**Clinical Foundations: PDA Case Input Exercise**  
**June 2004-5**

**Important:** In order to complete this exercise, you should have synched your PDA with the UCLA AvantGo server, and have the UCLA PDA Patient Log on your PDA. In case you need assistance with this, please call Katherine Wigan at 310-794-9008.

**About this exercise:**
The purpose of this exercise is to ensure that your PDA Patient Log is working, you can input your cases in this Log, synch with the AvantGo Server and view the results of your records on the Web. We therefore have set up a PDA log for the Clinical Foundations course. Although you will not be seeing real patients during this course, we have taken six cases from third year students over the past year. A couple of these cases will also be used during the week to practice Oral Presentations and Histories.

**Inputting Cases in the UCLA PDA Patient Log:**
Please review all the cases. For each case you need to input each of the Fields on the PDA Log. Most of these are simple “drop down” choices or choosing between two “radio” buttons. If a diagnosis is not listed, you can input it at the bottom of the screen using your PDA text entry facilities. However, our expectation for this course and all other courses is that you will be able to simply click and go without any scrolling.

**Assignment and important dates:**
You need to input all the cases by Tuesday, June 29th and synch your PDA to the AvantGo server to send us the case data. Please also PRINT out your case report from the website. You need to go to [http://apps.medsch.ucla.edu/medyear3/pdalog/](http://apps.medsch.ucla.edu/medyear3/pdalog/). Enter this web site by typing in your AvantGo login and password. **You will be required to hand in a copy of your PDA Log to receive credit.** We will review the information on June 29. It would be worthwhile to do this by Friday so if you have problems you can get assistance from IDTU (Katherine Wigan at 310-794-9008 or Zhen Gu at 310-825-8665).

**Review session on recorded cases:**
On Tuesday, June 29, we will review your case entries in a group. We will also point out special features of the web interface for retrieving and reviewing your data. This final debriefing session is intended to demonstrate the relevance of the PDA Patient Log to your clerkship experiences.

**Related Web sites:**

*UCLA AvantGo server:* [http://sync.medsch.ucla.edu](http://sync.medsch.ucla.edu)

*PDA Requirements Page:* Provides instructions on how to log on, synch and download applications into your PDA: [http://www.medsch.ucla.edu/pda/](http://www.medsch.ucla.edu/pda/)

Instructions: How to Input Cases

The **required fields** are:

**DOE:** Enter the date when you input cases

**Setting:** Select appropriate setting

**Responsibility:** Assume you are the admitting third year doing a full H&P

**Age:** Choose the appropriate age group

**Gender:** Choose male or female

**Ethnicity:** Enter ethnicity, if not known select “Unspecified”

**Continuity:** Assume all these are new to you

**Complaints** Enter the complaints that the patient presents with. You can select more than one.

**Review Complaints:** This will have been automatically filled in for you. You cannot edit this field. To remove a complaint, deselect it from the Complaints field above. **Please make sure that you have a clean list of diagnoses (no duplication or errors).** This will ensure accurate data for faculty and your own review.

**Dx:** Enter up to **THREE** major diagnoses at the time of discharge.

**Review Dx:** This will have been automatically filled in for you. You cannot edit this field. To remove a diagnosis, deselect it from the Dx field above. **Please make sure that you have a clean list of diagnoses (no duplication or errors).** This will ensure accurate data for faculty and your own review.

**Procedures:** These are the ones you believe you would have completed on admission or the first day.

**Review Procedures:** This will have been automatically filled in for you. You cannot edit this field. To remove a procedure, deselect it from the Procedures field above. **Please make sure that you have a clean list of procedures (no duplication or errors).** This will ensure accurate data for your own review.

**Imaging:** The X-rays you and the team did.

**Imaging Involvement:** Specify your involvement on the imaging technologies.

**Learning Experience:** Select the actions that you took during patient care.

**Supervision:** Select what type of feedback you received on this particular patient problem from residents and faculty.
My Notes: This field is for recording your own notes. In case you need a description for “Other” categories, you can add these here for your own review. Please make sure that this is HIPAA compliant, no private information is revealed.

SUBMIT: This button is at the bottom of the screen. Need to do this for each of the six cases. Remember, need to have ALL the cases inputted and sent by synching by Tuesday, June 29th.
Clinical Foundations – PDA Case Input Exercise

Case 1

MS3 Admission Note

This is the fourth UCLA admission of Ms. Susan Stone a 40-year-old obese second grade school teacher. History was obtained from the patient.

CC: Abdominal pain for last twenty four hours

HPI:
Ms Stone was in her usual state of health till yesterday afternoon when she acutely noted severe (9/10) abdominal pain in the mid abdomen. Patient is unable to describe the quality of the pain. The pain has remained steady in severity and has localized to the mid abdomen and right upper quadrant with some radiation to her back. She has been nauseated and has vomited on 3 occasions but without blood, coffee ground material or bile. She has been able only to take small amounts of water but no solid food. She has had a fever of about 100, chills but no rigors. Of note, her family has stated that she looks more “yellow” recently. She reports to having a similar, however less severe episode one year ago and was hospitalized at an outside facility. She is unaware of the diagnosis. Patient’s last BM was yesterday morning before the onset of pain.

