Identifying Data:

Full Name: Mr. M

Address: Queens, NY

Date & Time: December 1st, 2020

Location: NYHQ-IM, Queens New York

Religion: Christianity

Nationality: African American

Marital status: single

Source of Information: Self/ Brother

Source of Referral: self

Mode of Transport: private car

**Chief Complaint:** “I have lower belly pain” x 3 days

76 year old Africaan American Male with PMHx of DM II, HTN, CHF (EF 20-25%), prostate cancer stage 4 w/bone metastasis in remission, and inguinal hernia, presents to ED (11/28/20) complaining abdominal pain, more prominent on the RLQ and suprapubic for the past 3 days. According to the patient's brother who lives with him, after lunch (11/25/20), the patient started to complain of vague suprapubic pain. Patient’s brother brought him to the ER as the pain had worsened, and the patient was unable to urinate for the past 2 days. Upon arrival at the ER, the patient appears to be in distress but alert and oriented. Patient describes the pain as an intermittent, sharp, stabbing sensation, 9/10 radiating pain to the back. The pain aggravates with movement and alleviates with laying still. Patient reported that he has been fasting intentionally for the past 3 days because he has no appetite to eat or drink as the pain worsens with food. Patient reported the last bowel movement was yesterday, and it was normal. Patient’s brother mentioned that the patient stopped taking all his medications around one month ago because he believes in holism. At ED, bedside bladder scan showed >400cc retention and foley inserted with more than 1 L of drainage. Renal ultrasound showed mild right hydronephrosis, large bilateral renal cysts measuring up to 7.3 cm, Prostamegaly, trace perihepatic ascites. In ED, a chest Xray was ordered, which showed right infrahilar scarring/chronic atelectasis with elevation of the right hemidiaphragm but no pleural effusions, consolidations or pneumothorax. Following the foley catheter, the patient was stabilized, but the patient was admitted to the internal medicine service further monitoring.

Today the patient is complaining of mild constant dull suprapubic, nonradiating, 5/10 pain. Patient was seen by the urology service on 11/30/20; Foley was discontinued and Flomax was started. Patient reported feeling well yesterday, but since today morning he has not urinated. Bedside bladder scan on 12/1/20 showed >1327cc retention thus foley was replaced. Patient denies fever, chills, nausea, vomiting, urinary symptoms, headache, dizziness, vision changes, odynophagia, palpitations, epigastric pain, falls, melena and BRBPR. Patient denies recent trauma to the abdominal region, recent travel, or sick contact.

**Past Medical History:**

Type 2 Diabetes- about 15 years

Hypertension- about 13-15 years

CHF (EF 20-25%)- about 3-4 years

Prostate cancer stage 4 w/bone metastasis in remission-2-3 years

Inguinal hernia

Chronic normocytic anemia

Past Surgical History:

Bilateral inguinal hernia repair about 10 years ago on NYPQ queens, with no complications.

**Medications:**

Ferrous sulfate 325 mg 1 tab(s) orally 3 times a day -Indication: chronic anemia

Spironolactone 25 mg 1 tab(s) orally 2 times a day -Indication:HTN

Carvedilol 12.5 mg 1 tab(s) orally 2 times a day -Indication: HTN

Metformin 500 mg 1 tab(s) orally 2 times a day -Indication: DMII

Furosemide 40 mg 1 tab(s) orally once a day -Indication: CHF,

Entresto 24 mg-26 mg 1 tab(s) orally 2 times a day -Indication: CHF

**Allergies:** no known allergies

**Family History:**

Mother and father deceased of unknown cause and age. Family history noncontributory.

Brothers: 65 years old healthy with diet modified hypertension

**Social History:**

Mr. M is a single male, living with his brother and his family in a private house

Habits –no history of smoking or alcohol or illicit drug use

Travel - recently did not travel.

Diet - He has a fast food diet and admits of eating fruits and vegetables occasionally

Exercise – He likes to walk around in his neighborhood and spend time in the park with his friends.

**Review of Systems:**

General – Admits of generalized weakness and loss of appetite. Denies fever, chills, recent weight or night sweats.

Skin, hair, nails –Denies changes in texture, excessive dryness, discolorations, pigmentations, moles, sweating, changes in hair distribution rashes and pruritus.

Head –Denies headaches, vertigo or head trauma.

Eyes –denies lacrimation, visual disturbances (diplopia), pruritus, and photophobia. Last eye exam was years ago and uses reading glasses

Ears – Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses –Denies discharge, obstruction or epistaxis.

Mouth/throat –Denies bleeding gums, sore tough, sore throat, mouth ulcers, voice change Last dental- about 2-3 years ago

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion

Pulmonary system – Denies wheezing, dyspnea, cough, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – admits to mild edema/swelling of ankles denies irregular heartbeat, chest pain, palpitations, syncope or murmur.

Gastrointestinal system –Has regular bowel movements every other day. Recently experiencing decrease in appetite, abdominal pain. Denies intolerance to spicy food, dysphagia, pyrosis, flatulence, eructation, and constipation, nausea,vomiting, diarrhea, jaundice, hemorrhoids, rectal bleeding, or blood in stool.

Genitourinary system – Admits of oliguria Denies urinary frequency, urgency, nocturia, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain.

Sexual Hx - based on chart review, he is not currently sexually active. Denies history of sexually transmitted diseases.

Nervous system- Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, change in cognition / mental status / memory, or weakness.

Musculoskeletal system- Denies muscle pain, groin pain & calf swelling and erythema

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, color changes.

Hematological system – denies blood transfusions, history of previous DVT/PE, easy bruising or bleeding, lymph node enlargement.

Endocrine system – Denies heat intolerance, hirsutism polyuria, polydipsia polyphagia, or goiter

Psychiatric – denies depression/sadness, anxiety, OCD or ever seeing a mental health professional.

**Physical**

General: well-developed male, A/O x 3 , facial features symmetric. Pt is tall and skinny, appears to be reported age, moderate hygiene. Pt appears clean, cooperative, speaks in full sentences in a very soft voice and appears to be in no physical distress.

Vital Signs:

BP: 166/110 laying right arm

T 39.9 celsius oral

HR- 112 bpm

SPO2- 95% room air

RR: 18

Height: 72 inches

Weight 140 Lb

BMI:19.0

Nails**:** no sign of clubbing, cyanosis, koilonychia, paronychia. capillary refill <2 seconds throughout.

Skin:warm & moist and smooth to touch, good turgor. Nonicteric, no evidence of mass, lesions, scars or tattoos but bilateral lower extremities hyperpigmented scabs were noted.

Hair:medium quantity, course and evenly distributed without any sign of alopecia, no nits or seborrhea noted.

Head:normocephalic, atraumatic, no specific facies. non -tender to palpation throughout

Eyes: Symmetrical OU; no evidence of strabismus, exophthalmos, ectropion, entropion, ptosis, edema, inflammation, crusting, discharge; Lacrimal gland does not seem enlarged. Sclera white; conjunctiva & cornea clear. Visual fields are intact in all four quadrants. PERRL, EOMs intact with no nystagmus.

Ears:Symmetrical, no evidence of mass, lesion, erythema, inflammation, ear canal atresia. Non tender to palpation

**Auditory Acuity:** whisper test**,** intact to whispered voice AU**.**

Nose:Symmetrical, no evidence of mass, lesion, deformities, erythema, inflammation. Non-tender to palpation and no step-off. no evidence of nasal obstruction

Sinuses - Non tender to palpation

**Mouth & pharynx:**

Lips - Pink, moist; no evidence of cyanosis or lesions.

Mucosa - Pink ; well hydrated. No masses; lesions noted. No evidence of leukoplakia or oral candidiasis

Palate – Pink; well hydrated. Palate intact with no lesions; masses; scars.

Teeth – good dentition

Gingivae –Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge.

Tongue-Pink; no lesions or deviation noted.   
Oropharynx - Well hydrated; no evidence of injection; exudate; masses; lesions; foreign bodies.

Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions

**Neck, trachea, thyroid:**

Neck - Trachea midline. No masses; lesions; scars; pulsations noted. Non-tender to

Palpation no thrills or bruits, no adenopathy noted.

Thyroid - Non-tender; no palpable masses; no bruits noted.

Chest - Symmetrical chest wall movement, no evidence of deformities, kyphosis, scoliosis, masses, lesions, cyanosis. no evidence of trauma. Respirations rate normal and unlabored with no paradoxical respirations or use of accessory muscles noted. Lat to AP diameter 2 :1 no evidence of barrel chest. Non-tender to palpation.

Lungs - Clear to auscultation, Tactile fremitus intact throughout. No adventitious sounds.

Heart:  Regular rate and rhythm (RRR); S1 and S2 are normal, no evidence of JVP and carotid pulses are 2+ bilaterally without bruits, but no evidence of S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

Abdomen: Flat / symmetrical / no evidence of caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits noted over aortic/renal/iliac. Tympany to percussion throughout. tender to deep palpation in the suprapubic area. No evidence of hepatomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

**Rectal Exam**: patient refused a rectal exam. Based on the ER notes: rectal exam suggests the prostate is enlarged, nodular, asymmetrical and non-tender.

Peripheral Vascular: Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. no clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted.

Musculoskeletal system: no ecchymosis / atrophy / deformities in bilateral upper and lower extremities. Active range of motion in upper and lower extremities bilaterally. Muscle strength is 5/5 all throughout the body.

Neurologic: Mental Status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact.Cranial nerves grossly intact, thought coherent. No evidence of dysarthria, dysphonia or aphasia noted.

**Labs:**

UA- Appearance:yellow / Clear, pH: 6.0, glucose: 100, protein: 100, ketones: Trace, blood: Large, glucose: 100, nitrite: Negative, leuk est: Trace

UA culture: RBC: >100, WBC: 9, Bacteria: Positive

WBC: 13.13 / Hb: 11.5 (MCV: 93.8) / Hct: 35.0 / Plt: 150

-- Diff: N:74.00% L:10.00% Mo:14.00% Eo:1.00%

Prot: 7.2 / Alb: 4.2 / Bili: 0.7 / AST: 18 / AlkPhos: 224 / Lip: 12

134 | 97 | 51.6

--------------------< 211 Ca: 8.8 Anion Gap: 17

4.8 | 20 | 4.56

**Imaging:**

EKG:

sinus tachy HR 105, PVC, LVH, PR 160, QTC 381.

CXR:

IMPRESSION: Right infrahilar scarring/chronic atelectasis and/or atelectasis with elevation of the right hemidiaphragm.No pleural effusions. No pneumothorax.

US renal/Bladder:

IMPRESSION:

1. Mild right hydronephrosis, less pronounced compared to the prior study
2. Large bilateral renal cysts measuring up to 7.3 cm.
3. Prostamegaly.
4. Trace perihepatic ascites

**Differential Diagnosis:**

1. Acute Kidney Injury
2. Urinary tract Infection
3. Urinary Retention
4. Pyelonephritis
5. Appendicitis

**Assessment:**

76 year old Africaan American Male with PMHx of DM II, HTN, CHF (EF 20-25%), prostate cancer stage 4 w/bone metastasis in remission, and inguinal hernia, presents to ED complaining abdominal pain, more prominent on the RLQ and suprapubic for the past 3 days. Patient’s decreased urinary output and remarkable creatinine of 4.5 is suggestive of Acute Kidney Injury.

**Active problem list:**

1. Acute Kidney Injury
2. Urinary Tract Infection
3. CHF
4. HTN
5. DM II
6. Chronic normocytic anemia

**Plan**:

1. Acute Kidney Injury

* hold diuretics
* 11/30 foley d/c'ed and started Flomax - f/u TOV
* 12/1/20- foley was replaced as bedside bladder scan shown >1300cc retention
* renal consulted: f/u recs

1. Urinary Tract Infection

* s/p empiric cefepime - no need for further ABX

1. CHF, HTN

* TTE on 12/2019, EF 20-25. dilated LV, severely reduced LV function.
* hold home meds Entresto, Spironolactone, Furosemide

1. DM II

* hold metformin- initiate Insulin Sliding Scale (ISS).

1. Chronic normocytic anemia

* continue home med ferrous sulfate
* H/H 11.5/35 (baseline 10.5/34 in 12/2019)