Assessment done 8/11 at 15:00.
CC/ID: KM is a 62-year-old white male presenting with a one-week history of shortness of breath, with acute worsening on the morning of hospital admission.
HPI: Mr. Murray first became short of breath on morning of Tuesday, August 3, while walking the half-mile to his office. He reports that as soon as he was inside his building, he sat down and the shortness of breath resolved. He notes that he experienced similar episodes throughout the week, but assumed it was due to the summer heat. On the morning of Tuesday, August 10 he had walked under 30 yards when he became extremely dyspneic and reports gasping for air. After ten minutes of rest, the dyspnea resolved. Prior to the onset of this episode, he could walk up two flights of stairs before stopping to catch his breath. Patient denies any chest pain, palpitations, nausea, vomiting, fever, tachycardia or orthopnea. Past medical history is positive for well-controlled hypertension and a 45-pack year history of smoking, although he quit over 30 years prior. He denies any history of clotting disorders or recent surgery. Patient is fairly sedentary due to painful ankle bursitis and his occupation as a software developer. He makes a 6-hour drive between Des Moines and Oak Park, IL twice a week, during which he rarely stops.
Past Medical History:
1. Hypertension: diagnosed in 1994, controlled with Lisinopril HCTZ. Patient reports that it is well controlled, denies history of angina or MIs.
2. Ankle bursitis: Diagnosed several years prior. Patient has tried treatment with orthotics, heel wedges and steroid injections, which have all been unsuccessful. Currently rest is the only effective treatment.
3. Nasal polyps: Surgical removal in 2005.
Past Surgical History:
1. Remote removal of several sebaceous cysts.
2. Nasal polyp removal done in 2005 without complication.
3. Anal fistula repaired in 2005 without complication.
Medications:
1. Lisinopril HCTZ 20/12.5mg daily
2. Montelukast 10 mg daily
3. Mometasone
Allergies: No known drug allergies, but avoids aspirin and NSAIDs due to history of nasal polyps.
Social History: Mr. Murray is originally from England, but now resides in Oak Park, IL where he seeks primary medical care. He is a software developer and splits his time between Oak Park and Des Moines. He is married with two children, ages 19 and 21. He has a 45-pack year history of smoking and currently drinks three beers per day with meals. He states that he recently stopped drinking gin and whiskey.
Family History:
Father died of lung cancer at age 66. He also suffered a mild MI in his late 50s. He was a smoker.
Mother died of colon cancer at age 72. She also had breast cancer for which she underwent a double mastectomy.
Brother suffers from epilepsy.
He has no other siblings and does not know if his grandparents had any medical illnesses.
Review of Systems:
General: Possible 5-7 pound weight loss over past few months. No fevers, chills, night sweats.
HEENT: Six-month history of tinnitus. No changes in vision or hearing. No hoarseness, sore throat or difficulty swallowing.
Neck: No notable swelling or changes.
Chest: As per HPI. Patient's wife reports that he snores and occasionally stops breathing while asleep.
Cardiovascular: As per HPI.

GI: Patient had a positive FOBT three years prior and underwent a colonoscopy during which a precancerous polyp was detected and removed. He is due for another colonoscopy this summer. No diarrhea, constipation or changes in bowel movement frequency or consistency.
GU: No dysuria, urinary frequency or blood in the urine.
Extremities: Patient reports occasional numbness and/or tingling of toes and feet. No LE edema or tenderness.
Musculoskeletal: Pain in ankle bilaterally due to bursitis. No other swelling or tenderness of joints.
Neuro: Three-week history of morning headaches, which he feels are resolving without treatment.
Psych: No changes in patient's mood or behavior.

Physical Exam:
Vitals: Temp: 36.8 BP: 118/79 HR: 105 RR: 26 O2Sat: 95% on room air
General: Patient is 62-year-old obese, pleasant white man in no acute distress. Patient was alert and oriented X 3, but breathing heavily as he walked from bathroom to bed.
Skin, hair and nails: Normal skin temperature to touch. Capillary refill under 2 seconds. No cyanosis, clubbing or edema. No changes in hair color, texture or thickness.
HEENT:

Eyes: Patient wears glasses. Visual fields full to confrontation centrally and peripherally. Visual acuity and EOMs not assessed. Conjunctiva clear and moist. Pupils equally reactive to light and accommodation.

Ears: Hearing intact and symmetrical to finger rub.

Nose: Symmetrical without lesions.

Mouth/Throat: Buccal mucosa and gingival moist and pink without lesions. Symmetrical palate elevation. Tongue mobile without scars or deviation. Exam notable for enlarged tonsils.
Neck: Large neck circumference. No palpable lymph nodes or thyroid gland. No carotid bruits.
Chest: Chest wall appeared symmetric at rest and with deep breath. No accessory muscles used in breathing. Lungs symmetric and resonant on percussion. Breath sounds clear and audible posteriorly and anteriorly.
Cardiovascular: Regular rate and rhythm, no murmurs, rubs or gallops assessed in 4 areas while sitting upright. Apical impulse not found. No thrills, heaves or lifts. No edema of lower extremities.
Abdomen: Bowel sounds present in all four quadrants. No tenderness on light or deep palpation. No masses assessed on palpation. Liver edge and spleen tip not felt on exam. Liver span 8x5 cm with scratch test. Significant midline protrusion evident with flexion of abdominal muscles.
Musculoskeletal: No swelling, erythema or tenderness of joints. ROM not assessed.
Neurological: Cranial nerves II through XII assessed and intact. Upper and lower extremity strength 5/5 bilaterally. Touch and pinprick intact left lower and upper extremities bilaterally. Proprioception intact upper extremities and right lower extremity. Patient scored 2/5 on left lower extremity proprioception. He reports ongoing numbness of left big toe.
Laboratory results:

1. BMP: Sodium 135, potassium 3.9, chloride 104, HCO3 19, BUN 10, creatinine 1.13, glucose 205.
2. CBC: WBC 10.7, Hemoglobin/Hematocrit 15.2/43.1. Platelets 222.
3. D-dimer 10.86
4. BNP 124
5. CPK 70, CK-MB 2.6, troponin-I 0.45
6. Chest x-ray: No consolidation, effusion or pneumothorax.
7. VQ scan: Findings demonstrated a heterogeneous perfusion imaging with multiple defects in multiple lobes. Intermediate probability for pulmonary embolism.

Assessment and Plan:

Summary: Patient is a 62-year-old white male with history of hypertension, smoking and frequent long car trips presenting with a one-week history of dyspnea on exertion. Symptoms acutely exacerbated on morning of admission.

1. Acute shortness of breath on exertion, likely due to pulmonary embolism based on symptoms and predisposing factors (sedentary lifestyle, frequent long car trips). Patient has been placed on heparin and will begin warfarin therapy. Plan to discontinue heparin therapy when INR is above 2.0. Bilateral lower extremity Doppler and ECHO should be performed to evaluate for potential causes of pulmonary embolism.
2. History of snoring and reported apnea. Patient's wife reports frequent snoring and episodes of apnea. Patient has a history of hypertension, is obese and has large tonsils on exam. A sleep study should be performed for potential obstructive sleep apnea.

Submitted by MEDICAL STUDENT, M3