Dr. Davidson

LTC Site Evaluation 2 HP 1

Jay Kolasinac

10/01/2021

Identifying Information:

- Name: J.R.
- Sex: Female
- DOB: */*/1930 – 91-years-old
- Date: 9/27/2021 @ 9:00 AM
- Location: NYPQ - Flushing, Queens, NY - ED
- Source of Information: Self, daughter
- Source of Referral/Mode of Transport: Car
- Translator: Russian

CC:

Abnormal outpatient CT (+) for pulmonary embolism sent in by nursing home

HPI:

Patient is a 91-year-old female with PMHx of HTN, HLD, TIA, Renal cell carcinoma (L) s/p nephrectomy June 2021, and arthritis, who is wheelchair bound, is sent in from NH for an abnormal outpatient CT with (+) pulmonary embolus. Patient was awake, alert, oriented but unable to provide proper history - poor historian. As per patient's daughter, who had stated that a CT with IV contrast was done to assess for metastasis given patient's history of renal cell carcinoma; however, the CT was noted with an incidental finding of pulmonary embolus; thus, patient was sent to the ED for further evaluation.

At time of bedside evaluation on 9/27, patient denied any acute chest pain, difficulty breathing, cough, hemoptysis, or prior symptoms of blood clots in the past. No other acute complaints. Patient denied fever, chills, nausea, vomiting, melena, abdominal pain or urinary symptoms at that time.

Venous US of B/L lower extremities were performed, and thrombi were seen within the right common femoral vein, left common femoral, left femoral, left popliteal, and left posterior tibial veins. Patient was started on heparin drip and transitioned to Eliquis.

Next day, on 9/28, patient had developed new onset of left facial droop and left-hand weakness. NIHSS - 6 for left arm/leg weakness, facial sensory loss, and dysarthria. STAT CT was ordered – no acute intracranial hemorrhage or evidence of acute infarct. Chronic appearing lacunar infarcts in the left thalamus and right basal ganglia. Non-contrast MRI was ordered – Acute

infarcts in the posterior right frontal lobe. MRA w/OUT contrast was negative for large vessel occlusion.

Currently, patient is in no acute distress. Laying comfortably in bed. Pt still has slight facial droop and LUE weakness but now improved. She denies any fever, chills, cough, visual changes, SOB, chest pain, abd pain, or n/v/d.

PMH:

Renal Cell Carcinoma - s/p nephrectomy (June 2021)

TIA – 2001- No chronic deficits reported – on Dipyridamole-aspirin

HLD – 2000 – on atorvastatin

Arthritis –1990 – On acetaminophen PRN

HTN – 1980 – on amlodipine, carvedilol, and ramipril

PSH:

Left Nephrectomy – 2021, pt denies any complications or blood transfusions.

Medications:

- Amlodipine Besylate 2.5 MG Tablet PO qd
- Atorvastatin 10 MG Tablet PO qd
- Carvedilol 6.25 MG Tablet PO bid
- Dipyridamole-aspirin 25-200 MG Capsule Extended Release 12 Hours, PO, bid
- Ramipril 5 MG Capsule Take 1 Cap, PO, qd
- Docusate sodium 100 MG capsule, PO, qd - INPATIENT med
- Acetaminophen 325 MG tablet, 2 tablets, PO, q6h PRN
- Apixaban (Eliquis) 10mg PO bid – INPATIENT med

Allergies:

No known drug or environmental allergies, as per daughter.

Family History:

Mother – Deceased 69, hx of brain cancer.

Father – Deceased 88, hx of CVA.

Social History:

J.R. is a retired hospital clerk for 30 years. She currently resides in a nursing facility where she has around the clock care because she cannot bathe herself, has trouble going to and from bathroom, transferring from bed to chair, and dressing oneself. She can feed herself. She denies any alcohol abuse, tobacco, or illicit drug usage in the past or present. She is widowed and has one daughter who sees her regularly. She does not exercise. Admits to sleeping well.

