Emily Yeung
Rotation 7: Long Term Care, Gouverner
Final Site Evaluation

Identification:

- Date: 09/16/19
- Time: 9:30 AM
- Name: MB
- Sex: F
- Race: White
- Age: 94
- Marital status: Widowed
- Address: Long Term Care, Gouverner

Informant:

- Source of history: Patient and son, reliable

Referral Source: Mount Sinai

Chief Complaint:

- “Mild, crampy abdominal pain x 2 days”

Present Illness:
94 y/o female with PMHx aortic stenosis s/p bioprosthetic AVR, CAD s/p CABG (2004), CKD stage IV, pre-DM, HTN, diverticulitis, presented to ED BIBEMS activated by rehab center c/o “mild, crampy abdominal pain x 2 days”. Patient states that pain is mildly burning, crampy, and all over the abdomen but does not radiate elsewhere. Pain started about 2-3 hours after eating dinner two days ago and was on and off at first but progressed to a constant pain one day ago. Patient also presented with coffee-ground emesis with dark, tarry stools. Of note, from 7/24-8/9, patient was admitted to MSBI for coffee-ground emesis. She was intubated for airway protection and received 2U PRBCs, pantoprazole 80mg IVP. Esophagogastroduodenoscopy revealed 3 non-bleeding duodenal ulcers. Patient was then extubated but developed hypoxic respiratory failure secondary to suspected aspiration PNA.

On medicine floor, patient received 3U PRBC, which improved Hb to 7. Hospital course was later complicated by respiratory distress and RRT was called on 8/25/19 at 8:30PM. Cardiac auscultation revealed tachycardia and RUSB systolic murmur and lungs showed coarse crackles bilaterally. Respiratory distress thought to be secondary to fluid overload vs. aspiration PNA, complicated by anxiety. After receiving Lasix 40mg IVP, duoneb 3mL neb, lorazepam 0.5mg, she was transferred to MICU on BiPAP but was eventually transitioned to room air. On 8/28, patient started having multiple bloody BM with frank bleeding from rectum. Hb dropped to 6.8 overnight and 1U PRBC was given. Patient was transferred back to the medicine floor on 8/30.

On medicine floor, patient continued to have frank bloody BM for a few days that needed an additional 2U PRBC. GI recommended anusol, manual disimpaction, bowel regimen but patient was at high risk for procedural intervention. Colorectal surg was consulted and recommended no

surgical intervention at this time. Cardio increased Lasix to 80mg for fluid overload and recommended against anti-coagulation due to GI bleed. On 9/6, pt had another copious bloody BM with frank blood and 1U PRBC was given, with total 7U for this admission. She was found to be highly impacted, also confirmed by KUB. Bisacodyl suppository was added on top of oral bowel regimen for more aggressive disimpaction with tap water enema. After, patient did not have any more bloody BM with stable Hg but reported to have multiple copious, malodorous watery/pasty BM. Upon d/c, patient's bowel regimen was optimized and BM was stabilized with daily non-bloody stools. Aspirin is being held 2/2 to risk of recurrent GIB.

Currently, patient denies any active pain but still experiences mild discomfort all over the abdomen. She admits to having less frequent, less malodorous BM without any blood. Otherwise, she denies any HA, vision changes, dizziness, LOC, N/V/D/C, SOB, cough, chest pain, rectal bleeding, taking NSAIDs, ETOH/steroid use.

Past Medical History:

- Aortic stenosis, diagnosed over 30 years ago.
- HTN, diagnosed over 30 years ago.
- CAD, diagnosed over 20 years ago.
- Pre-diabetic
- Diverticulitis
- Anxiety
- CKD stage IV
- Patient is up to date with her immunizations.
- Patient admits to having chickenpox during childhood but denies any other childhood illnesses.

Past Surgical History:

- Aortic stenosis s/p bioprosthetic AVR 20 years ago at Mount Sinai, no complications.
- CAD s/p 1 v/s CABG in 2004 at Mount Sinai, no complications.
- Patient cannot recall other hospitalizations.
- Denies past transfusions or injuries.

