Jessica Brown 3/1/18
H+P - Physical Diagnosis

Identification: February 27, 2018, 9:05AM
NMS, F, African American, 43, Widow, 59-86 58th Ave, Flushing, NY 11378, Catholic.

Informant: The patient herself is a reliable historian

Referral Source: PMD: Dr. Mark Moradi

Chief Complaint: "I'm here for a blood transfusion." Low HgB

Present Illness: NMS is a 43-year-old female with a PMH significant for uterine fibroids, iron deficiency anemia, hypothyroidism, asthma + depression, presenting with constant heavy menses x 1 month, LMP 1/23/18. Patient notes using 2-4 pads per day since that date. Patient reports intense cramping associated with menstruation but reports pain of 0/10 at this time. Patient sent to the ED today by PMD/GYN for blood transfusion following outpatient lab findings of Hgb 6.4 drawn yesterday. Patient reports shortness of breath on exertion, notes no other aggravating or alleviating factors. Denies chest pain, blurred vision, weakness, fatigue, palpitations, dizziness, nausea, vomiting, diarrhea or chills. NO sick contacts.
great!
Of note, patient was seen in this ED on 2/6/18 for anemia + given a blood transfusion, without complications, at that time. Patient is scheduled to have a hysterectomy in 2 days.

- do we know the sizes and location of the fibroids?

PMH: Uterine fibroids x 3 years, iron deficiency anemia x 3 years, hypothyroidism x 5 years, asthma x 3 years, depression x 7 years. Immunizations up to date. Denies any childhood illnesses.

PSH: Tonsillectomy 1979 (44/0), unknown physician or location of procedure. Endoscopic carpal tunnel release Sx 2006, NYP Queens, physician unknown.
6 prior blood transfusions due to Hgb < 7, NYP Queens E. no complications. 3 C-sections (2000, 2003, 2004).

Medications. Folic Acid 1mg PO/day
Zoloft 50mg PO/day
Lexapro 5mg PO x 2/day
Ferrous sulfate 325mg PO, 3x/day
Synthroid: dose unknown
Albuterol inhaler PRN, dose unknown

Allergies: NKDA. No food allergies. Reports seasonal environmental allergies associated with eye pruritus + sneezing.

Family History: Mother, 54, deceased. HTN, asthma, kidney disease.
Father, 66, deceased. DM, HTN, stroke x 3
Sister, 51, alive. Fibroids + asthma
Brother, 50, alive. Downs Syndrome
Daughter, 18, alive. Asthma
Daughter, 15, alive. Depression
son, 14, Alive + well.
Of Note, patients husband committed suicide 7 years ago

maternal/paternal grandparents?

Social History: Denies ETOH, smoking or any illicit drug use. Patient is widowed, works as a cashier in Costco + lives with her 3 children. Patient notes she tries to walk for exercise + sleeps 6 hours a night. Reports drinking 1 20 oz soda a day + notes she "eats whatever she wants." Patient has not done any recent traveling.

REVIEW OF SYSTEMS

General: Denies any recent weight loss or gain, loss of appetite, generalized weakness / fatigue, fever or chills or night sweats.

Skin, Hair + Nails: Denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles / rashes, pruritis, changes in distribution.

Head: Denies headache, vertigo, lightheadedness, or any head trauma.

Eyes: Denies visual disturbance, lacrimation, photophobia, pruritus. Patient wears glasses - last eye exam: 1 year ago. normal

EARS: Denies deafness, pain, discharge, tinnitus or wearing hearing aids

Nose/sinus: Denies discharge, epistaxis, obstruction.

Mouth + Throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers or voice changes. Patient does not wear dentures - notes last dental exam August 2017. normal ?

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

Breast: Denies lumps, nipple discharge, pain. Last mammogram: December 2017. normal ?

Pulmonary System: Reports dyspnea on exertion. Denies cough, wheezing, hemoptysis, cyanosis, orthopnea or PND.

Cardiovascular System: Denies chest pain, HTN, palpitations, irregular heartbeat, edema, swelling of ankles / feet, syncope or known heart murmur

Gastrointestinal System: Denies any change in appetite, intolerance to foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding. NO stool guaiac. ✓

Genitourinary System: Denies any frequency, nocturia, urgency, oliguria, polyuria, dysuria. Change in color of urine, incontinence, awakening at night to urinate, pain-flank.

Sexual History: Patient is sexually active with men. Denies anorgasmia or STIs. Uses condoms for contraception.

Menstrual + Obstetrical: LMP: 4/23/18. Patient actively bleeding >1 month. Heavy flow, denies clots, dysmenorrhea. Reports metorrhagia + menorrhagia. Denies post coital bleeding, vaginal discharge, dyspareunia, menopause. G4P3 (3013)

pap smear?

Nervous System: Denies seizure, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition, or weakness.

Musculoskeletal System: Denies muscle/joint pain, deformity or swelling, redness or arthritis

Peripheral vascular System: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change. ✓

Hematologic System: Reports anemia. Denies easy bruising/bleeding, lymph node enlargement, history of DVT/PE. History of 6 previous blood transfusions

Endocrine System: Denies polyuria/polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating or hirtuism.

Psychiatric: Patient reports depression, notes she sees a psychiatrist once a month + a therapist every 2 weeks. Patient on zoloft 50mg PO/day. Denies anxiety + OCD.