Review of systems:

General: (+) **Weakness** (-) fever, fatigue, chills, nausea, vomiting, weight gain or loss.

HEENT: **(+) Left sided facial droop**. (-) any headache, sore throat, visual changes, auditory changes, rhinorrhea, or epistaxis.

Respiratory: (-) any SOB, cough, hemoptysis, dyspnea, or sputum production.

Cardiac: (-) any chest pain, palpitations, murmurs or dyspnea on exertion.

GI: (-) abd pain, nausea, vomiting, diarrhea, constipation or bleeding.

GU: (-) hematuria, frequency, dysuria, urgency, or discharge.

MSK: **(+) Joint pain, decreased ROM** (-) swelling, deformity, or redness.

Neuro: **(+) Decreased facial sensation left side, Weakness left hand.** (-) Denies any syncope, tingling, or numbness.

Psych: (-) Denies any depression, anxiety, or mood changes.

Physical Exam:

VS: Temp: 37.1°C Pulse: 91 Resp: 18 BP: 130/70 SpO2: 97 % on RA
Height: 5’5” (165.1 cm) Weight: 150 lb (68 kg)

GEN: Patient is AOx3 to person, place, and time. Appears stated age, fragile build, and in no acute distress. Awake, alert, and responds to verbal commands.

HEENT: Normocephalic, atraumatic, pupils reacting to light, sclera white. Ears symmetrical. Nose atraumatic. Pharynx non-erythematous. Mucus membranes moist/pink. Patient has set of implantable dentures.

NECK: Supple, no JVD, no lymphadenitis, or tracheal deviation.

HEART: No masses/lesions noted on chest. No visible lifts, heaves, or thrills. Regular heart rate and rhythm noted. Distinct S1/S2 are heard with no obvious murmurs, gallops, or rubs.

LUNGS: Chest wall is symmetric with no deformities. Nontender. No signs of respiratory distress. Lungs are clear to auscultation bilaterally. No wheezing, rhonchi, or crackles heard.

ABDOMEN: Multiple 1-2cm, well healed surgical scars with an 10cm oblique well healed surgical scar on the left lateral portion of abdomen. No masses/lesions/ noted. Bowel sounds are normoactive in all four quadrants every 2 mins. Abd is flat, soft, and nontender with no distention. No hepatosplenomegaly appreciated. No guarding or rigidity. No suprapubic tenderness noted.

EXTREMITIES: Upper and lower extremities are atraumatic in appearance without tenderness or deformity. No swelling, erythema, warmth. Capillary refill is less than 3 seconds in all extremities. Pulses palpable.

NEURO:

- Mental Status Exam: Awake, alert, and oriented x 3. This is a patient who appears to be of stated age. She is neatly groomed. She maintains good eye contact. Speech is normal in rate, rhythm with decreased volume and intermittent slurring of words (As per Russian translator). Mood and affect are pleasant. She denies any suicidal or homicidal ideation. She denies any psychotic symptoms. Insight and judgment are fair. Able to follow all commands. Able to name and repeat.
- CN's: PERRL w/ out accommodation, EOMI, VFFC, Facial sensation is decreased on left lower side, face is asymmetric with mild left sided facial droop, hearing is normal to rubbing fingers, normal gag reflex, SCM/trap 2/5 on L 5/5 on right, tongue is midline on protrusion.
- Motor: Equal muscle bulk and tone throughout. Fine finger movements extremely decreased on the L. No tremors. In terms of strength: 5/5 RUE, 4/5 RLE, LUE 2/5 distally, LLE 4/5.
- Sensory: intact/symmetrical to touch throughout. No R/L confusion. No extinction to tactile DSS.
- Coord: No dysmetria compared to weakness.
- Gait: Deferred.

