present with fatigue and she notes some recent weight gain that's abnormal, about 8 pounds in the last week. She does have chest pain and discomfort. And she also notes some fluttering in her chest. She notes dyspnea dyspnea and orthopnea. She also notes joint aches and pains as we- along with lower extremity edem- edema. Um her vital signs today were temperature of 98.6. She was tachycardic at 110 beats per minute, and tachy- tach- ta- tachypneic at 20 um rates per minute. Her blood pressure was also a little bit elevator- elevated at 130/90 with her O2 a little low at 91%. She did, on physical exams, she did have jugular venous distention. Her PMI was displaced a little bit laterally, but she was at a regular rate with no murmur friction rub or gallop. On respiratory exam, she did have wheezes and rales, but there was no chest wall tenderness. As for extremities, she did have obvious lower extremity lower extremity edema, but her pulses were full and equal and her calves were not tender. She also had a negative Homin’s sign. For her chest Xray, she did have some cardiomegaly and some pulmonary edema with a normal mediastinum. Her echo showed dilated cardiomyopathy with a reduced ejection fraction at less than 30%. Her EKG showed a normal sinus rhythm with sinus tach and a right bundle b- right bundle branch block. Her troponin was a little bit elevated and her BNP was elevated at 4000. So with all of this, I decided that she's probably experiencing myocarditis dilated cardiomyopathy. So with this, I did decide to admit her to telemetry. Um we're doing strict Is and Os with um DVT prophylaxis, a low sodium diet. I'm gonna place her on acetaminophen for some of this chest pain. I'm gonna keep her on her lisinopril, but I am gonna put her on furosemide to clear out some of that fluid. As for lab orders, I'm going to do a CMP to monitor her potassium since we're adding the furosemide. I'm also gonna check serial troponin levels since they were elevated. I'm gonna repeat her echocardiogram. I'm also going to consult an interventional cardiologist, a radiologist and an infectious disease physician. Um interventional cardiologist to consider an AICD, CRTD placement, a infectious disease physician to take a biopsy and assess immunoglobulin and glucocorticoids, and then consulting radiology to do an MRI to look for any changes that could be caused by this myocarditis. Thank you very much.

24. Uh today, I had the pleasure of seeing 62 year old male, Mr. Leslie Palmer. He presented with shortness of breath and fatigue and was referred to the ER by his family medicine physician. His vitals uh were at a heart rate at 90, blood pressure at 80/50, and a O2 sat of 86% and respiratory rate of 22. Um he has been diagnosed with hypertension, diabetes, hyperlipidemia, coronary artery disease, and atrial fibrillation. Um he has had a triple bypass surgery done as well as 5 stents put in. And his last stent um was in the LAD in June of 2022. Um his current medications include lisinopril, atorvastatin, clopidogrel, metformin, furosemide, metoprolol succinate, and warfarin. Um his physical exam revealed JVD tachycardia with a split S2, um rales in the lungs, a displaced PMI, and pitting edema in the lower extremities. Um in terms of relevant ROS, he has had a weight gain of about 8 pounds recently and has been experiencing fatigue, orthopnea, and dyspnea. He smokes every day and I did counsel him on stopping to avoid exasperating the symptoms that he's currently um experiencing. Uh lastly, I looked at I looked at his labs and imaging and reviewed um it with the patient. His troponin and BNP levels were elevated. His Xray revealed pulmonary edema and cardiomegaly. Um and his echo revealed left ventricular dilation with an ejection fraction of less than 35%. Um and according to his EKG, it looks like he had normal sinus rhythm, left axis deviation and a left bundle branch block. Um I diagnosed him with ischemic dilated cardiom- cardiomyopathy and referred him to the cardiologist. I also took him off all of his medications except for the clopidogrel, warfarin and added dobutamine. Um I submitted the rest of his nursing orders um and has now he has now been admitted to the ICU. Thank you.

23. Hope you’re doing well this morning. A 62 year old man came into the ED this morning, name is Leslie Palmer. He presents to the ED with shortness of breath and fatigue that has been worsening over the last 6 months. State tha- states that his shortness of breath um happens at rest and gets worse with any physical activity. His vitals were his heart rate was um 90 his respiration rate was 22 BP was 80/50 and O2 sats were down low at 86%. He has a past medical history of afib, hypertension, hyperlipidemia, and diabetes. Um he has had a triple bypass in the in the past and 5 stents. Um his mom died of breast cancer, his dad currently has Alzheimer's, he's a pack a day smoker in good health, good diet, good exercise, um no alcohol or drugs. He has a long list of medication atorvastatin, clopidogrel, furosemide, metoprolol, lisinopril, metformin, and warfarin. He has no known d- no known drug allergies. Um on his review of systems, he presented with fatigue, as I mentioned, weight gain, wheezing, dyspnea, orthopnea, and he did present with lower extremity edema. On physical exam, he had jugular jugular venous distension um an irregular rate with a split S2. His PMI was displaced laterally. Um he did present with rales and wheezing, but no chest wall tenderness, and he did present with pedal edema. On his chest Xray, it showed cardiomegaly and pulmonary edema. His echo showed DCM with left ventricular ejection fraction of less than 30%, and his EKG showed a left bundle branch with LVH voltage criteria. Um his troponin was 0.04 and his BNP was 4000. Uh I did diagnose him with ischemic cardio dilated cardiomyopathy with an NYHA class 4. And I admitted him to the ICU because of that. Vitals every 2 hours, strict bed rest, low sodium diet, um KVO fluids. I kept him on his clopidogrel and his warfarin, but I took him off everything else and I added dobutamine IV. And I put him on an insulin sliding scale. I put him on BiPAP because his O2 sats were so low. I also had a PT/INR because he's still on warfarin and serial troponins to make sure that's um going in the correct direction. Um and then I referred him to the interventional cardiologist for ICD and CRTD placement. Thank you so much and hope you have a good day.

