Keziah Babu- CUNY York College PA Program
Rotation 9- Internal Medicine NSUH
H&P 3

Identifying Data:
Full name: C.C
Address: Long Island, NY
Date of Birth: XX/XX/1985
Date & Time: 12/05/2022
Location: NSUH
Ethnicity: Black
Source of Information: Self
Source of referral: Self
Reliability: Fair

HISTORY

Chief Complaint: "My asthma has been getting worse and I've been wheezing a lot"

History of Present Illness: 37 year old female with PMH of asthma, PCOS, migraine, gastritis, COVID (March 2020) s/p prolonged ICU intubation and ECMO complicated by tracheomalacia, laryngeal spasms, and dysphagia, presents with 3 days of worsening shortness of breath and cough. Patient states that in the past she has had cold-induced asthma and believes that this is the trigger of her current symptoms. Patient states her symptoms significantly worsened the day prior, when she could not catch her breath and experienced coughing fits. Cold and exertion make the patient's symptoms worse. The patient works as an EMT and gave herself an IM epi pen, duonebulizer, Magnesium 2 mg and decadron 12 mg. Per EMS, she received another round of the same medications once EMS arrived.

Patient was placed on CPAP in the ambulance and then on BIPAP in the ED. Patient states that she is feeling better now, but notes that her symptoms come and go, and continues to note a wheeze. Per patient, she has not received dupixent since 8/2022 and had also stopped taking her PPI/H2 blocker. Denies fever, chills, chest pain or sick contacts.

Past Medical History:
Asthma on multiple inhalers
Chronic respiratory failure with hypoxia related to COVID-19 pneumonia 3/2020 with intubation
Pneumonia due to COVID-19 virus 3/26/2020- 4/30/2020 intubated/ had ECMO/ chest tubes @ NSUH
GERD, unknown years
Tracheitis fungal 7/2021 treated with diflucan
Laryngospasm (followed by ENT and Pulm)
Tracheomalacia (followed by ENT and Pulm)

Immunizations:

Up to Date on childhood vaccinations
COVID x3 (Pfizer)- last booster was 12/2021
Influenza vaccination- 10/2022

Past Surgical Hx:
Right bunionectomy 3/21/2021 at Queens Presbyterian

Medications:
Advair Diskus 500 mcg-50 mcg inhalation powder: 1 inhalation inhaled bid
Albuterol 90 mcg/inh inhalation aerosol: 2 puffs inhaled every 4 hours PRN
Amitryptiline 10 mg oral tablets: 1 tablet orally qd
Benzonatate 200 mg oral capsule: 1 capsule orally tid
Budesonide 0.5 mg/2 mL inhalation suspension: 2 millimeter(s) inhaled bid
Montelukast 10 mg oral tablet: 1 tablet orally once a day (at bedtime)
Omeprazole 40 mg oral delayed release capsule: 1 capsule orally once a day
Pepcid 40 mg oral tablet: 1 tablet orally once a day at bedtime
Tudorza Pressair 400 mcg/inh inhalation powder: 1 puff inhaled bid
Valacyclovir 500 mg oral tablet orally qd at bedtime
NKDA

Family Hx:
Mother- hx of asthma
Other family hx noncontributory

Social Hx:
Denies alcohol abuse
Denies tobacco abuse- never smoked
Denies substance abuse
Single
Travel: No recent travel
Diet: healthy diet
Exercise: is moderately active
Sexual history: Patient is a heterosexual female,with no previous history of STDs

Review of Systems:

General: Patient denies fever, chills, fatigue and weakness

Skin, hair, nails: Denies changes in texture, moisture, discolorations, pigmentations, moles/rashes, pruritus, changes in hair distribution

Head: Denies headache, migraines, head trauma, vertigo, loss of consciousness, or coma

Eyes: Denies eye pain, visual disturbances, pruritus, photophobia, or lacrimation

Ears: Denies vertigo, deafness, pain, discharge, tinnitus, hearing loss

Nose/sinuses: Denies discharge, obstruction, epistaxis

Mouth/throat: Denies sore throat, bleeding gums, sore tongue, mouth ulcers, hoarseness

Neck: Denies localized swelling/lumps, stiffness, decreased range of motion

Pulmonary: **Admits to cough, wheezing, and shortness of breath, and dyspnea on exertion**

Cardiovascular: **Admits to chest pain,** denies, palpitations, arrhythmias, edema/swelling of ankles or feet, syncope, known heart murmur

Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, loss of appetite, dysphagia, pyrosis, unusual flatulence or eructations, hemorrhoids, rectal bleeding

Genitourinary: Denies urgency, polyuria, dysuria, nocturia, hematuria, discharge, lesions, flank pain.

