Identifying Data:

Full Name: Mr. T

Address:  Queens, NY

Date & Time: December 9th, 2020

Location: NYHQ-IM, Queens New York

Religion: Christianity

Nationality: African American

Marital status: single

Source of Information: Self

Source of Referral: self

Mode of Transport: private car

**Chief Complaint:** “I have chest pain” x 1 day

64 year old male, retired warehouse worker, living with his sister in a private house with PMHx of former smoker (quit 15 years ago) HTN (not on medication), HLD, kidney stones s/p stents presented to the ED (12/08/2020) complaining of substernal chest pain for one day. Patient states that the chest pain began while he was laying down on the sofa watching TV. Patient describes the pain substernal, felt like tightness, 8/10 radiating down the left arm, and lasted for 1-2 minutes. Patient never experienced this type of pain before and even though the chest pain subsided he was continuously feeling tingling and spasm on the left arm. Patient tried taking an aspirin 81mg 1 tablet with mild to no relief. Patient was worried so his sister brought him to the emergency room. Patient reports orthopnea for the past one month but he denies diaphoresis or SOB at that time of chest pain. During evaluation in ED, patients denied chest pain, SOB, abdominal pain, fever or chills, nausea, vomiting, diarrhea, headache, or dizziness. In ED, ECG was done which showed sinus HR 80, PR 151, QRS 110, QTc 500, minimal T wave inversions in aVR, V1, no ST elevation, no changes from 7/2019. Chest x ray impression was unremarkable as there were no pulmonary infiltrate, effusion or consolidation. Troponin trend 3 negative (<0.010). Patient was admitted to the internal Medicine floor for further evaluation and monitoring.

Today the patient appears comfortable. Alert and oriented with no acute complaint of chest pain or shortness of breath. Patient states he has not felt chest pain since he arrived in the ER and he is feeling well. Patient reports that he last saw a cardiologist in 2018 for a check up and a stress test and angiogram were done and everything was normal at that time. Patient denies family history of cardiac disease.

**Differential Diagnosis:**

1. Myocardial Infarction
2. Unstable Angina
3. Stable Angina
4. GERD
5. Costochondritis

**Past Medical History:**

HTN, HLD, kidney stone

**Past Surgical History:**

s/p Bilateral Percutaneous Nephrostomy Tube Urology **(**PCNT) (3/16/18) B PCNT exchanged (6/18/18)-> B PCNU (6/29/18), B PCNU change (9/25), B/L PCNU change (10/12), L PCNL with ureteral stent placement (10/16/18), Cyto, left URS, laser lithotripsy, left stent exchange (11/6/18)

**Home medication:**

Simvastatin 20mg orally once a day at bedtime for HLD

Aspirin 81mg orally once a day

**Hospital Medication**

Carvedilol 3.125mg oral every 12 hours

Aspirin TAb 81mg oral daily

Atorvastatin 10mg oral at bedtime

Docusate sodium cap 100mg oral TID

**Allergies:** no known allergies

**Family History:**

Mother - dies at the age of 67 due to lung cancer

Father- died at the age of 72 due to prostate cancer

Sister: 63 years old healthy with diet modified diabetes

**Social History:**

Mr. T is a single male who lives with his sister in a private 2nd floor house.

Habits –former smoker (smoked 1 pack a day for 20 years) and quitted 15 years ago, denies alcohol or illicit drug use.

Travel - recently did not travel.

Diet - He reports of eating lots of green vegetables, salad, whole wheat bread, lean meat.

Exercise – He likes to walk around and he lives in a hilly area so if the weather permits he likes walking around his house.

**Review of Systems:**

General – Denies generalized weakness, fatigue, 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.

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 1 year 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 –denies irregular heartbeat, chest pain, palpitations, edema/swelling of ankles, syncope or murmur.

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

Genitourinary system –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, appears to be reported age, good hygiene. Pt appears clean, cooperative, speaks in full sentences and appears to be in no physical distress.

Vital Signs:

BP: 131/78

T 36.7 celsius oral

HR- 68

SPO2- 98%

RR: 18

Height: 71

Weight 213 Lb

BMI: 29.7

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.

Hair:good quantity, rough 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 with few filling.

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. No adventitious sounds.

Heart:  Regular rate and rhythm (RRR); S1 and S2 are normal, no evidence of JVD 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.

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

**Labs:**

141 | 105 | 28.4

--------------------< 92 Ca: 9.1 Anion Gap: 14

4.3 | 22 | 2.22

WBC: 7.48 / Hb: 13.0 (MCV: 93.9) / Hct: 41.8 / Plt: 243

 -- Diff: N:67.9% L:17.90% Mo:10.3%

**Imaging:**

Myocardial Stress Test:

Nuclear SPECT analysis reveals a large size, severe intensity defect in the entire inferior wall and apical walls in rest that partially improves with stress and partially corrects with prone. There is global hypokinesis

**Impression:** abnormal study. Nonischemic cardiomyopathy with small area of infarct involving the apex

**Assessment:**

64 year old male, retired warehouse worker, living with his sister in a private house with PMHx of former smoker (quit 15 years ago) HTN (not on medication), HLD, kidney stones s/p stents admitted to the internal medicine floor for chest pain x 1 days. Patients clinical presentation and labs suggest tele monitoring and ACS workup.

**Plan:**

Chest pain

* Continue tele monitoring
* Repeat EKG in the morning
* Continue Statin, carvedilol and ASA
* f/u lipid, a1c, BNP, TSH
* Cardiologist consulted, stress ECHO was abnormal with nonischemic cardiomyopathy.

Elevated BUN/CR [CKD ]

* Cr 2.22 today and if it worsen tomorrow then consider US renal ultrasound and Neurology consultation
* avoid nephrotoxic agents

**Patient Education**

* Patient was advised to follow up with the PCP annually
* Patient was advised to follow up with cardiology and Neurology
* Avoid fatty and oily food and increase the amount of leafy greens, vegetables and fruits in daily diet
* Patient was advised to the medication as prescribed
* Patient was advised to get at least 30 mins of moderate exercise everyday