History and Physical Notes - Final Report

Service

Service Date :10/07/2007

Admit Date :10/07/2007

Performing Service:MEDICINE::HEMATOLOGY/ONCOLOGY

Patient

Name : [redacted]

Present Illness

Chief Complaint:
Dyspnea on Exertion

The history was obtained from the patient who seems to be a reliable informant.

History of Present Illness:

This is a 51 year old gentleman with no significant past medical history presenting with 3 weeks of worsening dyspnea on light exertion, chest pain, cough, and a 10 lb weight loss in 8 days. Just over 6 months ago the patient was at his normal baseline state of health. Now he has had progressive worsening of his dyspnea on exertion (DOE) to where he cannot walk across a room or talk while sitting up without becoming short of breath; he has never had anything like this before. He rates his breathing troubles as a 7 of 10, with 10 being can't breathe at all and 1 being normal. He says the breathing troubles are from his lungs/chest and not his nose/congestion. He has had the DOE for ~6 month but progressive worsening in the last 3 weeks. He says the quality of his breathing is just "like suffocating" but he denies burning in his lungs or other feelings. He says that hot temperatures bring on his breathing troubles and coughing while cold temperatures will help relieve those symptoms.

Additionally, he has a productive cough with whitish mucus that is not bloody or bilious, and often coughs so hard that he ends up vomiting; he has averaged vomiting once a day over the past few weeks. He has tried Mucinex which made his cough worse and Nyquil to help him get to sleep w/o coughing. He often experiences an aching/burning pain across his whole anterior chest, and sometimes he has more of a tightness in his chest. The chest pain is like bad heartburn. All of his symptoms have always occurred after eating and sometimes without a noticeable trigger.

He has had no fevers, chills, or night sweats. He has no allergies, seasonal or otherwise, and no hx of breathing troubles/asthma. He reports feeling like he is wheezing, but no dyspnea at rest (as long as he is lying down), no orthopnea, and no paroxysmal nocturnal dyspnea. No hx of recurrent pneumonia. He has no sick contact, TB exposure (that he knows of – ie incarcerated, homeless). He also has no pets, has not been around any farm animals, and has not traveled recently or been around those who have. He has about a 20 pack year history with tobacco and has still smoked during the past three weeks despite the fact it will often bring about coughing symptoms. He does not have the CAD risks factors of Diabetes, HTN, or Hypercholesterolemia. There is no hx of cancers in his family, but while he's never been diagnosed with asthma, his son does have this condition. He has worked as a car mechanic but does not seem to have any significant occupational risk factors (coal mining/worked around asbestos).

The patient presented 9 days ago to the UNC ED with the same set of symptoms and had a CT Chest that showed a large right-sided mediastinal mass with "mass effect on the trachea and endobronchial extension as well as perihilar soft tissue lesion that was most concerning for a primary bronchogenic carcinoma." The patient said that at that time he wasn't prepared to be an inpatient and stay overnight, so he signed out AMA. He had little to no change in his symptoms over the next 9 days and came to the ED again today.

Medical/Surgical History

No primary care provider, No past diagnoses, no hospitalizations, no surgeries.

In particular: no known DMII, HTN, or hypercholesterolemia

Social/Family History

Social History:

The patient lives in [redacted], NC in a trailer by himself. He is divorced and works as a [redacted]. His smoking hx per HPI and his EtOH intake is about 6-7 beers on weekends. He has no hx of about of illicit drugs. The patient is functionally independent and able to provide for cheaper medications (Walmart $4's).

Family History:

Pt's Mother was diagnosed with DM2 8 years ago at age 65, and she is in good health otherwise. Pt's father is in good health, as well as his siblings. His children are all healthy with the exception of his 18 year old year son who was diagnosed with asthma in his early teens.
His mother side of the family has many family members with HTN and DM. Nothing of note for his father's side. No hx of cancers on either side.

Allergies

Description	Type	Reaction	Date
NKDA - VERIFIED	Drug Allergies	UNCODED	2007-10-07
NO OTHER ALLERGIES	NO SEASONAL, ETC.		

Medication Reconciliation

I reviewed the medication history. Source of the medication history:

Verbal history per patient

Pertinent Medications

Medications Notes:

Mucinex, Nyquil, Ibuprofen PRN in past 2-3 weeks (doses unknown)
No other OTC drugs.
No prescription medications.
No herbal remedies.
No vitamins/supplements.

Review of Systems

Constitutional
See HPI, no weakness, no fatigure

Eyes
No changes in vision. No pain, redness, diplopia.

ENT
Ear: no recent hearing loss, no tinnitus, no discharge, no ear pressure or pain *Nose*: no sinus congestion, no epistaxis *Throat*: Neck sore from coughing/vomiting, no hoarseness, no bleeding gums, no dry mouth, no sore throat.

Skin/Breast
No rashes, bruising, sores, lumps, dryness, or color changes,

Cardiovascular
See HPI. Racing heart race beat felt at times. No palpitations.

Pulmonary
See HPI, no pleurisy, no emphysema

Gastro Intestinal
See HPI, no change in appetite, no trouble swallowing, no excess belching, no nausea; bowel movements fine (last one yesterday morning), and stools are negative for change or blood. +flatus. No bloating.

Genito Urinary
No dysuria, no incontinence, no polyuria, no nocturia, no urgency, no hematuria, no UTI's, no stones, no reduced flow, dribbling.

Musculo Skeletal
sore chest from coughing/vomiting, no other aches, pains, stiffness, or gout.

Neurologic
no headaches, no numbness, no tingling, no dizziness, no fainting, no blackouts, no seizures, no tremors

Psychology
no anxiety, tension.

Physical Examination

Vitals
T36.9 P104 R24 BP139/91 O2 sats : 95%RA

General
NAD, resting on stretcher and very alert during interview

Eyes
sclera and conjunctiva clear, EOMI, PERRLA, no ptosis.

ENT
oropharynx, nares clear

Lymphadenopathy:
No cervical, supraclavicular, axillary, or inguinal nodes

Neck
Supple, no thyromegaly or thyroid nodules, no bruits

Cardiovascular
RRR with a soft S1 and normal S2. no mrg. No edema, pulses 2+ bilaterally (radial, posterior tibialis, dorsalis pedis), no JVD.

Lungs
Normal to percussion. On auscultation, decreased to no breath sounds in lower right lung field. Lower left lung field sounds overly bronchial (no vesicular sounds). No wheezes, rales, or rhonchi and no stidor. No tactile fremitus or egophany.

Skin
Poor turgor, no rashes, bruising, petechiae; no signs of gynecomastia

Psychiatry
mood stable

Abdomen
Normal bowel sounds, soft, NT, ND, no masses, no hepatomegaly (liver comes being 0-1 cm below costal margin), no splenomegaly.

Rectal
Negative for occult blood, and no prostate hypertrophy or nodules.

Extremities
no clubbing, cyanosis, edema

MusculoSkeletal
Normal bulk, and power was 5+ grip and elbow, knee, and ankle flexion and extension bilaterally.

Neurological
Alert and oriented x 3. CN 2-12 intact. Sensation to light touch and cold stimuli intact bilaterally. Finger to nose nl. Babinski is downgoing. DTR's (biceps, patellar, and achilles) nl.

Pertinent Diagnostic Tests

Notes:
Metabolic panel wnl
CBC wnl except WBC 15.1

CREATINE KINASE 63 (70-185)
CK-MB 1.5 (0.0-6.0)
TROPONIN T <0.029
(2nd and 3rd set pending)

EKG – Normal sinus rhythm, PR is <0.20, QRS is <0.12. No PVC's or signs or hypertrophy.

10/07/2007 CHEST 2V PA + LAT
FINDINGS: Cardiac silhouette and mediastinal contours are in appearance with large right paratracheal mediastinal mass again identified. The lungs are clear bilaterally without evidence for focal airspace consolidation, pleural effusion, pneumothorax, or edema. The visualized osseous structures and soft tissues are grossly unchanged.
IMPRESSION: Stable appearance of the chest as compared to study dated 09/28/07 with stable right paratracheal mediastinal mass again identified.

09/28/2007 CTA CHEST w/contrast
IMPRESSION: 1. No CT evidence of acute pulmonary emboli. 2. Large mediastinal mass with mass effect on the trachea and endobronchial extension as well as perihilar soft tissue lesion
is most concerning for a primary bronchogenic carcinoma. Tiny nodules in the right upper and lower lobes may represent tumor spread vs bronchial obstruction and mucus impaction.

Problem List
1) LUNG MASS
2) DYSPNEA ON EXERTION
3) CHEST PAIN/ HEARTBURN/ TIGHTNESS
4) COUGHING/VOMITING
5) DECREASED PO INTAKE/WEIGHT LOSS
6) SMOKING Hx/NICOTINE ADDICTION
7) EtOH INTAKE
8) LEUKOCYTOSIS
9) FAMILY Hx + for DM
10) NO PRIMARY CARE PROVIDER/REGULAR HEALTH CARE

Assessment and Recommendation

Patient is a 51 year old gentleman with no significant past medical history presenting with 3 weeks of dyspnea on light exertion and a 10 lb weight loss in 8 days. He presented 9 days ago to the UNC ED with the same set of symptoms and had a CT Chest that shows a large right-sided mediastinal mass.

LUNG MASS –
While the diagnosis is unconfirmed at the moment, it seems likely that this patient has lung cancer. Smoking status is the primary risk factor leading to lung cancer (bronchogenic carcinoma or squamous cell) with a lifetime smoker's risk being 10- to 30- time that of a non-smoker. Persons with lung cancer are most often (~95%) diagnosed because of some symptom or symptoms. Symptoms may be related to the primary lung lesion or to intrathoracic spread, distant metastasis, or paraneoplastic syndromes. The symptoms most commonly presented include cough, SOB, wheezing, chest pain, hemoptysis, loss of appetite, weight loss, or pneumonia. This patient has a significant smoking hx while exhibiting at least 4 of these symptoms in addition to also having a mass found on imaging studies. Other conditions on the differential for this pt's lung mass include TB vs aspergillous (fungus ball) vs sarcoidosis vs uncomplicated pneumonia, though the hx has pertinent negatives for much of this differential.

The Xrays and CT Chest from last weekend and an additional Xray today show a similar mass. Additionally, a new CT Chest is pending to further evaluate if mass has changed at all. We have scheduled a Bronchoscopy/Biopsy to further workup the tissue/mass. Also ordered is an Induced sputum culture to assess for fungal or bacterial infection. Blood cultures will assess for systemic infection due to pneumonia or some other cause, but this is unlikely due to lack of fevers or other constitutional symptoms. A PPD was placed to be read in 2 days. Despite the lack of TB exposure the pt should be assessed for current TB status. And we will have regular Chem10 and CBC draws to assess for paraneoplastic syndromes including hypercalcemia or resultant hyponatremia (1st set is not suggestive of such); will consider PTH, CEA, and CYFRA 21-1 testing. Also an ACE blood level will be pulled with the AM draw to assess for possible Sarcoidosis, since epidemiologically speaking, the patient is the right age and race for this diagnosis, though

it is rare.

DYSPNEA ON EXERTION - Likely due to the effect of mass on Right lung, but should consider other concomitant causes such as asthma or CHF. We will watch O2 sats and obtain "O2 sats on exertion" for comparison before discharge. Supportive therapy as needed with Albuterol 2.5mg neb q4hr PRN daily and Ipratropium nebs 0.5mg q4hr PRN daily. IF Sat levels go below 92%, apply O2 2 liters nasal cannula. Further workup will be dictated by symptomology.

CHEST PAIN/ HEARTBURN/ TIGHTNESS – Quite possible cause by the right sided mass, but these symptoms also required a cardiac workup and GI prophylaxis. EKG and first set of cardiac enzymes were not alarming and the hx does not really fit this kind of pain with such a prolonged course. Telemetry was initiated but has now been pulled. We will draw for two other sets of cardiac enzymes. For now, will give acetaminophen 650 mg PO q6hr pain, with consideration for narcotics if pain persists or worsens. Heartburn prophylaxis with Nexium 40mg PO qhs and sucralfate 1g PO q6hrs PRN qd.

COUGHING/VOMITING: Since this patient's coughing often leads to vomiting (but this is without nausea) it would be helpful to try and prevent the cough. No antiemetic regimen needed. Any foods but soups seem to trigger coughing, so diet with soups and liquids only as tolerated. Also will try Guaifensin 200mg PO q6hr PRN cough.

DECREASED PO INTAKE/WEIGHT LOSS: Pt has experienced a 10 lb weight loss and has poor skin turgor. Possible effects of neoplastic disease but also of decreased PO intake and dehydration. Chem10 currently does not show signs of dehydration. Pull again in AM to reassess. Start pt on Mechanical soft diet, which will hopefully be tolerated w/o triggering cough and subsequent vomiting. Start normal saline IV @ 100 ml/hr x 10 hours. Hydrate tonight and reassess volume status. Nutrition c/s for recommendations on patient situation. Thank you for your recommendations.

SMOKING Hx/NICOTINE ADDICTION: 20 pack year history. UNC is a non-smoking campus and pt likely to have cravings. Nicotine patch 7mg transdermal qd.

EtOH INTAKE: Patient has a consistent intake of about 6-7 beers on weekends, which indicate he may be using the drug in a binge fashion which has been shown to have many negative effects on health. Patient should be educated on how these choices can affect his health.

LEUKOCYTOSIS: WBC of 15.1. Despite constitutional signs, infection workup is indicated as already mentioned above. This includes blood cultures, sputum culture, U/A, and urine culture.

NO PRIMARY CARE PROVIDER: This patient could benefit greatly from having a primary care provider and getting regular physicals and screening for common cancers. Unfortunately there is not a reliable way to screen for lung cancer, but having a PCP still promotes healthier life choices and screening for other conditions. This could include a fasting lipid panel, a check of blood sugars and an A1c, and perhaps a colonoscopy to assess for colonic polyps and cancer.

PROPHYLAXIS: Heparin (rectal occult blood was negative and this is for DVT prophylaxis) and Nexium/Sucrulfate (see above)

DISPO: Full Code
--- Discharge and outpatient followup pending workup of mass and stabilization of dyspnea.