22. I just met with Leslie Palmer. He's a 62 year old male who presented the ED with complaints of shortness of breath and fatigue that's gradually worsened over the past 6 months. Um he's unable to carry out any exercise and is having symptoms at rest. He expressed that he's been sleeping in a chair at night um because he can't lay down because of his shortness of breath. Um he denied any pain and stated that he went to his family med doc 3 days ago and they told him if it gets worse um to go to the ED, so that's why he came in. His past medical history, he has hypertension, diabetes, hyperlipidemia, and afib, and his immunizations are up to date. Um for his meds he's on atorvastatin 10 mgs every day clopidogrel 75 mgs every day furosemide 20 mgs twice a day metoprolol succinate 50 mgs every day lisinopril10 mgs every day metformin 500 mgs twice a day, and warfarin 2.5 mgs twice a day. Um he has had a CABG 12 years ago and he had 5 stents placed and the cardiologist said he doesn't qualify for any more stents. Um his dad is in a nursing home with Alzheimer's and his mom died of breast cancer. He has a balanced diet. He walks every day, um doesn't use illicit drugs. He's a pack a day smoker. Um we talked about potentially quitting. He doesn't drink alcohol, um drinks a cup of coffee a day. He's a school teacher and he's married and lives with his family. Um, he has no allergies and for his review of systems he expressed fatigue and an 8 pound week in the past 2 weeks. Um he has swelling in his legs no skin, eyes, ear, nose, and throat or neuro problems. He denied palpitation, syncope and chest pain, and he has wheezing, dyspnea and orthopnea. His vitals, his temp was normal at 98.6. He uh has a heart rate of 90. Respiratory rate was up at 22. His BP was hypotensive at 80/50 and his oxygen was low at 86%. On physical exam, I found no carotid bruits. He did have JVD, no murmurs. Um he was tachycardic. His PMI was displaced laterally. Um he had wheezing and rales, but he wasn't in respiratory distress and he had chest wall tenderness. His calves weren't tender. He had pedal edema and his posterior tibialis and dorsalis pedis pulses were full and equal. On his imaging um he had cardiomegaly and pulmonary edema. Also got an echo done that showed dilated cardiomyopathy with an ejection fraction less than 30%. And he also got an EKG that was normal sinus rhythm with a left bundle branch block. His troponins and BNPs were elevated on his lab work. So my differential was ischemic dilated cardiomyopathy um myocarditis dilated myo- cardiomyopathy restrictive cardiomyopathy. Um but I diagnosed him with ischemic dilated cardiomyopathy because his medical history of having hyperl- uh hyperlipidemia, hypertension, diabetes, and having all those stents place and his echo showed that he had a reduced ejection fraction. So I went ahead and admitted him to the ICU. He's in serious condition um get vitals every 2 hours, still strict bed rest, strict IO, daily weight, DVT prophylaxis, he's on a low sodium diet, KVO IV fluids. I discontinued all his meds except for his clopidogrel and warfarin and I added a dobutamine IV drip. Put him on insulin sliding scale and he's on BiPAP for his low oxygen. Um I ordered to repeat the PTT/INR and serial troponin labs and um I ordered him to have a consult with the interventional cardiologist for an ICD or CRT placement. Um but he has a good support system with his family to take care of him, and he seemed like he was in good spirits and just really wanted to have his symptoms go away. So hopefully the medication we give will help with that.