Nervous: Denies seizures,numbness, loss of consciousness, ataxia, loss of strength weakness

Musculoskeletal: denies instability, deformity, redness, swelling, reduced range of motion

Peripheral Vascular: Denies intermittent claudication, coldness or trophic changes, varicose veins, color changes

Hematologic: Denies bruising, petechiae, purpura, anemia

Endocrine: denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, goiter

Psychiatric: denies stress, anxiety, depression/sadness; denies ever seeing a mental health professional

PHYSICAL

Vital Signs
BP: 118/73
HR: 98
Resp: 16

Temp: 98.1 F
SpO2: 95%- 100% on BIPAP
Weight: 160 lb
Height: 5’5”
BMI: 26.62

General: 37 year old woman in no acute distress who appears stated age, cooperative, good-hygiene, well- developed, alert and oriented x 3
Skin: warm and moist, good turgor; nonicteric, no scars or tattoos noted; capillary refill < 2 seconds throughout
Neck: thyroid non-tender, no palpable masses, no thyromegaly; trachea midline, no masses, lesions, scars, pulsations, no lymphadenopathy noted
Chest: symmetrical; no gross deformities or evidence of trauma; no paradoxical respiration or use of accessory muscles noted; contended to palpation
Lungs: **+ expiratory wheezing bilaterally and cough,** no rales, rhonchi, or other adventitious lung sounds
Heart: regular rate and rhythm; S1 and S2 are distinct with no murmurs, S3 or S4; no splitting of S2 or friction rubs appreciated
Abdomen: no rebound tenderness; soft symmetrical; no evidence of guarding, CVA tenderness, or pain out of proportion to the exam
Musculoskeletal: no soft tissue swelling, erythema, ecchymosis, atrophy, deformities in bilateral upper and lower extremities; no calf tenderness or edema
Peripheral Vascular: no edema noted in bilateral lower extremities; pulses 2+ bilaterally in upper and lower extremities; no bruits, clubbing, cyanosis, stasis changes, ulcerations, erythema
Neuro: Full active/passive ROM of all extremities without rigidity or spasticity. Symmetric muscle bulk with good tone. No atrophy, tics, tremors or fasciculations. Strength 5/5 throughout. No pronator drift noted. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis.

Labs and Imaging:

CBC:
- Hgb 13.0
- Hct 41.8
- WBC 7.64
- Plt 533

Blood lactate: 1.3

BMP:
- Na 136
- K 4.8
- Cl 103

HCO3- **15 (L)**
BUN 14
Cr 0.75
Glucose **157 (H)**

Liver Function:
AST 31
ALT 21
Alk Phos 111
Total Bilirubin 0.3
Protein 8.0
Albumin 4.3

Rapid RVP: not detected 12/5/22
PCR COVID-19: not detected 12/5/22

CXR on 12/5/2022 reveals: heart size normal, lungs are clear, no pleural effusion or pneumothorx; Clear lungs

Differential Diagnosis:

1. Asthma exacerbation
2. Pneumonia
3. MI
4. PE

Assessment:

37 year old female with PMH of asthma, PCOS, migraine, gastritis, COVID (March 2020) s/p prolonged ICU intubation and ECMO complicated by tracheomalacia, laryngeal spasms, and dysphagia, presents with shortness of breath over the past few days due to cold air. Patient is currently on BIPAP and seems to be comfortable. Will admit to medicine and continue to monitor patient.

Plan:

1. Acute Asthma Exacerbation
    a. Continue Duoneb, budesonide neb and Singulair
    b. Continue Prednisone 40 mg
    c. Pulmonology consult
2. Respiratory distress
    a. Patient to continue BIPAP 16/5 40% for now
3. GERD
    a. Patient to restart PPI/H2 blocker
    b. GI consult
    c. Educated patient on importance of taking reflux meds and advised patient not to eat 3 hours prior to going to bed
4. DVT Prophylaxis

a. Lovenox