Full H&P

Rotation 4: LTC

Ling Yi Mei

Note: exams in light grey shade are NOT performed

**Identification:**

Patient’s name: SF

Age: 80

Gender: M

Race: Asian

Location: Gouverneur Hospital

Date: 4/29/19

**Informant**: self, reliable

**CC:** “abdominal pain and vomiting” x 2 days

**HPI:**

80 y.o M with PMHx of HTN, HLD, chronic LBP, and a PSH of appendectomy was admitted to Gouverneur Skilled Nursing Facility on 4/26/19 to receive skilled nursing w/ wound care along with PT/OT services to achieve highest functional status in activities of daily living. He was transferred from NY Pres Low Manhattan where he was admitted on 4/15/19 for intestinal bowel obstruction. Pt initially presented to ED with abd pain and vomiting x 2 days. Small bowel obstruction did not resolve with NG tube placement. Diagnostic laparoscopic followed by exploratory laparotomy revealed small bowel foreign body which was removed on 4/17. Pt tolerated the procedure well without major complications. Umbilical incision was noted to be mild erythematous for which pt was started on Keflex. On the day of discharge, pt was sent 6 days of Keflex to be completed at SAR. Pt was urinating, ambulating, tolerating diet, and pain was well controlled. Pt requires extensive assist in most ADL’s with supervision for eating.

**PMH:**

HTN

HLD

Chronic LBP

**Past Surgical History:**

Appendectomy

**Medications:**

Meloxicam 15mg PO daily

Keflex 500mg PO BID x 6 days

Multivitamin daily supplement

Amlodipine 5mg PO daily

Calcium 600 1 tab PO BID

**Allergies:**

NKDA

**Family History:**

Denies having children

Others unable to obtain from patient.

**Social History:**

Tobacco use: quit 5 yrs ago- smoked cig 1 ppdx 50+ years

Alcohol use: quit 5 yrs ago – drank a shot a day

Drug use: no

Lives at home with his wife. Retired restaurant worker.

**ROS:**

General: Patient reports, Patient denies recent weight loss or weight gain, loss of appetite, fever, chill or night sweats

**Positive: generalized weakness and fatigue**

Skin, Hair, Nails: Patient denies any changes of texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, or changes in hair condition

Head: Patient denies headache, vertigo, head trauma, or fracture

Eyes: Patient denies visual disturbance, lacrimation, photophobia, pruritus, or last eye exam

Ears: Patient denies deafness, pain, discharge, tinnitus

Nose/Sinuses: Patient denies discharge, epistaxis, or obstruction

Mouth and throat: Patient denies bleeding gums, sore tongue, sore throat, mouth ulcers or last dental exam

Neck: Patient denies localized swelling or lumps, stiffness or decreased range of motion

Pulmonary System: Patient denies SOB, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular System: Patient denies chest pain, palpitations, edema, syncope, or known heart murmur

Gastrointestinal System: Patient denies changes in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructation, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool

**Positive: abdominal pain. Colonoscopy done last year: negative**

Genitourinary System: Patient denies changes in frequency, nocturia, urgency, oliguria, polyuria, dysuria, change in color of urine, incontinence, awakening at night to urinate, or pain

Male ONLY: denies hesitancy, dribbling or last prostate exam

Sexual history in not in social history: Pt denies sexually active

Nervous System: Patient denies seizures, headache, loss of consciousness, sensory disturbances, numbness, paresthesia, dysesthesias, ataxia, loss of strength, change in cognition, mental status, memory, or weakness

Musculoskeletal System: Patient denies muscle or joint pain, deformity or swelling, redness, arthritis

Peripheral System: patient denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes

Hematological System: Patient denies anemia, easy bruising or bleeding, or lymph node enlargement

Endocrine System: Patient denies polyuria, polydipsia, polyphagia, heat or cold intolerance or goiter

Psychiatric: Patient denies depression, sadness, feeling of helplessness, hopelessness, lack of interest in usual activities, anxiety, obsessive or compulsive disorder, seen a mental health professional, or use medications

**Physical Examination:**

General 80 years old male is alert and cooperative. He is well dressed and doesn’t appear to be distressed. Neatly groomed, looks younger than his stated age of 80 years. Well developed.

Vital Signs:

BP (seated): 131/87

HR: 98 BMP, regular

RR: 18,not labored

Temp: 97.7 F oral

O2 sat: 98% room air

Skin: Warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair: Average quantity and distribution

Nails: No clubbing, capillary refill <2 seconds throughout.