Other than acute problem she rarely sees her doctor other than to get renewal of her BCP’s

PMHx
Usual Childhood illnesses, Positive for croup and scarlet fever
Fx Right forearm falling out of swing when 5 years old
HTN

Allergies: NKDA

Medications:
Ortho novum 7,7,7
Minocycline 100 qd
Hydrochlorthazide 50 bid
Prilosec 20 qd
Paxil 10 qd
St Johns Wart (occasionally)
Ginseng (when feels tired)

Fm Hx
Mother 68, Osteoporosis, Obesity
Father 70, Alcoholism, HTN, AODM
Brother 45, Alcoholism, HTN, IVDU

Social Hx: Born in Hawaii. She graduated USC and has a Masters in Education. Married without any children. Smokes 2 PPD since age 20. Alcohol 3 – glasses nightly. No drugs. Pt. Is monogamous with husband.
ROS
Head: Migraine headaches with menses
Eyes: Astigmatic with glasses
Mouth: TMJ pain, and grinds teeth at night
Ears: hx frequent ear infections as a child
Neck: often has hoarse voice
Chest: Exercise induced asthma. Dry cough in AM, Husband reports she snores
Yearly PPD skin tests negative.
Cardiac: No CP, orthopnea or PND. No nocturia. No hx of rheumatic fever or murmurs
Abdomen: GERD on Prilosec for two years. Notes both bouts of constipation and
diarrhea for 10 years. No blood or mucus in stools. No history of jaundice. Has
received Hep B vaccine.
GYN: Started menses age 13. Regular every 30 days. Light menses. No pregnancies.
Only has sexual relationship with husband, unprotected
GU: UTI's times three since college; HTN for 5 years on HCTZ
Endo: has always been heavy, since High school but no diabetes
Neuro: hx seizures after MVA but stopped age 21
Psych: Very anxious, has difficulty sleeping

PE
Obese female in moderate pain. WD
BP: 160/100  P 125  T 38  R 22  Wt 250 lbs
Head: NC/AT
Ears: cerumen bilaterally
Eyes: PERRLA, EOM's =full, conjunctivae pale, +scleral icterus
Nose: mucosa pink
Mouth: clicking and displacement of TM on opening mouth widely
Neck: obese, soft none tender.
LN: no lymphadenopathy
Chest: Increased tissue, clear to percussion, decreased breath sounds. No appreciated
rales or rhonchi. No wheezes.
Cardiac: No thrills, heaves. Distant heart sounds. No appreciated gallops or murmurs
Abdomen: Obese, absent BS. Tender to palpation in mid abdomen and RUQ. No
rebound, mild guarding. No masses or HSM appreciated. Jaundice noted. Positive
Murphy's sign.
Back: no edema, no CVA tenderness.
GU: deferred
Breasts: Pendulous without gross abnormalities
Rectal: Heme negative. No masses appreciated.
Ext: No C, C or E. Full ROM
Neuro: Oriented times 4. CN II-XII intact. DTR's none.

Labs:
Hgb 12   Hgb 36   WBC 15.3
Na 131   K 3.0   Cl 95   CO2 25   glucose 105   Creat 1.4   BUN 35
Direct Bili 3.5 Indirect Bili 1.4   Alk phos 220   AST 100   ALT 125   Amylase 210
Ca 9.5    Albumin 3.7   Mg 1.5   PO4 2.5   Uric Acid 8.0
Pregnancy Test: Negative

RUA:  Sp gr 1.028  protein trace,  WBC 4, RBC 1, mod squamous cells

CXR:  No acute disease

ABD film:  ileus, sentinel loop, several air fluid levels

ABD US: hyperechoic region in gall bladder consistent with a gallstone, thickened gallbladder wall and mild pericholecystic fluid noted. CBD 11 mm. Sonographic Murphy’s sign.

Assessment: 42 year old female with one day of abdominal pain, jaundice, nausea and vomiting. Has ileus with sentinel loop and increased amylase. Likely pancreatitis. Pt also has leukocytosis with increased AST/ALT and bili (predominantly conj. Bili) with gallstones, pericholecystic fluid, thickened gallbladder wall and dilated common bile duct on ultrasound. Although, patient has multiple reasons for pancreatitis, her presentation is consistent with gallstone pancreatitis with gallstone obstructing the common bile duct and ampula of Vater. Patient also fits profile for gallstones. Patient is a 42 y/o obese female with gallstone pancreatitis.