Medications:

- Amlodipine 10mg tab, 1 tab PO once daily
- Quinapril 20mg tab, 1 tab PO once daily
- Aspirin 81mg, 1 tab PO once daily
- Furosemide 20mg tab, 1 tab PO once daily

Allergies:

- No known drug allergies.
- Denies any food or environmental allergies.

Family History:

- Mother, deceased due to old age.
- Father, CAD, HLD, deceased from stroke at age 78.
- Son, alive and well.

Social History:

- Nonsmoker.
- Denies drinking caffeine or alcohol at present.
- Sleeps 6.5 hours per day, on average.
- Denies exercising regularly due to difficulty ambulating.
- Lives alone in apartment (3rd floor) with elevator, independent ADLs with walker use.
- Occupation: retired.
- Denies being sexually active currently, any past or current STIs, or contraceptive use.
- Patient is DNR/DNI.

ROS

- General
  - Admits to fatigue.
  - Denies any recent weight gain/loss, fever, chills, night sweats, loss of appetite.
- Skin, hair and nails
  - Denies any discoloration, moles, pruritus, changes in hair distribution, excessive dryness/sweating, change in hair/skin texture, lacerations.
- Head
  - Denies headache, vertigo, lightheadedness, head trauma, facial swelling.
- Eyes
  - Denies photophobia, pruritus, blurring, diplopia, lacrimation, other visual disturbances. Wears glasses for reading. Last eye exam years ago.
- Ears
  - Admits to difficulty hearing on left ear.
  - Denies any deafness, pain, discharge.
- Nose/Sinuses
  - Denies any epistaxis, obstruction, discharge, congestion.
- Mouth and throat
  - Denies any dry mouth/lips, bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, use of dentures. Last dental exam years ago.
- Neck
  - Denies localized swelling/lumps, stiffness/decreased range of motion.
- Breast
  - Denies any lumps, nipple discharge, pain.
- Pulmonary system
  - Denies any cough, SOB, wheezing, hemoptysis, cyanosis, orthopnea, PND, choking, chest tightness, stridor.
- Cardiovascular system
  - Admits to heart murmur.
  - Denies any chest pain, palpitations, irregular heartbeat, syncope, edema.
- Gastrointestinal system
  - Admits to generalized abdominal discomfort.
  - Denies any N/V/D/C, indigestion, heartburn, flatulence, diarrhea, jaundice, anal bleeding, rectal pain, loss of appetite, bloating.
  - Has one BM every day.
- Genitourinary system

    - Denies any frequency, polyuria, urgency, nocturia, hematuria, oliguria, dysuria, incontinence, flank pain.
- Menstrual and Obstetrical
    - Age of menarche = many years ago.
    - LMP = many years ago.
    - G1P1. Last GYN visit 3 years ago, WNL.
- Nervous system
    - Denies headaches, sensory disturbances, ataxia, change in cognition, LOC, loss of strength/weakness, slowing of speech.
- Musculoskeletal system
    - Denies current joint/muscle pain, deformity, erythema, edema, tenderness, arthritis.
- Peripheral vascular system
    - Denies any peripheral edema, intermittent claudication, varicose veins.
- Hematologic system
    - Denies any easy bruising, bleeding, lymph node enlargement, blood transfusions.
- Endocrine system
    - Denies any polyuria, polydipsia, polyphagia, goiter, excessive sweating, Hirsutism, heat intolerance.
- Psychiatric
    - Admits to anxiety. Last seen mental health specialist/therapist half a year ago.

General Survey:
- Small build female, frail but well nourished, looks stated age of 94 years, resting comfortably, breathing unlabored. A/O x3.

Vital Signs:

	09/06/2019 8:30AM
Blood Pressure	110/68, bilateral arms, lying
Heart Rate	74 bpm, regular
Respiratory Rate	18 breaths per min, unlabored
O2 Sat	98%, 2-3L NC
Temperature	97.8°F, orally

- Height: 5 ft 0 inches
- Weight: 101 lbs.
- BMI: 19.7

Physical Examination:
- General appearance: alert, frail but well nourished, NAD.