Labs:

CBC: 9/27

WBC COUNT: 7.83
HEMOGLOBIN: 11.4
HEMATOCRIT: 44.3

MEAN CORPUSCULAR VOL (MCV): 94.7
MEAN CORP HGB (MCH): 32.1
MEAN CORP HGB CONC (MCHC): 33.9
RED CELL DIST WIDTH (RDW): 12.3
RED BLOOD CELL COUNT: 4.68
NUCLEATED RBC AUTO: 0.00
NUCLEATED RBC ABSOLUTE: 0.00
PLATELET COUNT, AUTO: 366

CMP:

SODIUM: 139
POTASSIUM: 3.9
CHLORIDE: 99
CARBON DIOXIDE: 22
UREA NITROGEN (BUN): 19.2
BUN/CREATININE RATIO: 24
CREATININE: 0.74
GLUCOSE: 107 (H)
ANION GAP: 15

TP 5.2*
ALB 2.9*
GLOB 2.3
TBILI 0.3
DBILI 0.1
IBILI 0.2
AST 12
ALT 5
ALK 95

EKG: 9/27

Normal Sinus rhythm at a rate of 87bpm with no acute ST segment changes or t-wave inversions.

CXR: 9/27

No acute focal consolidation, significant pleural effusion or acute cardiopulmonary abnormality identified.

US Venous Lower Extremity – Bilateral: 9/27

Deep vein thrombosis of the right common femoral vein and the left common femoral, femoral, popliteal, and posterior tibial veins.

CT Head w/ OUT contrast: 9/27

No evidence of acute intracranial abnormality. Moderate chronic cerebral microvascular ischemic changes. Chronic appearing lacunar infarcts in the left thalamus and right basal ganglia.

MRI Brain w/ OUT contrast:

Acute infarcts in the posterior right frontal lobe. Old lacunar infarct in the left thalamus. Old small infarcts in the bilateral cerebellar hemispheres.

MRA Brain w/ OUT contrast:

Unremarkable non contrast MRA of the cervical arteries. Aberrant origin of the right subclavian artery.

Assessment and Plan:

Patient is a 91-year-old female with PMHx of HTN, HLD, TIA, Renal cell carcinoma (L) s/p nephrectomy, arthritis, is sent in from NH for an abnormal outpatient CT with (+) pulmonary embolus. While being treated for DVT/PE, patient developed new onset facial droop/LUE weakness.

#Stroke/TIA/New onset facial droop

- Etiology of infarct maybe due to the patient's underlying malignancy with hypercoagulable state.
- Cardioembolic cause needs to be ruled out -- TTE ordered.
- Started on Heparin in ED switched to Eliquis 10mg bid x 7 days → 5mg bid

#B/L DVT/Pulmonary Embolism

- Patient had an outpatient CT with IV contrast to assess for metastasis given hx of renal cell carcinoma to evaluate for metastasis. Incidental finding of pulmonary embolus. Sent to ED for further evaluation.
- Oxygen Saturation 97% on RA current
- Patient started on Heparin drip in the ED and switched to Eliquis the next day
- Currently on loading phase of Eliquis 10mg bid x 7 days → 5mg bid

#History of Renal Cell Carcinoma

- CT head was negative for metastasis
- Continue outpatient follow up

#History of HTN

- Continue taking current outpatient regimen

#History of HLD.
- Switch Atorvastatin 10mg PO qd → 40mg PO qd

#History of Arthritis
- Tylenol 325mg PO PRN for joint pain

#DVT prophylaxis.
- Patient being treated for DVT/PE. Heparin → Eliquis

#GI prophylaxis.
- Protonix

#PT Eval
- Continue goal oriented physical therapy - 5-7x/week - for - patient/family education/training, gait training, ADL training, bed mobility, transfer training, endurance training, therapeutic activities, therapeutic exercise.
- Will benefit from Acute Rehab To Improve ADLs, Mobility, Left sided weakness

#SLP Eval
- Oral and pharyngeal stages of the swallow are within functional limits. No overt signs of airway protection deficits observed across all p.o. consistencies tested. Patient denies difficulty swallowing currently.

#Ethics
- Code status FULL