Plan:
2. Keep Patient NPO.
3. Start IV fluids. NS at 100 cc/hr for 102 liters.
4. NG suction to low suction. Follow NG tube output.
5. Follow lytes. Replace as needed.
7. Start patient on cefotetan 1 g IV q 12 hours.
Case 2

Medicine MS# H&P

CC periumbilical and back pain

HPI This is first Oliveview UCLA Medical Center admission of Mr. Gomez a 19 year old male with a history of cocaine use who first noted onset of periumbilical pain 6 days ago after a night of heavy cocaine use. This pain has been increasing since then. At the same time, he stopped urinating for 4 days. In the past days, his urine has been tea-colored. Since taking Aleve 4 days ago for pain relief, he has also been feeling midline lower back pain. The patient attributes this pain to Aleve use. The patient reports that the pain has been accompanied by nausea, and he has vomited in the last 24 hours prior to admission. He has also had diarrhea for 6 days but denies fever or chills. He regularly uses EtOH, marijuana, and cocaine, but has not used any of these in the past days.

PMH None

PSH None

ALL NKDA

MEDS Aleve x 3-4 tabs, 4 days ago

SOC EtOH: 12-pack per day
Crack cocaine: 2-3x per week
Frequent marijuana
Tobacco: ½ - 1 pack per week
Unprotected sex with several women in the past 6 months
No IVDU

ROS Negative except for above

Vitals BP 174/96 HR 69 RR 18 T 36.5
GEN WDWN male in NAD, sleeping comfortably
HEENT PERRL, EOMI, OP with mild erythema but no lesions, no sclera icterus
NECK supple, no LAD
PULM CTAB
CV PRR, loud S1 and S2, no M/R/G
Abd soft, ND/NT, +BS, no skin lesions
Back no CVAT, no spine tenderness
Ext normal pulses, warm and pink
Neuro tone, strength, and sensation grossly intact
Skin no lesions
Lymph no LAD
A/P

19 year old male with acute renal failure.
1. ARF: with a current Cr of 13.0 and 4-day history of no urination, this patient has a high likelihood of acute renal failure. Etiology is as of yet unclear. FENa of 0.5 indicates that at least a portion of his ARF is prerenal, which may be due to dehydration, NSAID use, or a vascular problem. His UA indicates that there is glomerular and possibly parenchymal damage as well. Postrenal failure is unlikely given his normal U/S and lack of history consistent with obstruction. Most likely etiologies for his ARF are rhabdomyolysis from cocaine use and acute interstitial nephritis from either cocaine or NSAID use. Rhabdo is made less likely by his normal CK, but may have normalized in the 6 days since his symptoms began. The patient also has risk factors of HIV, and it is possible that this may be causing his ARF as well.
2. Hypertension: This is likely related to the patient’s acute renal failure. Will continue to follow, and consider adding a pharmacological agent if his flood pressure does not normalize as his ARF resolves.
MS3 Medicine Admission H&P

**Chief Problem:** Cellulitis in bilateral lower extremities.

**History of Presenting Illness**
48yo female with a history of morbid obesity, HTN, COPD/Restrictive lung disease, anemia, and umbilical hernia presenting with bilateral LE cellulites x4 years. Cellulitis began in 1999 secondary to weight gain reaching a peak of 401 lbs. Medical work-up at the time ruled out hypothyroidism and DM with no medical cause for weight gain discovered per patient. Severity of cellulites fluctuated over the years. 6 months ago, patient was told she had to lose approx 100 lbs to have surgical repair of umbilical hernia. She lost 98 lbs over 6 mos on an ADA diet and walking 1 hr/d. The cellulites flared up in 3/02 despite the weight loss requiring the patient to take Keflex qD that did not improve symptoms much. Over the past 1 month, the area involved doubled in size bilaterally. Currently, patient goes to PT for foot wrapping. She received whirlpool therapy in the past. She is on her feet a lot and does not raise them as much as she should.

**Medical Walk-in Course**
Patient initially presented to Tujunga Clinic and was referred to Med Walk-in. A dose of Levaquin 500mg IVPB was given, and chemistry and CBCs were drawn. Tib-Fib XR series on bilateral LE were done to r/o osteomyelitis.

**Past Medical History**
- Morbid Obesity
- HTN
- Incisional Hernia
- Anemia – Secondary to heavy menses
- COPD/Restrictive lung disease – Secondary to obesity. Exacerbated by URI in February and needed O2. +Cough since then with no significant sputum production. Takes Albuterol BID for sx relief. Has not needed o2 since losing weight.
- GERD

**Past Surgical History**

**Social History**
- Tobacco – quit 20 yrs ago. 10 pack/yr history.
- Etoh – Denies.
- IVDU – Denies.
- Occupation – Disabled by obesity. Receives SSI and MediCal.

