Lodi Memorial Hospital

History & Physical, Admission

Date **06/28/14**
Ali,Nazish Nawaz MD -HOSP

M053082 V025938127
PARVIN,MARY JEAN
03/16/43 71 F

DATE
06/28/2014

PRIMARY MEDICAL DOCTOR
Dr. Edmund Freund

CHIEF COMPLAINT
The patient was transferred from the skilled nursing facility because of change in mental status.

HISTORY OF PRESENT ILLNESS
The patient is a 71-year-old Caucasian female with past medical history of CVA, cardiomyopathy, diabetes, hypertension, coronary artery disease status post a pacemaker in place, who was in her usual state of health at Arbor assisted living facility where she lives. She was noted by the staff there to be a little bit drowsy and difficult to arouse and that is why she was transferred over to the emergency room. In the emergency room, the patient was evaluated and was noted to have above-mentioned symptoms. In the ER, the patient had a head CT done which showed age-related atrophic and chronic white matter changes and remote old occipital infarct. Also noted that the patient had an elevated lactulose level of 73, so the patient will be admitted for metabolic encephalopathy and change in mental status. No complaints of chest pain or shortness of breath were noted by the patient. The patient seems to be drowsy at this time, but she is arousable. She opens her eyes. She is alert and oriented to place and person but not to time.

PAST MEDICAL HISTORY
1. Cerebrovascular accident.
2. Cardiomyopathy.
3. Congestive heart failure with systolic dysfunction and EF was about 30% to 35% on echo done in March of 2013.
4. History of coronary artery disease.
5. History of hypothyroidism.
6. History of hypertension.
7. History of peripheral vessel disease.

CC:

8. History of diabetes.

PAST SURGICAL HISTORY
1. Pacemaker placement many years ago.
2. Coronary artery bypass grafting done many years ago.

OCCUPATIONAL AND SOCIAL HISTORY
The patient lives at the Ann Arbor assisted living facility. She is widowed and retired. She does not have any history of cigarette smoking, alcohol abuse, or any intravenous or recreational drug use.

FAMILY HISTORY
Reviewed and was noncontributory.

ALLERGIES
1. LATEX.
2. SULFA DRUGS.
3. MORPHINE.

HOME MEDICATIONS INCLUDE
1. Aspirin 81 mg p.o. daily.
2. Tylenol 650 mg p.o. q.4-6h. p.r.n. for pain.
3. Norco 5/325, 1-2 tablets p.o. q.6h. p.r.n. for pain.
4. Biotin 1000 mcg p.o. daily.
5. Coreg 25 mg p.o. daily.
6. Lexapro 20 mg p.o. daily.
7. Pepcid 20 mg p.o. daily.
8. Lasix 20 mg p.o. b.i.d.
9. Neurontin 300 mg p.o. b.i.d.
10. Amaryl 2 mg p.o. daily.
11. Imdur 30 mg p.o. daily.
12. Levothyroxine 100 mcg p.o. daily.
13. Cozaar 100 mg p.o. daily.
14. Milk of magnesia 30 mL p.o. daily p.r.n. for constipation.
15. Nitroglycerin 0.4 mg sublingual p.r.n. as directed.

CC:

16. Zofran 4 mg p.o. q.4h. p.r.n. for nausea, vomiting.
17. Potassium 10 mEq p.o. daily.
18. Onglyza 2.5 mg p.o. daily.
19. Ambien 5 mg p.o. at bedtime p.r.n. for insomnia.

PERTINENT REVIEW OF SYSTEMS
CARDIOVASCULAR: No complaints of chest pain or shortness of breath.
PULMONARY: No complaints of cough, sputum production, or any dyspnea.
GASTROINTESTINAL: No complaints of abdominal pain, nausea, vomiting, diarrhea.
NEUROLOGICAL: No complaints of headache, vertigo, dizziness but complaining of this change in mental status.
MUSCULOSKELETAL: No complaints of joint pains or body aches.
SKIN: Essentially normal. No significant complaints were noted.
GENITOURINARY: No complaints of burning micturition, urgency, dysuria or frequency.