21. Okay start um today I assessed uh Leslie Palmer. She came in with a chief com- chief complaint of shortness of breath and fatigue with a 2 month history of this. She went and saw her primary care physician 3 days ago um and then got a lot worse today, called them and they said to come to the ED. So she presented to the ED with a chief complaint of um fatigue and shortness of breath. Um she has a past medical history of hypertension and pulmonary sarcoid. Um she had a cardiac cath a year ago and it came back normal. Um she had a family history of um cardiac sudden death on her maternal side. Her mother passed away at 40 and her father passed away um from a heart attack. Um her vitals were 139/99 um blood pressure, her O2 she was a little bit hypoxic she had uh 91. Um a little bit of tachycardia she had uh 110. Um respiratory rate was 20 and temperature was normal at 98.6. Um and so then um we did a intake. We did um social history. She doesn't use alcohol, drugs, tobacco. She drinks coffee just a cup a day. Um she's currently employed she’s a school teacher. Um she is unable to exercise. Uh she's an NYHA of 3. Um so rest does help, but every other kind of activity does make her um have her symptoms of fatigue and shortness of breath. Um she's currently for her blood pressure taking lisinopril 10 uh milligrams, and for her sarcoid she's taken prednisone uh 10 milligrams as well. She's got no allergies. Um she had a bit of a weight gain about 8 pounds. Um and again fatigued, no skin um ROS, no HEENT ROS. She did have a presyncope. She's never passed out, but she does feel like she's going to pass out. Um she said she had a fluttering in her chest and actually used the word palpitations. Um she's got dyspnea, orthopnea, wheezing, um some lower extremity edema. Uh she did have JVD. Um, all of her neuro ROS was negative, uh no gait changes, no confusion. Um, she's awake alert oriented. She's just tired fatigued. Um, she didn't have any cardiac bru- or no carotid bruits. She did have JVD. Um, she had a regular heart rate. Her PMI was normal on inspection. Um there was a murmur there was an S4 murmur and there was a gallop um no friction rub and um no regular rate. Uh, she did have wheezes and bilasel bilat- bi laser rales um she had no chest wall tenderness um and was on respiratory distress. Uh her calves were not tender. She did have um +1 pitting edema. Um her pulses um her peripheral peripheral pulses were full and equal. Um she did not have a Homan’s sign. Um so then we did her imaging and her Xray. Um she showed normal heart size. Uh she did have pulmonary um edema and some mediastinal fullness as well as um she had the characteristic pawn broker sign on chest Xray. Um her labs did show a um elevated BNP at 4000 and I informed the patient of what that meant um and her echo came back with um a restrictive cardiomyopathy with increased wall thickness, ejection fraction of 55%. Um she I gave her the diagnosis of sarcoidosis restrictive cardiomyopathy. Um and I admitted her to telemetry, her condition serious. I did vital q2, um out of bed with assistance, um nursing intervention, strict IO daily weight, uh 2 nasal cannula, maintain her O2 sat cause she was a little bit hypoxic at 91. Um we did low sodium uh KVO IV fluids. Um and I continued her lisinopril at 10 milligrams. I upped her prednisone to 60 milligrams, um amiodarone because her EKG did show that she had um nonsustained ventricular um tachycardia. So she had 3 or more um of the consecutive ventricular beats in V1, V2 and um V3. Uh the axis was normal. Um and it was a normal sinus rhythm as well. Um so she had an EKG cardiac dysrhythmia, a nonsustained vtach. So we would place her on amiodarone 150 IV. Um so I also put her on some furosemide 40 milligrams IV uh to help with that fluid in the legs. Um no endocrine, no BiPAP. Uh we did order a CMP. Um we did no more diagnostic orders and I consulted a radiology and an interventional cardiologist um for an AICD placement and a po- possible PET scan. Um other than that, um I believe everything else on her physical exam we have covered um and we admitted the patient to telemetry. Thank you.

20. Um okay, so the patient that presented to me today was Leslie Palmer. Uh she's a 62 year old female. Um she was alert, um awake, uh fatigued and oriented, um but her vital signs showed that her heart rate was 90, her blood pressure was 80/50, respiratory rate was 22, O2 sat was 86, and her temperature was 98.6. Um her chief complaint was shortness of breath and fatigue at rest. Her um she described uh progressively worsening shortness of breath over the last 6 months. Um her shortness of breath was noted uh while lying down at rest and physically, and when physically active. Um she noted that she had started, she began sleeping um in a chair at night to relieve her shortness of breath when sleeping. Um her past medical history was pertinent for hypertension, hyperlipidemia, and type 2 diabetes diagnosed 15 years ago as well as uh atrial fibrillation diagnosed 5 years ago. Um her medications include, uh at the time of presentation, her medications included um metoprolol succinate 50 milligrams lisinopril 10 milligrams atorvastatin 10 milligrams metformin 500 milligrams furosemide 20 milligrams clopidogrel 75 milligrams and warfarin at 2.5 milligrams. Uh her surgical history shows um a coronary artery bypass grafting, as well as a 5 drug eluding stents within the last year. Um family history showed that her father uh is alive at 89 years old, but uh does have Alzheimer's disease. Um her mother is deceased, um deceased at 80 years old due to breast cancer. Social history shows that she follows a balanced diet, moderate exercise, no illicit drug use. Um she has smoked 1 pack of cigarettes per day for the last 30 years. She does not drink alcohol. She has moderate caffeine consumption. She's employed and she does have a social support system. Um so her general review system shows that she uh has um claimed that she has fatigue and an 8 pound weight gain over the last couple weeks. Um in addition, so her skin was negative for any bruises, rashes or anything of the sort. Um her head and neck exam uh was negative. Cardiovascular exam uh showed an irregular rate um with uh no murmur or friction rub, um as well as uh a regular uh PMI was normal upon inspection. Um for her respiratory or her um sorry according to her she was not presenting with anything. Her um pulmonary ROS shows wheezing orthopnea and dyspnea. Her MSK, uh she claims uh lower extremity edema and neuro was good. On her physical exam, uh we found in the neck uh no carotid bruit. Uh she did have um jugular venous distention. Uh she was tachycardic. Um she had a normal PMI. Uh no friction rub or murmur uh or gallop noted on auscultation. Uh respiratory exam showed uh bibasilar rales and wheezing. Um and that concludes the physical exam portion. So for orders, we um sent her to the ICU, took vitals every 2 hours, put her on strict bed rest, a strict IO, daily weight, and DVT prophylaxis. We placed her on BiPAP. Uh for labs, we ordered PT/INR and serial troponins. Um for her medications, we discontinued metoprolol, uh uh li- lisinopril, atorvastatin, metformin, and furosemide. We continued her clo- clopidogrel and warfarin, and we added dobutamine, as well as placed her on an insulin sliding scale. Um and post visit, we consulted interventional cardiology for potential uh AICD or CRTD placement. Thank you, and this concludes my uh case presentation.

19. a 62 year old pat- uh male patient presented to the clinic today with shortness of breath and fatigue. Um and the history of the illness the patient stated that the that he was on a track on a run or on a walk and then experience a shortness of breath and um fatigue as well as palpitations while he was walking his with his friends. The patient mentioned that um there was um that uh he experience palpitations within the next 20 minutes upon the onset of the shortness of breath. This event occurred a couple weeks ago and has not improved ever since. And the patient’s shortness of breath and palpitations as well as fatigue exacerbated with physical activity. In terms of the review of systems um um patient experienced fatigue, no cough, fever, malaise or any kind of uh illness or any kind of cold like symptoms but experienced weight gain um of for the past couple of weeks. Um patient mentioned there was uh palpitations but with no chest pain. Um along with the uh um palpitations patient experienced uh dyspnea and uh raspy breathing. In terms of the past medical history the patient um has a past medical history of um receiving a cardiac catheterization in an outpatient clinic. Um medical history wise, patient has been diagnosed with hypertension. No known um allergies. Um in terms of the social history the patient is on balanced diet uh tries to uh exercise regularly. Doesn’t take illicit drugs, tobacco, or alcohol. Drinks 1 cup of coffee every day. Um patient is also a teacher so is currently employed. Patient has been sexually active with um his significant other but hasn’t tried ever since the onset of symptoms. Um um the patient has no hospitalizations and um in terms of family history the patient uh the patient’s mother experienced sudden death in the family um and his father experienced a myocardial infarction at the age of 69 and unfortunately died um from that. The patient’s medication the patient is on lisinopril uh 10 milligrams uh QID. In terms of physical history um the patient is positive for um jugular venous distention but had no carotid um bruits bruits. In terms of a heart auscultations they were irregular. There was no murmur, frictional rub, or gallop. The PMI was displaced laterally and um there was no chest wall tenderness. In terms of the chapman point um there was no um such um there were no positive chapman uh points. For the lungs uh the patient have a bibasilar rale and um experienced wheezing in the upper quadrant um in the superior lobes. For the m- for msk uh physical exam there was a nontender calf uh with pitting edema of the lower extremities. But the pulse the dorsalis pedis and the posterior tibialis um pulses were present and symmetric. Um in terms of the vitals the patient um the only abnormal vital was uh the heart rate which was 110 beats per minute all the other vitals temperature being 98.6 blood pressure was uh 130/90, the pulse ox was 96% and the respiratory rate was 16 uh beats was 16 per minute. Um all those others were normal. In terms of diagnostic imaging the patient um the patient had cardiomegaly in the chest Xray the 2D echo revealed left ventricular asymmetric hypertrophy um and that’s because of an increased interventricular septum as well as an enlarged lym- left ventricle um uh left ventricular ejection fraction of 60%. The EKG reveal a normal sinus rhythm at 90 beats per minute um with an abnormally tall R wave in the septal leads particularly in V1 V2 and V3. Um this suggests the interventricular septal septal hypertrophy due to a large anterior voltage and that suggests that there’s a this fits the LVH uh voltage criteria. The labs were uh unremarkable in terms of everything being normal so uh troponin levels were normal BNP was normal CBC and CMP were normal. Um a procedure with the uh EMR um and the consult so I diagnosed the patient as familial hypertrophic obstructive cardiomyopathy explained that the disease in which the this was a disease in which the heart muscle became thickened um which makes it harder for the heart muscle to pump blood and because it’s so thick, it’ll cause abnormalities in the electrical conduction. Um in terms of the new York heart association the classification was uh 2 because of the fact that uh with slight there was slight limitation of physical activity. Um even though the patient was comfortable during uh rest. Um he mentioned that the physical activity resulted in fatigue, palpitation, and um shortness of breath which is why it led me to believe that it was NYHA classification of 2. For the MR the EMR treatment plan and counseling um I uh admitted I told the patient that he was going to be admitted to telemetry because it was a serious condition with q2 vitals, activity as tolerated. Um nursing intervention include I and O daily, daily weight uh obtaining um dai-daily weight measurement, DVT prophylaxis, and the patient would be on um 2 liters uh 2 liters per minute on a nasal cannula to make sure that the pulse ox was above 96%. Diet was um I instructed the patient to be on a regular diet um IV fluids wise it would be KVO. Um in terms of medications um I instructed the patient to be discontinued on uh lisinopril but started on uh disopyramide with uh 100 milligrams uh QID. Um there is no diagnostic labs or imaging required. I did mention to repeat an EKG reading once at the hospital just to make sure that is no repeat of the um the tall uh just to make sure that is not uh just to track the tall R waves if there was uh any feature uh EKG abnormalities. In terms of special- specialists or consults instructed the patient to vis- to have um uh an interventional cardiology visit then for an AICD placement and uh cardiothoracic surgery to visit uh uh for septal myo- myomectomy or um alcohol injection to reduce the LVOT.