**Family History**
- Dad – 80yo. Pulmonary heart disease with MI at 75yo.
- Mom – 75yo. Alcoholic.
Medications
- Keflex 500 mg 1 tab PO QID since 3/02
- Albuterol 1-2 puffs TID prn SOB x 1 yr.
- Colace 1 tab PO qD
- Lotensin 20mg 1 tab PO qD
- HCTZ 25 mg 1 tab PO qD
- ASA 81mg 1 tab PO qD

Allergies
- Possible reaction to Iodine → nausea.

Review of Symptoms
- +Chills and night sweats w/ facial flushing x 6 D - periods are irregular.
- GI - No diarrhea. Takes colace for constipation. +Hemia.
- MS - Diffuse, non-specific back pain w/o radiation.

PHYSICAL EXAM
Vital Signs: T 36.8 BP 130/71 P 82 RR 24
General: WD obese female, NAD, pleasant.
HEENT: PERRL, EOMI, MMM, OP clear, uvula midline, geographic tongue.
Neck: No LAD. No thyromegaly appreciated.
Heart: RRR. Grade II/VI Systolic murmur heard best along left sternal border.
Lungs: CTAB
Abdomen: +BS S/NT/Obese. Incisional hernia 11:00 from umbilicus – Facial defect palpable.
  Bowel reducible, non tender. No HSM appreciated.
Back: Diffuse musculoskeletal TTP without radiation. No distinct CVAT bilaterally.
Extremities: Blanching, indurated, mildly warm areas of hyperpigmentation with distinct borders.
  +TTP. L sided 1 cm area of skin breakdown with oozing. No pitting. Severe varicose veins
  and edema in ankles/feet. DP 2+bilaterally.
Neuro: A +0 x 4. CN III-XII grossly intact.

Test Results
- Chem 7 and CBC results pending.
- Tib-Fib XR pending.

ASSESSMENT/PLAN
48yo morbidly obese female with HTN, hernia, COPD/Restrictive lung disease, and cellulites
1) Cellulitis – Well demarcated regions of blanching tender hyperpigmentation not well controlled by
   Keflex 500mg PO BID. Most likely the result of chronic venous stasis dermatitis.
   • Levaquin 500mg IVPB x 1, then switch to Levaquin 500mg PO per attending
     Dr. Applebaum.
   • CBC with differential in AM
   • Reduce venous stasis
     • TED hose
• Elevate legs while in bed.
• PT for whirlpool treatment.
• HCTZ 25 mg PO qD to reduce fluid overload.

2) Obesity – Encourage pt to continue to lose weight.
   • ADA diet

3) HTN – Well controlled
   • Continue HCTZ 25 mg qD
   • Continue Lotensin 20mg qD
   • Chem 7 in Am

4) Hernia – Not incarcerated, no abdominal pain. Surgery agreed to repair once patient loses desired amount of weight.
   • Continue Colace to prevent constipation.

5) GERD – Pt has history of severe water brash that has decreased since losing weight.
   • Zantac 150mg PO BID

6) COPD/Restrictive lung disease with non-productive cough – pt is afebrile, cough is chronic, infectious pulmonary process not likely.
   • Continue Albuterol 2 puffs prn SOB/cough

7) Prevention
   • DVT: Encourage OOB TID. Consider SQ heparin if long admission is anticipated.
   • CAD: Encourage weight loss. Continue ASA 81mg 1D
CC Falls

HPI This is the third Cedars Sinai admission of Mrs. Jones a 80 year old African American retired librarian with a history of CAD with MI in 1999, 2-vessel PTCA with stent placement, chronic CHF, past antipsychotic use with resulting tardive dyskinesia, and progressive dementia for the past several years. Her cognitive function and memory have progressively deteriorated to the point where she is unable to carry on a conversation, and her personality has changed over the past several years as well. Her husband, from whom the entire history is obtained, reports that she frequently forgets specific words, occasionally replacing them with unrelated words. Over the past several years she has also fallen numerous times, both at night while attempting to sit on the commode and also during the daytime while walking. None of her falls have been witnessed, but her husband reports that they do not always happen immediately after standing. He also reports that she is not confused after falling, and that he is convinced that she does not lose consciousness; he attributes her falls to instability and weakness. She is able to get around the house relatively well with her walker.

For the past several weeks, her general condition has worsened significantly. She has begun falling more frequently, and yesterday fell four times. Her dementia has increased significantly, she has had increasing difficulty dressing herself, and she is considerably more somnolent. She is also drooling more than usual. 4 or 5 days prior to admission she developed a “wet” cough but has not produced much sputum. Over this time she has eaten less, and has lost approximately 5 lbs. She was seen by her PMD Dr. Parker yesterday who noted that she was bradycardic with HR in the 30’s and told her to go to the ER. She was admitted to the CCU team, her metoprolol was discontinued, and her HR is now in the 50’s. She has transferred to the A medicine team after an acute MI was ruled out.