All other pertinent review of systems were unremarkable.

PHYSICAL EXAMINATION
GENERAL: This is a middle-aged lady seems to be well-oriented in place and person. Opened her eyes and was able to provide me with some history.
VITAL SIGNS: When I examined her, her blood pressure was noted to be 127/64, pulse was 69 a minute, temperature 36.8. Bedside pulse oximetry was 94%, respiratory rate was 20 a minute.
HEENT/NECK: Neck was supple. No JVD. No lymphadenopathy. No thyromegaly was noted. No carotid bruits were present. Eyes: Pupils were equal and reactive to light. Ocular movement was intact.
LUNGS: Clear.
HEART: No S3, no S4. No murmurs.
ABDOMEN: Soft and nontender. No organomegaly. Bowel sounds were audible.
EXTREMITIES: No pedal edema. No calf tenderness.
NEUROLOGICAL: The patient was alert and oriented to place and person. No gross neurological deficits were noted.

CC:

LABORATORY DATA
Showed hemoglobin of 10.4, white blood cell count 6.0, platelets were 158,000. Chemistry showed sodium of 140, potassium of 5.7, CO2 was 26, BUN was 84, creatinine was 2.56, glucose was 147, calcium was 8.6, magnesium was 2.6. Alkaline phosphatase was 73. Troponin was 0.07, BNP was 618, albumin was 3.4, lipase was 30.

Chest x-ray showed mild congestive heart failure. CT examination showed the results as noted above.

ASSESSMENT

IMPRESSION AND PLAN
1. Change in mental status with elevated lactulose level in a patient who is not known to have any liver problems in the past, not sure how her ammonia level is elevated at this time. The patient had a CT scan of the abdomen performed in May of 2012. The results showed pleural effusions with minimal ascites, no mention of any cirrhosis of the liver was noted even on the lab data at this time. Chemistries show that her intracellular liver enzymes are unremarkable. The patient will be started on some lactulose for the elevated ammonia, will repeat ammonia levels in the morning and then will follow it up from there.
2. Acute on chronic renal insufficiency, it seems that the patient's baseline creatinine is around 1.8. Her creatinine is slightly elevated at 2.56. She does take Lasix 20 mg p.o. b.i.d. in the nursing home, but that is because of her history of cardiomyopathy and systolic dysfunction. I think right now she needs to be a little bit dehydrated. She looks like she is intravascularly volume contracted. Will give her some IV fluids for the next 12 hours at about 62 mL per hour and then will follow it up in the morning.
3. History of congestive heart failure with high BNP. It does seem that the patient has elevated BNP, but the patient is lying down flat, currently she has no complaints of any orthopnea or dyspnea. I do not think the patient is in florid CHF, I think she has got compensated congestive heart failure

CC:

at this time and is close to being euvolemic maybe. Will hydrate the patient very slowly and probably will discontinue IV fluids tomorrow morning. Will followup the BUN and creatinine, and BNP, and will follow the patient symptomatically. Will hold Lasix for now.
4. History of hypertension. The patient takes Coreg and Cozaar at home. Will continue the patient on the same.
5. History of diabetes. The patient is on Amaryl, will continue the patient on the same. Also, the patient takes Onglyza, but we do not have Onglyza here, so I am going to put her on Amaryl and will put her on correctional insulin for now.
6. History of coronary artery disease status post coronary artery bypass graft. No complaints of chest pain, but troponin is slightly elevated. Will do serial cardiac enzymes and then will follow it up from there.
7. History of cerebrovascular accidents in the past.
8. For gastrointestinal prophylaxis, the patient takes Pepcid 20 mg p.o. daily at home, will continue the patient on the same.
9. Deep venous thrombosis prophylaxis, will put the patient on SCDS.

ESTIMATED LENGTH OF STAY

cc: Edmund A. Freund, MD MD

<Electronically signed by Nazish Nawaz Ali, MD -HOSP>
Signed Date/Time: 06/28/14 1646

Date Dictated: 06/28/14 1535
Date Transcribed: 06/28/14 1625

CC:

M053082 V025938127
PARVIN,MARY JEAN 03/16/43

CC:
