November 23, 2010
1:30 PM, Internal Medicine Clinic

**CC**: Difficulty breathing and wheezing
**HPI**: Mr. G is a 54 year old Caucasian male with a past history of asthma, benign paroxysmal positional vertigo and hyperlipidemia reporting to clinic with a one day history of wheezing and difficulty breathing. He first noticed the acute onset of shortness of breath and chest tightness mid-afternoon yesterday. He believed the onset of symptoms to be related to a spicy hamburger he ate for lunch, however, symptoms continued to worsen throughout the afternoon and evening. He was unable to lay supine last night due to difficulty breathing and did not sleep well. He also reports a cough which was mildly productive for thin yellow sputum and worsened last night. Today he reports rhinitis, scratchy throat and a dizzy feeling. He believed he had a fever today but did not take his temperature. Mr. G denies any sick contacts, seasonal allergies, chest pain, myalgias, ear pain or sinus pressure. He has a history of asthma for which he takes Singulair and Advair daily. He has an albuterol inhaler, but rarely uses it. He has not used his inhaler during this episode. Mr. G states that this episode feels "more like an infection than asthma."

**PMHx**:
1. Asthma: Mr. G was diagnosed approximately 20 years prior. He has rare exacerbations and is well-controlled with Singulair 10 mg daily and Advair 1 puff twice daily.
2. Benign Paroxysmal Positional Vertigo
3. Hyperlipidemia: Currently stable on simvastatin 20 mg daily.
No known drug allergies

**Physical Exam**:
Vital signs: BP: 132/80 P: 80 RR: 20 T: 98.3F Wt. 170 lbs BMI 26.5
General: Patient is a well-groomed, well-nourished man who is alert and oriented and in no acute distress. Visible diaphoresis along brow-line.
HEENT: Normocephalic, atraumatic. TMs clear, moderate dark orange cerumen in canals bilaterally. Nasal mucosa boggy and inflamed without obvious purulent discharge. Oropharynx pink and moist, no drainage, erythema or swelling visible.
Neck: Supple, no thyromegaly or lymphadenopathy.
Cardiac: Regular rate and rhythm, no murmurs, rubs or gallops.
Pulmonary: Diffusely decreased breath sounds bilaterally. Diffuse expiratory wheezes, particularly evident with forced expiration.
Extremities: No edema or skin changes noted. Radial, posterior tibial and dorsalis pedis pulses 2+ bilaterally.

**Assessment/Plan**:

1. Asthma exacerbation: Patient is slightly tachypneic and wheezing, making an asthma exacerbation a very likely occurrence. Wheezing and urge to cough with forced expiration is a soft indication for asthma exacerbation. Given the patient's past history of asthma and current symptoms, treatment need not be delayed for objective lung function measurements (i.e. measurement of FEV1). He will be started today on a burst and taper regimen of prednisone, taking 40 mg for the first three days and then decreasing the dose by 5 mg every two days. He was also instructed not to hesitate using his albuterol inhaler when he feels short of breath, regardless of underlying cause.
2. Bronchitis: While Mr. G's symptoms of productive cough, wheezing and dyspnea have been present only for one day, his status as an asthmatic lowers the threshold to treat bronchitis. His cough is productive of yellow sputum, which could be a sign of bacterial infection, although this is not specific as a viral infection may also lead to a similar productive cough. However, given his history of asthma and the subjective report of fevers, he will be treated with antibiotics to prevent worsening of current condition. He will be placed on a ten-day course of oral doxycyline 100 mg twice a day. He is to report back to clinic if symptoms do not improve.

MEDICAL STUDENT, M3