PMH Hypertension
Anemia: the patient was hospitalized in late 2000, eventually diagnosed with bleeding gastric ulcers.
Rheumatoid arthritis since age 10. This disease has been active for much of her life.
Coronary artery disease: MI in 1999, cath revealed EF of 40%, 70% LAD stenosis, 90% LCX stenosis, 80% RCA stenosis. She subsequently underwent PTCA of LCX and OM with stent placement

PSH PTCA, 1999 (see above)  
Hysterectomy, 1999

ALL Penicillin (symptoms unknown to husband)

MEDS Metoprolol XL 50 mg PO QD  
Lipitor 10 mg PO QD  
Hyzaar 100/25 mg PO QD  
Methotrexate 10 mg Q week  
Reminyl 8 mg PO BID  
Folate  
Lidex cream

FAM The patient’s father had rheumatoid arthritis. Her mother died of a CVA in her 70’s. There is no other history of heart disease
SOC  The patient lives with her husband. He was professor and chairman of the Redlands computer science department; she was a college librarian. He now serves as her caregiver and assists her with most of her basic activities of daily living. No tobacco, EtOH, or other drug use. They have a son who is alive and well.

ROS  Husband reports bladder incontinence x 5 years and a recent right knee scrape which is now healing well. Otherwise negative.

VITALS  T 36.4  BP 110/60  HR 55  RR 18  SAO2 100%

PE  GND  WDWN female lying in bed sleeping in NAD, receiving 2L O2 by NC
HEENT  NC, small right occipital scalp hematoma, PERRL but small, EOMI, MM dry, OP clear
NECK  supple, no LAD, JVP 6-7cm
CV  RRR, normal S1, soft S2, no murmurs, no rubs, no gallops, PMI not displaced
PULM  coughing on deep inspiration, no wheezes
ABD  soft, ND/NT, normal bowel sounds, no HSM, no masses
EXT  no clubbing, cyanosis, or edema, normal pulses 3 superficial healing lesions on R knee
NEURO  no CN deficits noted
Strength, tone, and sensation grossly intact

LABS  CBC  WBC 7.25, Hgb 9.8, Hct 27.8, MCV 88.3, Plt 188
P 81, L10
Retic count 0.87%, 4.1% immature
Chem  Na 127, K 3.6, Cl 91, CO2 28, BUN 15, Cr 0.7, Glu 149
Ca 8.7, Mg 1.3
Serum osm 264 (calculated osm gap –2)
UA  SG 1.009, pH 7.5, no abnormalities
Thyroid TSH 2.1, free T3 98, total T3 89, uptake 0.9, TSH 2.1
Clotting  PT 10.6, PTT 35.2, INR 1.0
Cardiac Troponin I negative x 3
Liver  Alb 3.0, AST 34, ALT 27, alk phos 66, Tbili 0.6, direct bili 0.1
Iron  Fe 48, ferritin pending
Vit  Folate pending, B12 pending
Lipids  Chol 122, LDL 37, HDL 77, TG 39

STUDIES  Head CT shows mild to moderate atrophy, no bleeds, no infarcts, no mass effects, no sinus disease, normal skull
EKG shows sinus bradycardia, 1st degree AV block, ST evaluation in V2-V4

IMP  This is an 80 year old female with a history significant for CAD with past MI, CHF, and dementia, admitted with falls and bradycardia. Her PE reveals somnolence, scalp hematoma, and orientation only to name. Her laboratory data are significant for anemia with insufficient reticulocyte response, hyponatremia, and hypochloremia. Head CT shows no acute changes. Her falls may be related to her bradycardia, to her progressive neurological deterioration, or to increasing weakness.
Problem list and plan

1. Falls: Her workup has so far not yielded a specific etiology. Will replete Na and fluids, will hold Hctz and metoprolol, and evaluate more fully once fluid and electrolytes have normalized.

2. Bradycardia: This was at least partly caused by her metoprolol, and her HR is more normal now that her metoprolol has been discontinued. Will continue to monitor.

3. Hyponatremia: This may be due to a number of factors, but is very likely related to her HCTZ. The patient appears to also be slightly volume depleted. Will continue to hold HCTZ, give D5NS to replete Na and volume. If hyponatremia does not improve with this therapy, will evaluate more completely.

4. Hypochloremia: This is most likely related to her hyponatremia.

5. Anemia with insufficient reticulocyte response: This may be an anemia of chronic disease related to her rheumatoid arthritis. Iron studies are pending.

6. Dementia: The patient’s chronic progressive dementia may be of Alzheimer’s, multi-infarct, or other etiology. Her acute mental status deterioration may be due to her fluid and electrolyte status, and we will correct this before looking for other causes.

7. CAD: This does not appear to be an active issue at this time, but indicates that the patient may have other vascular disease, which could be causing her cognitive impairment as well as her falls. Will work this up more fully if fluid and electrolyte abnormality correction do not result in improvement in mental status and stability.

