Malka Einhorn

8/29/23

H&P- IM

History

Identifying Data:

Date & Time: August 23, 2023, 10:00 AM

Full Name: I.A.

Location: Flushing, Queens, NY

Sex: Male

Date of Birth: October 29, 1946

Marital Status: Married

Religion: Muslim

Source of Information: Self

Reliability: Reliable

Source of Referral: Doctor

Mode of Transport: Self

Chief Complaint: "My waist was hurting" x1 month.

History of Present Illness:

77 year old male with history of lung cancer presents with lower back pain x1 month. Pt admits to smoking a pack a day from age 17 until he cut back to half a pack a day 10 years ago. Pt is a retired editorial assistant, with no known exposures to lung carcinogens. Pt states that prior to back pain he experienced tolerable leg pain x1 year. He was told he would need a hip replacement. Last month, pain became localized to the lower back above the gluteal cleft with radiation towards the bilateral sides ("belt area"). Pain is rated as a 10/10 "bone crushing" pain and is constant. Pain is worse when standing and taking even just one step and is relieved with sitting and laying on his back and side. Pt denies any similar episodes in the past. Pt admits to losing more than 10% of his body weight in the past 6 months, without any weight loss attempts, and constipation.

Pt denies loss of appetite, fever, chills, night sweats, cough, dyspnea, chest pain, nausea, vomiting, diarrhea, paresthesia, numbness to extremities, urinary frequency and urinary urgency.

Past Medical History:

Present illnesses: BPH x15 years, well controlled on medication

Atrial Fibrillation x10 years, well controlled on medication

Previous illnesses: Lung cancer two different times

Childhood illnesses: None

Immunizations: up to date, flu vaccine received 11/22, received 4 doses of the Moderna covid vaccine

Screening tests and results: Colonoscopy 6/2023, small polyp removed

Past Surgical History:

- Tonsillectomy, 1965- unknown reason, unknown hospital in Egypt, no complications
- Inguinal hernia repair, 1998- unknown hospital in Long Island, no complications
- Lobectomy, 2013- removal of tumor, NYPQ, no complications
- Lobectomy, 2020- removal of tumor, NYPQ, no complications

Medications:

- Tamsulosin (unknown dose), for BPH
- Dutasteride (unknown dose), for BPH
- Rivaroxaban (unknown dose), for A. Fib

Denies use of any other medications/supplements.

Allergies:

NKDA, denies food/environmental allergies.

Family History:

Paternal/maternal grandparents – deceased at unknown ages due to unknown cause

Mother – deceased at unknown age due to unknown cause

Father – deceased at unknown age due to unknown cause

Children- two sons (aged 56, 45) and two daughters (aged 40, 50), all alive and well

Siblings- three brothers and two sisters, deceased at unknown ages due to unknown causes

Social History:

Habits: Pt admits to a smoking history of 60 years. Pt smoked a pack a day x50 years and says he cut back to half a pack a day ten years ago. Pt denies drinking alcohol and coffee. Denies illicit drug use and history of substance abuse.

Travel: Returned from Egypt on July 1, 2021.

Marital History/Home Situation: Married, living with wife.

Occupational History: Retired, previously was editorial assistant

Diet: Admits to balanced diet with meats, chicken, fruits, vegetables, healthy grains and no pork

Sleep patterns: Pt sleeps 8 hours daily and feels rested

Exercise: Cannot stand/ambulate due to pain so does not exercise, pt used to play soccer.

Safety Measures: Admits to wearing seatbelts.

Sexual History: Heterosexual. Reports being sexually active with 1 female partner in the past 6 months. Denies use of barrier protection.

Review of Systems:

General: Admits to weight loss (215 lbs.→ 158 lbs. in 6 months). Denies generalized weakness /fatigue, recent, loss of appetite, fever, chills, or night sweats.

Skin, Hair, and Nails: Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, or changes in hair distribution.

Head: Denies headache, vertigo, or head trauma.

Eyes: Denies visual disturbance, lacrimation, photophobia, or pruritus. Wears contact lenses, last eye exam was in 07/23.

Ears: Denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses: Denies discharge, epistaxis, or obstruction.

Mouth and Throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures. Last dental exam 02/23, normal.

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

Breast: Denies lumps, nipple discharge, or pain.

Pulmonary System: Denies shortness of breath, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

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

Gastrointestinal System: Admits to constipation with passing of hard stools approx. twice weekly. Denies loss of appetite, nausea and vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, rectal bleeding, hemorrhoids or blood in stool.