18. Leslie palmer is a 62 year old female presenting to the emergency department with fatigue, heart palpitations, and dyspnea both exertionally and at rest. Patient stated that she’d been experiencing symptoms for around 2 months with gradual worsening and was instructed to go to the ED as per her primary care provider. Patient denies any chest pain or any other pain. Uh patient is a well-developed well-nourished uh 62 year old female uh in no immediate distress upon entering exam room. Patient states that she has a history of hypertension and sarcoidosis. Reports cat- cardiac catheterization 1 year ago with no major complications. Uh patient reports uh that her father died due to myocardial infarction at 59 years old. That her mother died at age 40 from unknown causes. Patient’s medications include lisinopril at 10 milligrams once daily and prednisone 10 milligrams once daily. There are no known drug allergies. Patient eats a balanced diet. No alcohol, drugs, or tobacco use with moderate caffeine consumption. Patient states that she used to walk regularly but cannot anymore due to her symptoms. Uh patient is a elementary school teacher and is in a monogamous sexually active relationship. Her vitals are as follows heart rate of 110 beats per minute, blood pressure at 136/99. Respiratory rate of 20. She is stating 91 on room air. And her temperature is 98.6 degrees Fahrenheit. Review of systems shows fatigue, unexplained weight gain, leg edema, palpitations, presyncope, and dyspnea as well as orthopnea. Physical findings show jugular vein distention but no carotid bruits. Patient does have a systolic murmur with an S4 no regurge- regurgitation with PMI displaced laterally. Bibasilar rales can be heard on lung auscultation. Peripheral leg edema is noted. Patient is negative for homin’s sign. Chest Xray shows hilar lymphadenopathy but no pulmonary edema or cardiomegaly. 2D echo shows restrictive cardiomyopathy with left ventricular ejection fraction of 55%. EKG shows sinus rhythm, normal axis with a brief period of nonsustained ventricular tachycardia. Lab findings include negative troponin and a BNP of 4000. The differential diagnosis for this patient includes restrictive cardiomyopathy and heart failure but the most likely diagnosis is restrictive cardiomyopathy secondary to sarcoidosis given the patient’s history of sarcoidosis sarcoidosis and imaging findings showing hilar lymphadenopathy and restrictive cardiomyopathy on the echo. Patient was admitted to telemetry uh with activity out of bed with assistance and nursing instructions to be given as follows. Strict monitoring of intakes and outputs, daily weight checks, DVT prophylaxis, and O2 therapy via nasal cannula with goal of maintaining oxygen saturation at 96%. Patient is also placed on a low sodium diet and saline lock is initiated. Patient is to be continued on lisinopril 10 milligrams once daily but the prednisone will be increased to 60 milligrams once daily and amiodarone 150 milligrams IV as well as furosemide 40 milligrams IV should be started. Complete metabolic panel was ordered. And a consult will be made to cardiology for uh consult for uh implantation of an automatic implantable cardiovert defibrillator or an AICD as well as a consult with nuclear medicine for an FDG.

17. uh compliant with a complaint of uh shortness of breath and fatigue. Uh he said this happened while he was exercising, he was on a walk and he just out of no where got uh short of breath. This happened 2 weeks ago. Um just got really out of breath. Uh and uh proceeded to almost pass out felt like he was going to pass out. Uh his past medical history is that he was he’s um he has hypertension he has a cardiac cath uh his past his uh family history is that his mother died of sudden death and his father died of an MI. I think his uh his mother was 40 and his dad was 59. His sister is fine though. So that heart cath and the he he had an EKG and a heart cath those were both about a year ago. Um his social history is he doesn’t use alcohol, he doesn’t use tobacco, doesn’t use illicit drugs. He is an elementary school teacher. Uh he eats a balanced diet and um he drink a couple cups of coffee a day. Exercises um as often as he can. He said usually walks everyday but for the past 2 weeks hasn’t been able to because of this shortness of breath that he’s been having. Uh he lives with his wife as well. His previous medication that he was on was lisinopril 10 milligrams per oral. Uh he has no known drug allergies. Um his review of systems is that he has fatigue, um uh palpitations, presyncope, wheezing, and dyspnea. Uh patient on uh initial uh examination was awake and aware and oriented. Uh his heart rate was a little his heart rate was 90, respiratory rate was 22 so uh very slightly uh uh tachypneic. And uh his blood pressure uh he was hypotensive it was 80/50 I believe. And O2 level was 86%. So we uh on physical examination he had no carotid bruits, no JVD, um let’s see uh no JVD uh regulatory regular uh heart rate. Murmur was present with an S4 and uh a systolic murmur was present with S4 and a gallop. Um his PMI was normal. He was clear his respiratory area was clear to auscultation. Nothing obvious in there. His calves were nontender. He had no pedal edema. He had negative Homan’s sign and all of his peripheral pur-pulses were full and equal. His chest Xray appeared uh to have cardiomegaly and it was kind of iffy but I uh said he had pulmonary edema it was just a little cloudy in there not incredibly obvious but a little cloudy. Uh his 2D echo said that he had left ven- his left ventricle was asymmetric and hypertrophic with a um with an EF value of 60%. Um