General Survey: 43 y/o female. A/O x 3. Patient appears to be of stated age, is in no acute distress + resting comfortably in the ED.

Vital Signs

BP: Sitting, Right arm: 130/84 mm Hg
Supine, Right arm: 136/90 mm Hg

R: 17 breaths/min, unlabored

P: 90 beats/min, regular rhythm

T: 36.8°C (oral)

SpO_2: 100% on RA

Height: 5'5" Weight: 220 BMI: 36.6

PHYSICAL EXAM

Skin: Warm + dry, good turgor. Nonicteric, no lesions noted, no scars, no tattoos.

Hair: Average quantity + distribution

Nails: no clubbing, capillary refill < 2 seconds throughout

Head: NC/AT nontender to palpation throughout

Eyes: Pale conjunctiva noted, bilaterally. Symmetrical OU; no evidence of strabismus, exophthalmos or ptosis | sclera white; cornea clear. Visual acuity: 20/200s, 20/20 OD, 20/20 OU, corrected. Visual fields full OU. PERRLA. EOMI with no nystagmus. Fundoscopy - red reflex intact OU. Cup: disc ≤ 0.5 OU | no evidence of AV nicking | papilledema | hemorrhage | exudate | cotton wool spots | neovascularization OU.

Ears: Symmetrical + normal size. No evidence of lesions | masses | trauma on external ears. No discharge | foreign bodies in external auditory canals AU. TMs pearly white | intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline | Rinne reveals AC > BC AU.

Nose: Symmetrical | no obvious masses | lesions | deformities | trauma | discharge. Nares patent bilaterally | nasal mucosa pink + well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions | deformities | injection | perforation. No evidence of foreign body.

Sinuses: Nontender to palpitation + percussion over bilateral frontal, ethmoid + maxillary sinuses

Lips: pink, moist; no evidence of cyanosis or lesions

Mucosa: pink; well-hydrated. No masses; lesions noted. No evidence of leukoplakia

Palate: Pink; well hydrated. Intact with no masses, lesions or scar

Teeth: Dentition intact. No obvious dental deformities | caries noted.

Gingivae: Pale, moist. No evidence of hyperplasia, masses; lesions; erythema or discharge

Tongue: Pink; well papillated; no masses, lesions or deviations noted

Oropharynx: well-hydrated; no evidence of injection; exudates; masses;

lesions; foreign bodies. Tonsils present with no evidence of injection or exudates. Uvula pink; no edema; lesions.
Neck: Trachea midline: No masses; lesions scars; pulsations noted. Supple: nontender to palpation. Full ROM; no stridor noted. 2+ carotid pulses bilaterally. No thrills bilaterally, no bruits noted bilaterally, no palpable adenopathy noted.
Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted
Chest: Symmetrical, no deformities, no evidence of trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. LAT to AP diameter 2:1. Nontender to palpation
Lungs: Clear to auscultation + percussion bilaterally. Chest expansion + diaphragmatic excursions symmetrical. Tactile fremitus intact throughout. No wheezing, rhonci, crackles, rales noted.
Heart: JVP is 2.0 cm above sternal angle with head at ~30°. PMI is in 5th ICS in midclavicular line. Carotid pulses 2+ bilaterally without bruit. RRR. S1+S2 normal. No murmurs, gallops noted
Abdomen: Flat/ symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits noted over aortic / renal / iliac / femoral arteries. Tympany to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT bilaterally
Female Genitalia: normal pubic hair pattern, no erythema, inflammation, ulcerations, lesions or discharge noted. BUS WNL. Vaginal mucosa without inflammation, erythema or discharge. Cervix multiparous without lesions or discharge. No cervical motion tenderness. Uterus retro-flexed, mobile, non-tender + of normal shape, size + consistency. Adnexa without masses or tenderness

Rectal: No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative.
Breast: Symmetric, no dimpling, no masses, nipples without discharge. No axillary nodes palpable.

ASSESSMENT: 43 y/o female, PMH of uterine fibroids, iron deficiency anemia, hypothyroidism, asthma + depression presents to ED for a blood transfusion due to uterine fibroids, >1 month of heavy menstrual bleeding + an Hgb of 6.4, prior to hysterectomy.

PLAN:

1. Low Hgb: • 1 unit RBCs
   • Repeat CBC

essentially the same

2. Anemia: monitor Hgb + continue medication as perscribed

which medication?

3. Depression: continue to see psychiatrist + therapist. Continue medications as perscribed.

4. Hypothyroidism: monitor thyroid hormone levels + continue medication as perscribed

which medication?

5. Asthma: use albuterol inhaler as needed.

6. Uterine Fibroids: Hysterectomy - scheduled 3/1/18

Differential Diagnosis

1. Uterine Fibroids: most likely. Causes heavy menstrual bleeding, prolonged periods, leading to low Hgb
2. Iron Deficiency Anemia: very likely in culmination with the uterine fibroids, due to the SOB on exertion + noted pale conjunctiva in the eyes.
3. Hypothyroidism: likely given it can cause heavier than normal/irregular menstrual periods. Pt also suffering from depression, which can result from thyroid hormone imbalance.
4. Cirrhosis: unlikely as no jaundice, loss of appetite, nausea, weight loss, social contributing factors, pruritis or confusion.
5. Cancer: unlikely, as this is recurrent with long periods. No weight changes, fevers, difficulty eating, skin changes, unexplained masses/lumps.

96.80 (A)

good job!