Head: Normocephalic, atraumatic, non-tender to palpation throughout

Eyes: Symmetrical OU; no strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity with glasses 20/20 OS, 20/20 OD, 20/20 OU. Visual fields full OU. PERRLA (old people do not accommodate), EOMs full with no nystagmus. Fundoscopy - Red reflex intact OU. Cup:Disk < 0.5 OU, no AV nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU

Ears: Symmetrical and normal size. No lesions, masses, trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TM's pearly white, cone of light at 4 o’clock in right ear, 7 o’clock in the left ear. Auditory acuity intact to whispered voice AU. Weber midline, and Rinne reveals AC>BC AU

Nose: Symmetrical with no masses, lesions, deformities, or trauma. Nasal mucosa pink, no discharge or foreign bodies. Anterior septum deviated to left, no lesions, deformities, injection perforation

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses

Lips: Pink, dry, no cyanosis or lesions

Mucosa: Light pink, dry, no masses, lesions, or leukoplakia

Palate: Pink, hydrated. Palate intact with no lesions, masses, scars, nontender to palpation, continuity intact

Teeth: Missing a few teeth on the left sides, not wearing dentures

Gingivae: Pink, no hyperplasia, masses, lesions, erythema, or discharge

Tongue: Pink, no masses, lesions, or deviations noted

Oropharynx: Hydrated, no injection, exudate, masses, lesions, or foreign body. Tonsil present with no injection or extrudate, uvula light pink, no edema or lesions

Neck: No masses, lesions or scars. Trachea midline, pulsation noted. Supple nontender to palpation. 2+ carotid pulses, no thrills, bruits bilaterally. No palatable adenopathy

Thyroid: Nontender, no palpable masses, no thyromegaly, no bruits

Chest: Symmetrical, lat to AP diameter 2:1, no deformities, no trauma. Respirations unlabored. Nontender to palpation

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No wheezing, crackles, rales

Heart: S1, S2 without murmur, no gallops, S3 or S4. RRR. No JVD. Carotid pulse are 2+ bilaterally without bruits

Abdomen: Flat, symmetrical, striae, caput medusae or abnormal pulsations. Bowel sounds in all 4 quadrants. No bruits. Tympany to percussion throughout. No organomegaly, guarding, or rebound tenderness. No CVAT bilaterally

**Positive: mild tenderness upon palpation. Mid umbilical incision noted, with redness and warmth.**

Male genitalia and hernia: Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes Descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias noted

Anus, rectum, and prostate: No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate smooth and nontender with palpable median sulcus (Or in a female, uterine cervix nontender.) Stool brown and Hemoccult negative

Rectal: No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative

Peripheral vascular: The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted

Neurological:

Mental status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted

Cranial nerve:

I - Intact no anosmia.

II- VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopic + red light reflex OS/OD, discs yellow with sharp margins. No AV nicking, hemorrhages or papilledema noted.

III-IV-VI- PERRLA, EOM intact without nystagmus.

V- Facial sensation intact, strength good. Corneal reflex intact bilaterally.

VII- Facial movements symmetrical and without weakness.

VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.

IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar: Full active and passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No Pronator Drift. Gait normal with no ataxia. Tandem walking and hopping show balance intact. Coordination by RAM and point to point intact bilaterally. Romberg negative

Sensory: Intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally

Reflexes R L R L

Brachioradialis 2+ 2+ Patellar 2+ 2+

Triceps 2+ 2+ Achilles 2+ 2+

Biceps 2+ 2+ Babinski neg neg

Abdominal 2+/2+ 2+/2+ Clonus negative

Meningeal signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Musculoskeletal System:

Upper extremities and lower extremities: No soft tissue swelling, erythema, ecchymosis, atrophy or deformities in bilateral upper and lower extremities. Nontender to palpation, no crepitus noted throughout. Full range of motion of all upper and lower extremities bilaterally. No spinal deformities

Pertinent Diagnostic studies:

CT abd/pelvis 4/15: partial small bowel obstruction with transition point in the RUQ with fecalization of the small bowel in this this region and collapse of distal small bowel loops. Small bowel distention measures up to 3.3 cm. Trace ascites, non-specific.

**Assessment:**

80 y.o male with PMHx of HTN/HLD, chronic back pain, and a PSHx of appendectomy was admitted to Gouverneur Skilled Nursing Facility after transferring from NY Pres where he was admitted for small bowel obstruction and s/p exploratory laparotomy and foreign body removal.

**Differential Diagnosis:**

Small bowel obstruction

Diverticulitis

Gastroenteritis

GERD/gastritis

Mesenteric Ischemia

**Plan:**

1. Continue Daily Multidisciplinary rehabilitation
* Monitor pt, V/S, assist with ADLs, and ambulation
* Rehab PT/OT
* Pressure ulcer prevention: pressure reducing device for chair and bed; turning/repositioning program
* Fall precaution
* DVT prophylaxis
* Aspiration precaution
* Use Bell for safety and help when needed-keep within reach
* Bed at lowest position
* Anticipate and meet pt needs
* Constipation prophylaxis
1. Small bowel obstruction and removal of foreign body
* Wound care: allow water to run over area, do not scrub
* Progress activity as tolerated
* f/u with general surgery in 1-2 weeks
* f/u with PCP in 1 week
1. Umbilical incision cellulitis
* Continue Keflex 500mg PO BID for 6 days from 4/26- 5/1
1. HTN/HLD
* Continue with amlodipine
* Monitor BP and assessment
* f/u lab
1. Chronic LBP
* Continue with meloxicam 15 mg daily.