8. Hypertension: The patient is currently not receiving either metoprolol or Hyzaar, and her BP is currently not high. Her hypertension is not an active issue at this time.

9. CHF: The patient does not have signs or symptoms of CHF. Will monitor for these as we continue to rehydrate.

10. Rheumatoid arthritis: This is not an acute issue at this time.

11. Social: The patient has signed documents giving her husband (and son, if her husband is unavailable) durable power of attorney for health care. Will discuss code/fever status with husband.

12. Disposition: The patient’s husband seems to be appropriately attentive to her needs, but it remains to be seen whether she will be functioning highly enough to return home after this hospitalization. Her husband indicates that this is a concern for him. Will continue to evaluate this issue.
Case 5

Medicine MS3 H+P

CC  shortness of breath for 2 weeks

HPI  The patient is a 52 year old Caucasian carpenter with an extensive past medical history who was in his usual state of health until 2-3 weeks ago, when he began to notice shortness of breath. He reports that he feels short of breath at rest, and that exercise exacerbates this symptom. He has also had a cough producing green and white sputum, low-grade fevers, and night sweats. On deep inspiration he feels a sharp left-sided chest pain. The patient has a long history of smoking, has been diagnosed with emphysema, and has been hospitalized several times in the past for pneumonia. A PPD placed during his current illness was negative.

During these past 2-3 weeks the patient has also had nausea and vomiting, but has not vomited blood. He has had constant, sharp bilateral upper quadrant abdominal/epigastric pain. His appetite has been decreased, when he does eat, he does not notice a change in his pain. He does note that he usually has melena and bright red blood streaks on his toilet paper after bowel movements, but has recently had watery diarrhea as well. The patient has a past history of chronic pancreatitis with pancreatic insufficiency and diabetes, as well as hepatitis C infection about 25 years ago. He denies history of peptic ulcer disease or other gastritis.

The patient additionally reports that he has recently had several “blackouts” during which he falls from a standing position. They have been going on for several months, but he thinks that they may be increasing in frequency. The patient has a long history of grand mal seizure disorder, but reports that these blackouts are different. He becomes dizzy, though the room does not spin, then he falls and regains awareness of his surroundings after he has fallen. He reports that he normally falls toward his left side and afterward his left arm tingles. His falls are not associated with standing up rapidly, and he does not feel any dizziness or light-headedness when he does so. He has not had any recent headaches, and reports that his last seizure was 2 weeks ago. He has, however, recently noticed that his visual acuity has decreased somewhat, and occasionally sees gray snowflakes in his central visual field or shadows in his peripheral fields. Since then, he has had several blackouts, up to 3 per day. None of his falls have been witnessed.

PMH  osteomyelitis x2 (left medial clavicle and right knee)
      hypertension
      diabetes mellitus
      grand mal seizures
      COPD
      hepatitis C
      chronic pancreatitis
      endocarditis leading to mitral valve regurgitation
      coronary artery disease
      myocardial infarction

PSH  balloon mitral valvulotomy x2, 1992, 1993
     mitral valve repair (porcine valve), 1994
     debridement and removal of osteomyelitis-infected tissue x2

ALL  NKDA
MEDS  sublingual nitroglycerin
Dilantin 300 mg QHS
theophylline 300 mg TID
captopril 25 mg BID
diltiazem 120 mg QD
methadone 45 mg QD
pancrelipase 4.5/10/25 TID
prednisone 60 mg QD

SOC  EtOH: former heavy use, only light use since initial pancreatitis diagnosis in 1972
heroin IVDU for many years, now in a methadone rehab program
tobacco: 40 pack-year history
has tried “most” other drugs
unemployed, lives in detox/rehab facility in Tarzana

ROS  dysuria, sudden urinary incontinence, feeling on incomplete voiding, nocturne 2-3x/night,
frequency (10x/day)

ER Vitals  BP 121/73  HR 102  RR 16  T 35.7  sat RA 94%
Floor Vitals  BP 130/74  HR 79  RR 20  T 35.8  sat RA 98%
GEN  WDWN but thin male in NAD, sitting in bed awake and alert
HEENT  PERRL, EOMI, OP clear without lesions, dentures
NECK  supple, no LAD
PULM  decreased breath sounds bilaterally, no rales/rhonchi/wheezes
CV  RRR, loud S2, I/VI holosystolic murmur heard best at apex
    PMI laterally displaced at anterior axillary line
Abd  somewhat hard, tender bilateral UQ, no rebound, no guarding, normal bowel sounds
Back  no CVAT, bilateral mid-back tenderness
Ext  normal pulses, medial malleolus discoloration bilaterally, mild pitting edema L > R
Neuro  tone, strength, and sensation grossly intact, cranial nerves intact, no focal lesions, no
    Babinsky
Lymph  no LAD
MMSE 24.30 (-5 for WORLD/serial 7s, -1 for 5-minute object recall)

Labs  WBC 12.7, Hgb 12.6, HCT 39.3, Plt 335, P76, L16, M8
    Na 140, K 4.3, Cl 103, HCO3 28, BUN 22, Cr 1.1, Glu78
    Lipase 257
    PT 12.4, aPTT 28, INR 1.03
    Ca 8.8, Mg 1.9, PO4 3.4
    Phenytoin 28
    ALT 80, alk phos 118, Tbili 0.4
    CXR: hyperinflation, o/w normal
A/P 52 year old male with possible CAP, asthma exacerbation.
1. possible CAP: the patient’s history is deemed questionable since he gave significantly different answers to other team members. He appears clinically well without fever or cough, has O2 saturations above 90%, and has a normal CXR. It is likely that any CAP is resolving. He has been treated with IV ceftriaxone and azithromycin, but ceftriaxone will be discontinued at this time. If he remains afebrile and clinically stable tomorrow, he may be discharged.
2. possible COPD exacerbation: the patient’s PEFR after his last atrovent/albuterol HHN treatment was 450 L/min. He has no wheezes on exam and O2 saturation is high. He is able to speak in long sentences without becoming winded. This exacerbation appears to be resolving. He has been difficult to wean off prednisone per PMD; we will continue his current dose at this time. If he continues to be clinically stable, he will be ready for discharge tomorrow with albuterol and atrovent MDIs and preadmission prednisone Rx.
3. abdominal pain: the patient complains of nausea and vomiting but tolerated his dinner well without problems. There is a possibility that his pain is caused by chronic pancreatitis or peptic ulcer disease. A fecal occult stool test is pending. In either case, he is currently tolerating food well and his HCT is 39.3; we will recommend a GI consult to evaluate his abdominal pain and possible GI bleed.
4. blackouts: these may be due to any number of causes: bleeds, thromboembolic events, infection, tumor, or seizures. His PMD reports that the patient has not complained of these in the past. We will continue to monitor his symptoms and consider brain imaging to rule out mass lesions.
5. seizures: the patient’s dilantin level is elevated. Will decrease his nightly dose from 300 mg to 200 mg and re-check levels in 1 week. He reports occasional seizures on dilantin, but that these happen when his dilantin levels are low.
6. hepatitis C: the patient is currently stable, though has some signs of chronic infection (elevated alk phos and ALT). Will check albumin levels, recommend GI consult to evaluate on a non-emergent basis.
7. diabetes mellitus: the patient has lower extremity findings consistent with venous insufficiency but not arterial insufficiency. He reports some visual changes: will recommend an ophthalmology consult to evaluate vision. Blood sugar is currently well-controlled.
8. heroin IVDU: PMD reports that the patient is currently NOT taking methadone, contradictory to the patient’s report. Will discontinue methadone.
9. endocarditis history, s/p valve replacement surgery: the patient is clinically stable without signs of heart failure. He has been notified that because of his history he will need prophylactic antibiotics before any dental procedures he may have in the future.
Case 6

MS3 Admission H/P

**Chief Problems** Shortness of breath, LE edema

**History of Presenting Illness**

62yo anemic LM presenting with 10 days of SOB, edema, and productive cough. His issues began 11/01 when the pt developed ascites after a 15D course of abx (PCN?). He was treated with Lasix x 10D with resolution of sx. On follow-up visit that month, pt expressed fatigue, weakness, and was dx with anemia. He was subsequently treated with B12 IM injection x 1 and iron tablets x 10 days with some resolution of symptoms. No BRBPR. No dark stools prior to iron supplementation. He denies F/C/N/V at the time. Pt remained asymptomatic until 10 days ago when he developed ascites, bilateral LE edema, DOE, orthopnea, petechiae on LE, and dry skin on face. No clear precipitating factors identified by the patient. Severity of DOE prevents him from walking. Orthopnea required him to sleep sitting in a chair x 10d. Shortly before sx began, pt reports new-onset productive cough with white sputum. He denies current F/C/N/V/diarrhea. He also denies CP, syncope, hemoptysis, wt loss.

**ER Course**

VS: BP 102/67 T36 P 108 R22 98% o2sat RA

Laboratory w/u showed ↑WBC, normocytic anemia, ↓platelets, normal renal fx, ↑Tbili/AlkP (22/156), low albumin (2.5), normal coags, Troponin I neg, normal RUA.

CXR: Prelim reading - R effusion +/- infiltrate with pulmonary vascular congestion.

EKG: ST depression V4-6 with LVH and LAE.

Guiac: Neg

**Past Medical History** – Hospitalized following an accident at 22yo.

**Past Surgical History** – None

**Medications** – FeSO4 TID x 10d

**Allergies** – NKDA

**Social History**

- Tobacco – denies
- EtOH – Drank approx 3 drinks/weekend quitting 12 yrs ago.
- Drugs – Denies IVDU
- Sex – denies HO unprotected sex

**Family History**

- No DM/HTN/CA/CAD
- Mom died of heart-related problem at 86yo.
- Dad died of “old age” at 92yo.