his EKG had normal sinus rhythm with left ventricular hypertrophy voltage criteria and tall R waves and septal waves really pointing to um familial hypertrophic cardiomyopathy. His uh troponins were within normal they were 0 and his BNP was less than 100 which is within normal. Um his uh level of dyspnea was a um I said it was NYHA score of uh 3 because uh he said he really struggled to breathe when he would just walk on on very slight uh slight things so has marked limitation of physical activity. Uh patient’s uh I had decided it would be uh quality idea to admit to telemetry. Uh patient’s condition was serious. Uh ordered vitals for every 2 hours. And activity with assistance. Uh nursing interventions all kind of uh generalized and normal strict IO, O2 2 liters per um minute via nasal cannula maintain O2 sat greater than 96%, DVT prophylaxis. Uh diet regular because he doesn’t anything that uh indicated otherwise and um IV fluids were just keep vein open. Uh no uh no pain medicine we changed his lisinopril to disopyramide 100 milligrams per oral um everything else I believe was negative we just gave none. Uh his in patient consultation that recommended was interventional cardiology and cardiothoracic surgery. Uh interventional cardiology specifically for a uh an AICD so that just in case his heart were to uh suddenly stop we restart it and get him over to the hospital. And uh cardiothoracic surgery we uh I uh suggested uh septal myectomy and or a uh alcohol uh ablation as those would uh effectively reduce his uh primary issue that being his septal hypertrophy which was um um present on the 2D echo.

16. a 62 year old female by the name of Leslie Palmer. She is presenting to us today with a chief complaint of dull constant chest pain, fatigue, shortness of breath and wheezing for the last 2 weeks. Of note, patient does endorse having flu like symptoms about 2 weeks ago and endorsed uh experiencing a fever, cough, and rhinorrhea at the time which has since resolved however the dull chest pain and shortness of breath during her flu is still present which is why she is with us today. Of note she has been experiencing palpitations, myalgia, joint pain, uh breathlessness and fatigue with activity. Um Ms. Palmer is normally active twice a week but lately has been unable to exercise due to fatigue and shortness of breath. She also endorses uh orthopnea and must quote sle- see- uh sleep sitting up in a chair every night end quote. She has a history of hypertension and takes lisinopril 10 milligrams per oral everyday consistently. She has no known drug allergies. No illicit drug use, alcohol, or tobacco use. Of note patient did specify that she did have a cardiac cath conducted 1 year ago during her annual physical which yielded no significant findings. No other hospitalizations. And her emertl- her maternal family history includes a mother who died of breast cancer and a father who has Alzheimer’s and is currently living in a nursing facility. Her support system at home is a husband and she works as a elementary school teacher. She denies any dizziness, confusion, syncope, headache, back pain or neck pain. Her vitals include a temperature of 98.6 Fahrenheit, heart rate 110, respirations 20, blood pressure 130/90, and O2 sats 91% on room air which I placed on her on uh 2 liters nasal cannula oxygen supplemental to help her breathe. Um her heart rate and respirations are consistent with her um palpitations. Um during her physical exam I did hear some bilateral bibasilar rales and wheezing as well as noticed some JVD in her neck and 1 plus pitting edema in her lower extremities. Her heart was regular no murmurs, rubs or gallops. No rashes no nuchal rigidity. And she had no uh abdominal or carotid bruits. No calf tenderness, negative homin’s sign and carotid and and uh uh dorsalis pedis uh her carotid and dorsalis pedis pulses were present 2 plus equal and bilateral. Her uh labs and imaging include an elevated troponin of 0.1 and um BNP of 4000. Uh her chest Xray showed a cloudiness of her lung vessels and kerley B lines consistent with pulmonary congestion um or pulmonary edema as well as cardiomegaly due to increased cardiothoracic ratio. Her 2D echo showed um dilated cardiomyopathy with an ejection fraction of less than 30%. Her EKG showed sinus tach with a right bundle branch block left axis and a PFC and a P uh PVC. Um due to her presentation and diagnostic imaging today I believe that she would be she should be admitted to telemetry with a diagnosis of myocarditis um dilated cardiomyopathy and is a class 2 on the NYH scale for heart failure. Um secondary diagnosis is uh hypertension. I consulted interventional cardiology for a AICD and CRTD pacemaker assessment and radiology a contrast MRI. During the encounter I did not get the chance to but I would also like to would have liked to consult infectious disease for a consideration of Immunoglobin or glucocorticoids for treatment management. I also ordered a diagnostic serial troponin, CMP test, and a repeat 2D echo. I also would have liked to um oh I also uh like would like to order uh lisinopril 10 milligrams per oral, Tylenol 625 milligrams per oral every 6 hours for pain and furosemide 10 milligrams IV to reduce her edema and heart strain. Um to also reduce uh the stress on her heart I also would like to order a low sodium diet and oral fluid restriction. Maintain her O2 sats above 96% uh via nasal cannula. Patient was understanding to the plan and agreed with the service and she was advised to um uh continue her uh balanced food diet and um physi- and uh increase her physical activity her um sorry take it easy on her physical activity. Thank you.

15. Mr. Leslie Palmer is a 62 year old male who to the emergency department complaining of generalized weakness and fatigue for the past 2 weeks. The patient reports worsening of symptoms with exertion and also experiences palpitations and shortness of breath with activity. He states that at times he feels light headed and like he might pass out but denies any syncopal episodes. He reports the symptoms improve with rest and denies chest pain. The patient went to his primary care doctor today to uh for the worsening symptoms where he they did diagnostic testing and sent him to the emergency department for further evaluation. The patient has a medical history of hypertension diagnosed 10 years ago. Immunization are up to date. And he has no previous hospitalization. He had a heart catheterization 10 years ago which was normal. His mother passed away um suddenly at the age of 40. And his father passed away from an MI a- at 59. He denies tobacco, alcohol, or drug use. He has a balanced diet with regular exercise. He’s an elementary school teacher and lives with his wife. He takes lisinopril 10 milligrams once daily for his blood pressure and he has no known drug allergies. Review of systems was positive for fatigue, generalized weakness, presyncope, and palpitations, shortness of breath. He denied fever, chills, weight changes, bruising, lesions, rashes, weakness, sensory changes, headaches, changes in vision, neck stiffness, hearing changes, and chest pain. Vital signs um his heart rate was 110, 96% oxygen saturation on room air, respiratory rate of 16, temperature 98.6, and blood pressure of 130/90. He was awake, alert, oriented, in no acute distress. He’s well developed well nourished male. He had no JVD, no carotid bruit, no chest wall tenderness, no epigastric bruit or tenderness. Normal um posterior tibialis pulses bilaterally, negative homin’s sign, no lower extremity edema or calf tenderness. He had a normal rhythm sys- sys- systolic murmur with a S4 and the PMI was displaced laterally. The lungs were clear to auscultation. And he had no chart- TART changes. For his um labs his troponin and BNP were both within normal limits. His chest Xray showed cardiomegaly and his ECHO showed left ventricular asymmetric hypertrophy with um an ejection fraction of 60%. His EKG showed sinus rhythm at 90, normal axis. Um LVH voltage criteria and tall R waves in the septal leads. So for this patient we are going to admit him to telemetry for the diagnosis of hyp- fam- familial hypertrophic cardiomyopathy NYHA class 2 and a secondary diagnosis of hypertension. His condition is serious and will be getting vitals every 2 hours. He has no known drug allergies. Activity as tolerated. We’ll put him on a regular diet and have DVT prophylaxis and an O2 nas- oxygen nasal cannula as needed to maintain a saturation of greater than 96%. We’ll put in an IV fluid saline lock discontinue the lisinopril and start disopyramide 100 milligrams four times a day. We don’t need any other labs or imaging at this point. We will consult with interventional cardiology for potential AICD placement. And we’ll also consult cardiothoracic surgery for um possible septal myectomy or alcohol injection. Um we discussed the plan of care with the patient. He denied any other questions. And he understood and agreed with the plan of care. The patient has insurance and lives with his wife who is his support system.

1. Mr. palmer presented to the ER um he is a 62 year old white male and he presented to the ER with complaints uh 2 weeks ago he noticed he was having dyspnea and fatigue um when he was going on his daily walk with his his friends and that typically doesn’t happen. And since those 2 weeks he’s noticed it’s gotten worse in particularly this morning what made him come into the ER was that his dyspnea was so bad his wife brought him into the ER. Um he doesn’t have any pain and he did say that one of the alleviate factors is that when he rests the shortness of breath gets better the dyspnea gets better. Um he hasn’t tried any treatments um he just described it as regular severity and really the only complaint he came in was with um shortness of breath and fatigue. Um looking into some relevant history he does have a history of hypertension which he takes lisinopril for- which he was taking lisinopril for regularly. He also um on his family side his mother had died of sudden cardiac um event his father had passed away from an MI age 59. Um his past surgical history he had a cardiac cath put in other than that no other hospitalizations um no other relevant history he’s not a smoker he doesn’t take any illicit drugs use, doesn’t drink. Um he has the like moderate cup of coffee a day um before this he did say he was pretty active regularly um it’s just now with the shortness of breath and fatigue he can’t exercise as much as he used to be able to. Um so then I conducted a physical exam um examining cardiac and pulmonary systems. Um when listening to his hearts I did notice a positive systolic murmur an S4 gallop. I also noticed that his PMI was laterally displaced um however everything else was normal. Uh didn’t hear any rales or anything lungs sounded good uh found nothing in the OMT screen. Um oh along with dyspnea he did mention wheezing that he would occasionally have. Uh his vitals when I had examined him heart rate was particularly high it was at a heart rate of a 110, um his blood pressure was normal and his oxygen was normal. But I told him I would that we would be concerned about that heart rate being particularly high. Um and then I moved on to review labs and imaging with him. So his troponin and his BNP BNP were normal all his bloodwork labs were normal. Um his Xray showed cardiomegaly and pulmonary edema. Um his uh EKG showed left ventricular hypertrophy I mean im sorry his ECHO showed left ventricular hypertrophy and so did his EKG with ta- tall R septal waves. Um and with