Identifying Information
Full Name: ES
Address: 82-68 164th Street, Jamaica, NY 11432
DOB: 2/7/1926
Date & Time of Encounter: 01/05/2021 @8:30 am
Source of Information: Daughter (Reliable), Self (Unreliable), and EMS
Mode of Transport: EMS

HPI:
ES is a 94 y.o. Jamaican female, poor historian, hard of hearing, residing with her niece and grandchildren, dependent in ADLs and IADLS with PMHx of HTN, CVA with residual blindness (2018), HLD, carotid stenosis, PVD, glaucoma, constipation, chronic anemia requiring multiple transfusion in the past, recently discharged from Skilled Nursing (at home) for generalized weakness and gait disturbance on 12/18/2020 brought in by EMS @1am for the complaint of vomiting for one month. Patient is a poor historian and was AAO x 0 in ED so history was taken from EMS, family member, and previous medical records. As per ED, patient appeared uncomfortable and complaining of vomiting for the past month that is associated with both solid and liquids. Pt stated that sometimes when she eats solids or liquids it immediately comes back up. Family member was unable to specify the severity or timing of emesis, but noted it contains stomach contents. Patient also vomited in the ED and was seen by surgery (12 F salem sump placed and attached to intermittent suctioning, nearly 400 cc of dark blood tinged liquid suctioned). Pt also found to be guaiac positive in ED.

Per chart review, patient was admitted to hospital with upper GI bleeding and emesis in July, September, and November of 2020 and patient's bleeding was considered to be most likely secondary to erosive esophagitis, although the thickening of the gastric wall on prior CAT scan was suggestive of an infiltrating malignancy (linitis plastica), per previous GI note, at the time. During all three admissions, patient and family declined upper endoscopy as they considered it an invasive procedure. Per surgery's note, patient endorses abdominal pain intermittently, including when she has emesis. Additionally, during NG tube placement pt expressed desire for God to relieve her suffering. The rest of the ROS was not completed because the patient was AAOx 0.

This morning, the patient reports feeling better compared to when she presented to the ED since the placement of the NG tube. She reports abdominal discomfort and says she "can't keep anything down" but says she really wants to drink water. Tried calling daughter Ms. Pauline Taylor for collateral information but she did not answer.

PMH:
HTN
CVA (cerebral infarction)
HLD (hyperlipidemia)
Carotid Stenosis
PVD
Glaucoma

PSH:
No pertinent surgical history on file.

Medications:
Latanoprost (Xalatan) 0.005 % Ophthalmic Solution- 1 drop to both eyes at bedtime
Simvastatin (Zocor) 5 MG Tablet PO at bedtime
Albuterol (Ventolin HFA) 108 (90 BASE) MCG/ACT Inhaler- 2 puffs Q6H PRN
Pantoprazole (Protonix) 40mg Tablet PO BID/Q12H
Bisacodyl 5 MG EC Tablet- 2 tablets PO QD
Lactulose (Enulose) 10g/15mL Solution- 45mL PO BID
Lisinopril 5mg PO QD
Amlodipine (Norvasc) 5mg Tablet PO QD
Clopidogrel 75mg PO QD

Allergies:
Aspirin- Itching, Nausea and Vomiting

Social History:
Per social work, the patient immigrated from Jamaica West Indies in 1964. Her highest level of education is 8th grade or less. She receives social security, and pension as an income source. She resides with her daughter and granddaughter in a single-family house that the patient owns. Pt used to ambulate with a cane earlier in the year but now requires a walker at home and requires assistance with ambulation, dressing and bathing. The patient’s family reported to have a wheelchair if needed. She is bladder and bowel continent and is able to feed herself. Her family reports that she has been moving slower and requiring more assistance with ADL's. Patient has no known history of substance abuse. The patient’s family reported that at baseline, the pt is alert and oriented; knows herself and her family. Pt is also noted to be talkative at baseline.

Family History:
Mother: deceased, unknown age and cause of death
Father: deceased, unknown age and cause of death
Sister: deceased, hx of colon cancer, unknown age and cause of death
Brother: deceased, unknown age and cause of death

ROS:
Unable to obtain ROS due to age and pt being AAOx0
Gastrointestinal: Positive for vomiting, abdominal pain.

Vitals:

BP	123/54 (Right arm, Supine)	Ht	1.6 m (5' 3")
Pulse	75	Wt	48.1 kg (106 lb)
Temp	98.2 °F (36.8 °C) (Oral)	SpO2	98% RA
Resp	17	BMI	18.78 kg/m²

Physical Exam:
Constitutional:
Appearance: Cachectic, elderly female, appears stated age, lying in bed, appears comfortable (due to relief after NG placement). Pt is awake and AAOx0.
HENT:
Head: Normocephalic and atraumatic.
Right Ear: Decreased hearing noted.
Left Ear: Decreased hearing noted.
Oropharynx: Poor dentition, dry mucous membranes.
Neck:
Musculoskeletal: Normal range of motion and neck supple.
Heart:
RRR, S1, S2 normal, no murmur, click, rub or gallop
Pulmonary:
Effort: No respiratory distress or increased breathing effort
Auscultation: Clear to auscultation bilaterally, good air entry
Abdominal:
General: Abdomen is soft, nontender, nondistended. Bowel sounds are normal.
Skin:
General: Warm and dry. No masses or rashes noted.
Extremities:
Lower Extremity: **+2 pitting edema in left lower extremity**, Dorsalis pedis pulses 2+