**Review of Symptoms**

- Gen: no f/c/h/v/diarrhea
• Eyes: no vision change
• Ears: occasionally, feels like “thinks sound louder,” but not associated with pain.
• Nose: no epistaxis, rhinorrhea, congestion
• Throat: no dysphagia/odynophagia
• Lungs: +SOB/productive cough
• Heart: +orthopnea/DOE/PND. No CP
• GI: No pain/BRBP. + dark stools only after taking FeSO4 tabs.
• GU: Normal prostate exam 11/01. No dysuria.
• Skin: Dry skin on face x 10 days, Vitiligo on dorsum of feet B x 14 yrs.
• MS: Pain on soles of feet. No joint pain.

PHYSICAL EXAM
Vitals: BP 103/58 P 104 RR 20 T36.9 100%oxSat on 2LNC
General: WD pale male, NAD, resting comfortably in bed, speaking full sentences w/o SOB.
HEENT: NCAT. PERRL, EOMI. MMM, OP clear, no petechiae.
Neck: JVD ↑, carotid pulses 1 +bilaterally
Lungs/Chest: Prominent bilaterally crackles up 2/3 area.
Abdomen: +fluid wave. +BS S/NT/distended. No HSM appreciated.
Back: No TTP. No CVATB.
Neuro: CN III-XII grossly intact.

TEST RESULTS
• CXR (PRELIM)- r EFFUSION +/- INFILTRATE. Pulmonary vascular congestion.
• EKG- ST ↓ V4-V6, LVH, LAE.
• Echo (TTE)- EF=35%, severe AS with heavily calcified valve with area 0.6cm2, severe MR, LAE

ASSESSMENT AND PLAN
62 yo male presenting with acute exacerbation of chronic CHF secondary to severe aortic stenosis, and normocytic anemia of unknown origin.
1) Aortic Stenosis – Echo showed severely stenosed valve. LVH, LAE, MR, LHF, RHF, and both murmurs can be attributed to AS. However, pt lacks the classic sx of CP and syncope. Also, we would have expected the pt to be symptomatic before 10D ago. Several issues need to be r/o as causes of CHF exacerbation including infection, ischemia, and thyrotoxicosis. N1 RUA rules out UTI.
• Digoxin 0.25mg PO qd for inotropic tx.
• Lasix 40mg IV q6hrs to reduce fluid overload.
• Avoid ACEI, nitrates, MSO4, beta blockers to protect BP.
• Valve is heavily calcified and needs repair per cardiology. Mitral valve will also require repair once CHF sx clears. Other tests to do include catheterization and angiography per cardiology.
2) **R/O Endocarditis** – Pt is presenting with 2 new prominent murmurs not detected in prior examinations. Infection is a potential precipitant of current CHF sx with ↑WBC, left shift, and petechiae supporting this dx. However, pt is afebrile. We will treat prophylactically until ruled out.

- Ampicillin 2g IV p6hr
- Gentamicin 80mg IV q8hr
- Vancomycin 1200mg Q12hr, anticipating ID approval
- Oxacillin 2g IV q4hr
- Other labs: ESR, AM CBC, BCx x3 looking for HACEK organisms.

3) **R/o Myocardial ischemia** – EKG showed ST ↓ in V4-V6. Ischemia can ppt CHF sx. 1st Troponin I was negative. Continue to r/o.

- Troponin I levels.
- Lipid levels – looking for other coronary risk factors

4) **R/o Pneumonia** – Preliminary report shows possible infiltrate in RLL. That and history of productive cough for a few weeks with SOB and ↑WBCs suggest pneumonia, but pt is afebrile.

- Will f/u on CXR reading.

5) **Normocytic anemia** – H/H is 11/33.5 with a normocytic picture. ↑Tbili suggests hemolysis. DDx includes hemolysis (RBC-drug hapten?), acute hemorrhage, mixed (Fe def with B12/folate def), chronic disease, hypothyroidism.

- Reticulocyte Ct P
- Blood smear P
- Fe/Ferritin/TIBC P
- B12/Folate levels P
- Direct Bilirubin P
- TSH

6) **FEN/Renal** –
   a) ↓K – Repleated in ED with KC1 40mEq x 1. Will check Chem 10 in AM
   b) ↑BUN/Cr ratio – Suggests prerenal problem consistent with CHF. Will monitor with chemistry panel.
   c) Edema – Could edema and low albumin be caused by nephrotic syndrome? Unlikely considering no proteinuria.

7) **GI**
   a) ↓Albumin – Consistent with picture of edema. Compromised liver synthetic function would account for this, but AST/ALT are wn1, and coagulation is wn1. This is possibly due to nutritional deficiency.