that finding and the physical exam findings and his family medical history we came up with the diagnosis of familial hypertrophic cardiomyopathy so I told him that we would be admitting him to the telemetry unit um along with changing his lisinopril like stopping lisinopril and putting him on disopyramide and that he would be able to get out of bed as needed but we would have you know his vitals tracked every 2 hours. We’d give him a couple standard nursing regulations like uh O2 nasal cannula, um DVT prophylaxis, all of those. And um I did let him know that we would refer him to an interventional cardiologist um for an AICD placement along with uh potentially referring to a cardiothoracic surgeon since he does likely have familial hypertrophic cardiomyopathy to see if we could get either a myectomy done or some alcohol inventions to help um relieve some of that left ventricular outflow obstruction. Um uh I did ask if he had any family or friends in the area his wife brought him in so I let her know that we were gonna admit him and if she could bring you know some stuff that he would need and um if they need any any support other than that um
2. I have Ms. Leslie Palmer she’s a 62 year old patient who comes in with uh chief complaint of shortness of breath and fatigue. Patient states that she went to a family medicine clinic um 3 days uh 3 days ago where she had some tests ordered and uh the results are here in the ER um. She presents to the ER after having worsening of her symptoms. She states her symptoms began 2 months ago she had episodes of shortness of breath. She had a fluttering heart um so she endorse palpitations and during these episodes she felt like she was going to pass out.  Um these episodes were short in nature but they worsened with activity um but they weren’t present at rest. And she said that she was sleeping in a chair and that improved her symptoms. She has a um surgical history of a catheter a cardiac cath uh she has a medical history of hypertension. And 25 years ago she was diagnosed with sarcoidosis. She denies any allergies at all. She states that she consumes a balanced diet. And she can no longer exercise due to her symptoms. Um and she denies um any alcohol use, any tobacco use, any drug use. She states she drinks one cup of coffee a day. Um she’s an elementary school teacher. Uh she states she sexually active with a male partner um and who she is currently living with. And um she states that her um she has no recent hospitalizations and she state that her father died from a myocardial infarction at 59 years old. And her mother died suddenly at 40 years old. Um she is compliant with her lisinopril 10 milligrams daily and she’s also taking pred- prednisone 10 milligrams for her um sarcoidosis. Uh she states that she’s up to date on her vaccinations as well. Um for her review of systems that was uh negative for weight loss but she did have 10 pounds of weight gain. Um she endorses uh fatigue she denies any fever or chills. Um she states that uh skin findings were negative. Um there was no head and neck findings significant. Um she states that she um um she doesn’t have any chest pain at all but she does have palpitations. She does have that pre- presyncope that I discussed. Uh she denies any cough or wheezing but she does endorse um some dyspnea and orthopnea. Um she endorses right leg swelling as well. Um she denies any muscle pain or any back pain or any joint pain. Um she there was no uh neuro findings so no dizziness uh no changes to her gait um and she note no confusion at all. Um her vital signs were she had a uh SpO2 of 91%, uh respiratory rate of 20, um heart rate 110, uh temperature 98.6 and BP of 136/99 and she was alert, oriented and and she was um awake and fatigue as well. Um oh on physical examination she had JVD and no bruit no bruits. Her heart rate was regular and her systolic she had a systolic murmur with an S4. She had no rubs or gallops. Her PMI was in a normal position. Um there was no chest wall tenderness. Her lungs uh were present with uh biba- bibasilar rales and wheezing. Um she had 1 plus pitting edema on her lower extremities. She had dorsalis pedis and posterior tibialis pulses were full. Uh no tender- tenderness in the calf and her homin sign was negative bilaterally as well. She had no tissue texture changes on um uh thoracic spine screening. I no red re- reflexes. Um no uh somatic dysfunction in the thoracic region as well and no anterior chapman points um positive. Chest Xray presented with pulmonary edema, mediastinal fullness, normal cardiac silhouette. And her 2D echo presented with restrictive cardiomyopathy with increased wall thickness of and ejection fraction of 55%. Her- her EKG presented with normal sinus rhythm with nonsustained vtach. And her CBC CMP were negative. PT/INR were negative um troponins were negative but her BNP was elevated at 4000. And I believe that she has class uh 3 new York heart association heart failure with a history of uh pulmonary sarcoidosis and hypertension. So our plan is to admit her to telemetry. We’re going to um we’re going so she’s in serious condition. We’re gonna get vitals every 2 hours um she is allowed to get out of bed with assistance. Uh we’re gonna get daily IOs, daily weight, DVT prophylaxis. We’re going to get um give her some O2 via nasal cannula. We’re gonna uh maintain her O2 sat at uh more than 96%. Sh-shes gonna be placed on a low sodium diet on a sa- saline lock. We’re gonna continue lisinopril 10 milligrams and amiodar- and we’re gonna put her on amiodarone 150 IV, up her uh prednisone to 60 milligrams daily and add furosemide 40 milligrams to diurese her. We’re gonna get a repeat CMP and we are going to send her to interventional cardiology for AICD placement and we’re going to send her to a nuclear med or radiologist for an FDG- uh PET scan. So um thank you very much it was great it was a pleasure to see this patient.