Labs: (01/05/21)
CBC: WBC 7.85/ **Hgb 9.2**/ **HCT 29.9**/ Plts 358k/ Neut 76.4% / Lymph 16.6%
CMP: Na **133**, K 5.0, Cl 100, CO2 23, **BUN 31**, **CR 1.43**, **Glu 125,** Calc 8.6, **Albumin 3.0, Protein 5.9,** TBili <0.3, AlkPhos 104, ALT 8, AST 23, **eGFR 34**
Lipase: 41
VBG: PH 7.372, PCO2 42.7, **PO2 28.5**, Lactate 1.1
Troponin <0.010
APTT 28.2

Imaging:
CT ABDOMEN PELVIS WO CONTRAST (01/05/2021)
FINDINGS:
Pleural space: Interval development of bilateral pleural effusions. Bilateral dependent consolidation.

Liver: Normal. No mass.
Gallbladder and bile ducts: Normal. No calcified stones. No ductal dilation.
Pancreas: Normal. No ductal dilation.
Spleen: Normal. No splenomegaly.
Adrenal glands: Normal. No mass.
Kidneys and ureters: Worsening right hydronephrosis. Right renal atrophy.

Stomach and bowel: Circumferential wall thickening of the gastric antrum, differential diagnosis includes antral gastritis as well as neoplasm. The stomach is markedly distended.
Appendix: No evidence of appendicitis.

Intraperitoneal space: Small amount of free fluid.
Vasculature: Low-attenuation in the aorta lumen suggests anemia.
Lymph nodes: Unremarkable. No enlarged lymph nodes.
Urinary bladder: Unremarkable as visualized.
Reproductive: Unremarkable as visualized.
Bones/joints: Unremarkable. No acute fracture.
Soft tissues: Mild changes of anasarca.

IMPRESSION:
1. Worsening right hydronephrosis, cause not clearly identified.
2. Findings concerning for gastric neoplasm versus antral gastritis with associated gastric outlet obstruction.
3. New bilateral pleural effusions and bibasilar consolidation.
4. Small amount of ascites.

DX Portable Chest 1 View (01/05/2021)
IMPRESSION:
1. Left lung base patchy consolidation.
2. Cardiomegaly and pulmonary hyperinflation are stable.

Assessment:
ES is a 94 y.o. Jamaican female, poor historian, hard of hearing, residing with her niece and grandchildren, dependent in ADLs and IADLS with PMHx of HTN, CVA with residual blindness (2018), HLD, carotid stenosis, PVD, glaucoma, constipation, chronic anemia requiring multiple transfusion in the past, recently discharged from Skilled Nursing (at home) for generalized weakness and gait disturbance on 12/18/2020 brought in by EMS c/o vomiting for one month. Findings concerning for gastric neoplasm versus antral gastritis with associated gastric outlet obstruction.

Plan:
 # Emesis -Non-intractable vomiting with nausea, unspecified vomiting type
- CT imaging findings concerning for gastric neoplasm versus antral gastritis with associated gastric outlet obstruction - rule out GI malignancy
- Gentle hydration 75 ml/hr
- Monitor for PO intake
- General surgery consulted in the ED regarding outlet obstruction symptoms (12 F salem sump placed and attached to intermittent suctioning, nearly 400 cc of dark and blood tinged liquid suctioned)
- F/u with general surgery recommendations
- NPO for now as patient vomited in ED and is high risk for aspiration
- Monitor CBC, H/H - 9.2/ 29.9, anemia
- Bilateral pleural effusions. Bilateral dependent consolidation - rule out PNA, f/u with Pro-cal

- Protonix 40 mg IV

 # CKD Stage III/IV
- Cr/BUN 1.43/31
- Gentle hydration 75 ml/hr
- Monitor BMP
- Avoid nephrotoxic drugs

 # Glaucoma/HTN/HLD/Hx of CVA
- Continue home medications

 # Left lower extremity edema- rule out DVT
- +2 pitting left lower extremity edema
- LLE duplex ordered
    - **Lower Extremity Venous Duplex Bilateral (**01/05/2021)
    IMPRESSION: Findings suggest acute thrombus in the left common femoral through the popliteal veins as described above. No acute DVT in the visualized veins of the right lower extremity. Complex fluid collections in the popliteal fossa bilaterally probably represent Baker's cyst.
    - Pt placed on heparin drip 10 units/kg/hr, monitor aPTT and GI as she has h/o recurrent GIB.

 # GI prophylaxis
- Protonix 40 mg IV

 # Ethics
Contact family to have a conversation regarding resuscitation measures
- DNR/DNI as per pt and family wishes

As patient's family would not like to pursue any surgery or endoscopy, will discuss with them regarding hospice/disposition.
- Daughter verbalized understanding that with her mother's intolerance to food or water, her mother's prognosis is days to weeks. Daughter is willing to take her home with home hospice service with pleasure feeding only and no NG tube. Pt discharged with home hospice care and family requested home health aide from Hospice program. Hospital bed was delivered to patient's home.