Genitourinary System: Denies urinary frequency, nocturia, dysuria, urgency, flank pain, oliguria, polyuria and incontinence.

Nervous System: Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory.

Musculoskeletal System: Admits to muscle/joint pain in lower back region. Denies deformity or swelling, redness or arthritis.

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

Hematologic System: Denies anemia, easy bruising or bleeding, lymph node enlargement, or history of DVT/PE.

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

Psychiatric: Denies feelings of helplessness, hopelessness, lack of interest in usual activities, or suicidal ideations, anxiety, obsessive/compulsive disorder, or ever seeing a mental health professional.

Physical

General: Well developed, well-nourished, healthy appearing male in no apparent distress. Appears stated age of 77. Neatly groomed, alert and oriented x3. Lying in bed so no assessment on ability to ambulate.

Vital Signs:

BP:

R- Seated:125/81 mm Hg

Supine :123/77 mm Hg

L- Seated: 125/82 mm Hg

Supine: 121/75 mm Hg

R: 19/min, regular rate and rhythm, slightly labored

P: 65 beats per minute, regular rate, rhythm and amplitude

T: 97.7 degrees F (oral)

O2 Sat : 98% room air

Height: 67 inches Weight: 158 lbs BMI: 24.7

Skin & Head:

Skin: Warm and moist, good turgor. Nonicteric, no lesions, scars, or tattoos noted.

Hair: Frontal balding with average texture. No alopecia, seborrhea, or lice on exam.

Nails: No clubbing, cyanosis, or lesions. Capillary refill < 2 seconds in upper and lower extremities.

Head: Normocephalic, atraumatic with no evidence of contusions, ecchymoses, hematomas, or lacerations, and nontender to palpation throughout.

Eyes: Symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink.

Visual acuity – 20/20 OS, 20/20 OD, 20/20 OU

Visual fields – full OU. PERRLA. EOMs intact with no nystagmus.

Fundoscopy – red reflex intact OU on fundoscopy. Cup to disk ratio < 0.5 OU. No AV nicking, hemorrhages, exudates, or neovascularization OU

Ears: Symmetrical and appropriate in size. No lesions, masses, or trauma on external ears. No discharge/foreign bodies in external auditory canals AU. TMs pearly gray/intact with light reflex in good position AU.

Auditory Test:

Auditory acuity intact on whisper test

Weber is midline

Rinne AC> BC bl

Nose/Sinuses:

Nose: Symmetrical. No masses, lesions, deformities, trauma, or discharge. Nares patent bilaterally. Nasal mucosa is pink and well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, or perforation. No foreign bodies.

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.

Mouth/Pharynx:

Lips: Pink and moist. No cyanosis or lesions. Non-tender to palpation.

Mucosa: Pink and well hydrated. No masses, lesions or leukoplakia. Non-tender to palpation.

Palate: Pink and well hydrated. Palate intact with no lesions, masses, scars. Continuity intact. Non-tender to palpation.

Teeth: Good dentition. No obvious dental caries noted.

Gingivae: Pink and moist. No hyperplasia, masses, lesions, erythema or discharge. Non-tender to palpation.

Tongue: Pink and well papillated. No masses, lesions or deviation. Non-tender to palpation.

Oropharynx: Well hydrated. No injection, exudate, masses, lesions or foreign bodies. Tonsils not present present. Uvula midline, pink with no edema or lesions.

Neck/Trachea/Thyroid:

Neck: Trachea midline. No masses, lesions, scars, pulsations. Supple and non-tender to palpation. FROM, no stridor noted. 2+ carotid pulses, no bruits or thrills noted bilaterally. No cervical adenopathy.

Thyroid: Non-tender to palpation. No masses, thyromegaly or bruits noted.

Thorax and Lungs:

Chest: Symmetrical, no deformities, no trauma. Respirations unlabored/ no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout.

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.

Cardiac Exam:

Heart: JVP is 2.5 cm above the sternal angle with head of bed at 30 degrees. Carotid pulses are 2+ bilaterally without bruits. PMI in 5th ICS in mid-clavicular line. Regular rate and rhythm. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdominal Exam:

Abdomen flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all 4 quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to

palpation and tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation. No CVA tenderness appreciated.

Male Genitalia:

Male Genitalia and Hernia: Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias noted.

Anus, Rectum and Prostate: No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate enlarged, smooth and non-tender with palpable median sulcus.