- Skin: warm and dry, moist, no rash. 4cm x 3cm unstageable pressure injury at sacrococcyx covered with dressing. No odor, discharge, periwound erythema, fluctuance, or induration.
- HEENT: normocephalic, atraumatic. Nasal cannula in place.
- Nails: No clubbing, capillary refill <2 seconds throughout.
- Eyes: sclera non-icteric, +conjunctival pallor.
- Throat: clear, no erythema or exudates, uvula midline.
- Lymph nodes: unremarkable.
- Chest: symmetrical, no deformities, trauma. Respirations unlabored.
- Lungs: Clear to auscultation and percussion bilaterally, no wheezes, rales, rhonchi.
- Heart: RRR, normal S1, S2. +RUSB systolic murmur 2/6. No JVD.
- Abdomen: Soft, non-tender, BS present in all 4 quadrants. No guarding or rigidity, no hepatosplenomegaly, no hernias, masses palpable.
- Peripheral vascular: extremities unremarkable in color, size, temperature. Pulses are 2+ bilaterally in upper and lower extremities.
- Neurologic exam: A/O x3, verbal, follows commands, able to communicate needs and wants. Cranial nerves II-VII intact. CN II-VII intact. Strength symmetric and intact. MMSE: 22.
- Musculoskeletal: No soft tissue swelling, erythema, ecchymosis, atrophy, deformities in upper and lower extremities. Non-tender to palpation. No crepitus.
- Psychiatry: cooperative, good eye contact, speech clear.

Lab Results & Radiological Studies (per chart review upon d/c on 9/14/19)

- CBC with differential
  - WBC: 6.75
  - RBC: 2.50 (L)
  - HBG: 7.4 (L)
  - HCT: 25.3 (L)
  - MCV: 101.2 (H)
  - MCH: 29.6
  - MCHC: 29.2
  - RDW: 20.7 (H)
  - PLTS: 246
- BMP:
  - Na: 143
  - K: 4.8
  - Cl: 103
  - CO2: 29.0
  - BUN: 20
  - Cr: 1.19
  - Ca: 8.9
  - eGFR: 39 (L)
- HBG A1C: 5.4
- B12: 1371 (H)
- CXR: Surgical changes status post AVR. Small right pleural effusion and dense left pleural calcification. No PNA or CHF.
- EKG: NSR. Left axis deviation due to old LBBB. Peaked T-waves in V1-V3 (old finding)
- PT note

    - Patient is a 94 y/o female presenting with generalized deconditioning, reduced activity tolerance and difficulty standing/ambulating. Pt requires mod assist for bed mobs and supine to sit transfers and max assist for sit to stand transfers with RW. Attempted to ambulate at this time but unable to do so safely secondary to weakness. Pt will benefit from continued PT services to progress towards functional goals as per PT IE.
    - Plan: Continue bedside treatment 3-5 times per week with goals, pt can tolerate 1-2 hours of therapy per day.
- Consult note: sacrococcyx pressure injury
    - F/u unstageable sacrococcyx pressure that was present in admission.
    - 4cm x 3cm unstageable pressure injury sacrococcyx covered with yellow/tan adherent eschar. There is no odor or discharge. There is no periwound erythema, fluctuance, or induration.
    - Recommendation: Apply Santyl Collagenase to pressure injury daily. After applying collagenase, apply small amount of Solosite gel on top and cover with foam dressing. Continue to pressure injury prevention protocol.

Assessment: 94 y/o female with PMHx AS, CAD, pre-DM, HTN, CKD stage IV, diverticulitis presented with mild, crampy abdominal pain, coffee-ground emesis and anemia concerning for upper GI bleed.

Differentials:
- Upper GI bleed from ulcer
    - Clinical sx significant for coffee-ground emesis, dark stools, weakness, fatigue
    - H/H on d/c 7.4/25.3
    - EGD revealed 3 non-bleeding duodenal ulcers
    - Patient could have gastric ulcer
- PUD
    - Most common cause of upper GI bleed
    - Although patient does not take NSAIDs, may be stress related from prior hospitalizations, risk increased in patients with respiratory failure/coagulopathy
- Gastritis/duodenitis
    - Check for H. pylori infection
- Esophageal varices
    - Usually occurs in patients with liver disease or portal HTN
    - May account for episodes of emesis and dark, tarry stool, can check for hepatic function
- Diverticulitis
    - Hx of diverticulitis
    - May account for dark, tarry stool

1. Gastroduodenal ulcer
- Clinical sx significant for coffee-ground emesis, dark stools, weakness, fatigue
- Currently hemodynamically stable, H/H 7.4/25.3

2. Aortic stenosis

- S/p AVR, TTE to assess severity

3. HTN
    - BP under good control, stable at 110/68

4. CAD
    - S/p CABG
    - Currently asymptomatic, cardiac exam normal, no reported chest pain

5. Pre-diabetes
    - Currently asymptomatic, HgA1c 5.4

6. Anxiety
    - Patient is doing well with quetiapine, has no c/o

7. CKD stage IV
    - BUN/Cr at 20/1.19
    - Patient is at baseline, dialysis not warranted as GFR >15

8. Respiratory distress
    - Currently asymptomatic, O2 sat 97% with 2-3L O2 via NC

9. Sacralcoccyx pressure ulcer
    - Currently unstageable without procedural intervention

Plan:

1. Gastroduodenal ulcer
    - Currently hemodynamically stable w/o bloody BM
    - H/H on ED admission was 5.2/17.2, baseline was 8-9 from 2 months ago
    - Continue omeprazole 20mg tab, 2 tabs PO q12h
    - CBC q8h, transfuse if symptomatic and Hb >7
    - Repeat vitals q6h

2. Aortic stenosis
    - S/p AVR, currently asymptomatic
    - Order TTE to assess severity
    - Holding aspirin until hemodynamically stable + risk of recurrent GI bleed decreases

3. HTN
    - BP under good control, stable at 110/68
    - Continue metoprolol succinate ER 50mg tab, 1 tab PO once daily, hold for SBP <110, HR <60
    - Continue furosemide 40mg tab, 1 tab PO once daily, hold for SBP <110

4. CAD
    - S/p CABG
    - Currently asymptomatic, cardiac exam normal, no reported chest pain

5. Pre-diabetes
    - Currently asymptomatic, HgA1c 5.4
    - Continue Kosher diet, pureed texture, thin consistency
    - Increase oral hygiene, sit upright after PO for 2-3 hours

6. Anxiety
    - Continue quetiapine 25mg tab, 0.4mg PO QHS

7. CKD stage IV
    - BUN/Cr at 20/1.19, continue monitoring renal function

8. Respiratory distress
    - Continue O2 2L-3L via NC continuously
    - Continue albuterol 108mcg, 1 puff q4h prn

9. Sacralcoccyx pressure ulcer
    - Wound consult
    - Continue triad hydrophilic wound dress paste, apply to sacrum topically every day for wound care
    - Monitor for s/sx infection
    - Change bed position q2h

10. Fall precautions
    - Patient educated on safety/technique with functional transfers, safety in room +call bell, role of OT, verbalizes understanding

Patient Education:

- GI bleed
    - Pt's GI bleed most likely from ulcers in stomach or in small intestine
    - Important to avoid NSAIDs (aspirin, ibuprofen, naproxen), thus holding off aspirin until risk of subsequent GI bleed decreases
    - Important to take omeprazole to decrease irritation in stomach
    - If there is bright red blood or coffee grounds in vomit, blood in stool, or if you experience any dizziness, LOC, return to ED immediately
- Wound care
    - Applying triad hydrophilic wound dress paste would minimize risk of subsequent infection
    - Important to change bed position every 2 hours to prevent subsequent ulcer formation
- Pain management
    - Only need Tylenol for mild to moderate pain as there are side effects such as nausea, abdominal pain, rash, bad for liver
- Occupational therapy

- Although patient is able to perform ADLs alone at home, she has been experiencing generalized deconditioning, reduced activity tolerance and difficulty standing/ambulating since hospital admission.
- Pt will benefit from continued PT services to progress towards functional goals