Problem List

- Lower back pain
- Constipation
- BPH
- A. Fib
- Smoking history

Assessment

77 year old male with past medical history of lung cancer, A. Fib and BPH presents with severe, localized lower back pain present for 1 month. Previously pt complained of leg pain for one year which spontaneously resolved. No notable abnormalities on physical exam, other than the inability to ambulate. The chief complaint is most consistent with metastatic tumors and should be worked up to find the source of origin and locations of metastasis, through the use of labs and imaging. No labs are available at this time.

Differential Diagnosis

1. **Metastatic tumor:** Due to multiple key details, metastatic cancer to the spine is the most likely diagnosis. Pt has had two previous episodes of lung cancer, which is one of the top 3 cancers that metastasizes to the bone. Pt's age (>50), unexplained weight loss and the duration of symptoms being about/ more than 1 month all also point to this diagnosis.
    - Based on this I will order an MRI of the back as it is the best imaging techniques used to visualize metastatic lesions of the spine. Additionally, obtaining LDH and alkaline phosphatase levels will be helpful in assessing for metastatic lesions to the bone. Doing a PET/CT will help evaluate the extent of the metastasis. Being that lung cancer is the most probable origin, due to his history of lung cancer and his extensive smoking history, a chest x-ray should be done to assess for any pulmonary nodules. If any is found, biopsy should be done. The choice of biopsy would be dependent on the location of the nodule- bronchoscopy for central mass, transthoracic needle biopsy for peripheral lesions, or open biopsy if not accessible via needle or if it is too risky.

2. **Herniated disc:** Considering the fact that the pt complained about leg pain prior to back pain, it may suggest a herniated disc which can cause spinal cord compression sending radicular pain down the leg. However, another characteristic of a herniated disc is the worsening of back pain after sitting for long periods of time which is inconsistent with the symptoms the patient is experiencing, with the back pain being relieved with rest. Additionally, herniation of discs primarily affects people aged 30-50 and this patient lies outside of that age range.
    - Performance of a straight leg raise (would normally be written in neuro portion of the physical exam) helps to rule this in or out. MRI will also be done to visualize any disc herniation.

3. **Spinal stenosis:** The pain associated with spinal stenosis is worse with extension and resolves with sitting down, characteristic of the pain that the pt is experiencing. Additionally, spinal stenosis usually affects adults over age 50, another criteria that the pt matches. It is also noted that slight lumbar extension can cause severe pain that radiates down the legs. This pt stated that his pain stays localized to the lower back and does not radiate toward the leg, which makes this diagnosis slightly less likely.
    - MRI of the back is the best imaging modality to recognize the extent of stenosis.

4. **Muscle strain:** Muscle strain is a stretch or tear of a muscle. It often happens when the muscle tightens during activity such as running, jumping or heavy lifting. Also, it is generally acute in onset and resolution. The pain is not either relieved with rest. Being that there was no physical activity noted at onset and that the pt's pain had a more chronic onset and duration, this diagnosis is less likely in this patient.
    - This is a diagnosis of exclusion.

5. **Cauda equina syndrome:** Whenever thinking about severe lower back pain, causa equina syndrome is a must not miss. In this case think it is an unlikely diagnosis, but because it is a must not miss I am including it in my list of differentials. Generally this is a more emergent situation, characterized by severe back pain (which is present in this patient) in addition to saddle anesthesia and urinary and bowel incontinence which are all not present in this patient.
    - Based on this I will order a STAT MRI of the back.

6. **Opioid induced constipation:** Pt is likely on an opioid for pain which is known to cause constipation.

Work-Up

MRI of the back, chest x-ray (biopsy if nodule is found), PET/CT, LDH and Alk phos levels

Plan

Back Pain

- Morphine PRN for pain
- Await imaging and lab results
- Oncology vs. neurosurgery consult depending on results

Constipation

- Sennoside 15 mg tablet, 2 tablets once daily
- If ineffective consider increasing dose of sennoside, mineral oil enema followed by irritant enema or manual disimpaction, also consider switching from Morphine to other forms of pain management such as Ketorolac.

BPH

- Continue Tamsulosin and Dutasteride as prescribed

Atrial Fibrillation

- Continue Rivaroxaban as prescribed

Cigarette Smoking

- Smoking cessation counseling
- Provide quitting options- gum, patch, oral meds

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History and Physical Verification Form

Class: Physical Diagnosis II (HPPA 522)

Student Expectation:

- Obtain medical history and perform physical exam up to the point covered in class.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

Student: Maika Enakira

Clinical Site: UYPQ

Date of Visit: 8/29/23

Activity performed: HPI- IM

Supervisor:

Name and Credentials: AISHA TOPPA PA-C

Supervisor Signature: Aisha Toppa

Supervisor Comments: