Identifying Information
Full Name: LS
Address: 82-68 164th Street, Jamaica, NY 11432
DOB: 3/10/1960
Date & Time of Encounter: 01/12/2021 @9:00 am
Source of Information: Self (Reliable)

HPI:
LS is a 60 y.o. female residing with her fiancé, independent in ADLs and IADLs, with PMH of diabetes mellitus, hypertension, hyperlipidemia presenting to the ED on 01/10/2021 % 1 week of sore throat with decreased oral intake secondary to pain. She also reported shortness of breath, upset stomach, unstable gait and shaky hands for 3-4 days. Pt said her shortness of breath was worse with exertion and when she tried to walk, she felt like she was swaying to one side. She reported she had been eating a lot of noodles/soup and drinking a lot of juice as she felt thirsty all the time. She has not been able to take any of her prescribed oral medications due to the throat pain but says she is otherwise compliant with her medications. Pt stated she was also urinating frequently and reported vaginal itching for a few days but unsure of the exact amount of time. Pt admitted to SOB, sore throat, polyuria, polydipsia, vaginal itching. Pt denied chest pain, abdominal pain, diarrhea, black/bloody stools, fever, rash, LE swelling, calf tenderness, or dysuria.

ED course:(01/10/2021)
Initial ED Vitals: BP 154/90, P 119, RR 24, Temp 98.0, O2 saturation 94%
Pt lab work showed: [**BMP-** Na 127, Cr 1.33, eGFR 41, CO2 8, glucose 481, anion gap 28] [**VBG**- pH 7.21, PCO2 24, HCO3 10], [**UA**- Glucose >1000, trace blood, Ketones >=160, WBC 21-50, Yeast present, few Bacteria], **D-dimer** 836
Patient also noted to have oral thrush and whitish/greenish curd-like vaginal discharge on physical exam.
Started on insulin drip, given NS IVF bolus 2L and started on NS 200 ml/hr, diflucan 150 mg x1
MICU service consulted for DKA.

MICU course:
Patient was admitted to MICU under the impression of DKA. Continued on Insulin drip, aggressive IV hydration and electrolyte replacement. Pt was started on D5%-NaCl which was stopped yesterday (01/11/2021) morning at 7:30 am as the patient's anion gap had normalized to 15, bicarbonate was >15 and patient was tolerating food. She was not complaining of any nausea or vomiting. Patient was switched to fluconazole 200 mg IV q q24hr for 7 days for oral and vaginal candidiasis. She was put on maintenance fluids of 100 ml/hr IV infusion. Patient had a phosphorus of 1.0 in the morning (01/11/2021) which got repleted with Phos-NaK x 4 doses. Patient was hemodynamically stable and was transferred to the medical unit for further management of her condition.

Today (01/12/2021), the patient was seen and examined bedside with the medical team around breakfast time. There were no acute events overnight. The patient has no new complaints this morning and reported feeling much better. She says her throat pain and vaginal itching have improved and that she was hungry and finally able to tolerate more PO. Upon review of morning

labs, it was found that pt's DM has been very poorly controlled since her A1c >15.5. Pt was started on Levemir 20 units daily yesterday. She denies any chest pain, shortness of breath, abdominal pain, nausea, vomiting, or swelling in her legs.

PMH:
Type 2 DM
Hypertension
Hyperlipidemia

PSH:
No pertinent surgical history on file.

Medications:
Metformin 500mg PO BID before meal
Amlodipine 5mg PO QD
Losartan/HCTZ 100/25 PO QD
Pravastatin 10mg PO QD

Allergies:
No known drug allergies.

Social History:
Pt lives at home with her fiancé, but her emergency contact is her son. She has 2 children; one son and one daughter. She works as a home attendant. She is independent in her ADLs and IADLs and ambulates without assistance. Pt reports that she generally follows a diabetic diet (low sugar, limited starches) but admits to drinking a lot of juice and eating a lot more starch than usual recently due to feeling unwell and increased thirst. She denies sick contacts or recent travel. She denies ever smoking, alcohol use, or any illicit drug use.

Family History:
Mother: deceased, unknown age and cause of death
Father: deceased, unknown age and cause of death
Daughter: 36, alive and well
Son: 32, alive and well

ROS:
General: Denies weakness, loss of appetite, fever, chills or night sweats.
Skin: Denies excessive dryness/sweating, changes in texture, rashes, pruritus.
Eyes: Denies blurriness, diplopia, or any visual disturbances.
Mouth/throat: **Admits to sore throat and dentures.** Denies voice changes.
Neck: Denies edema, masses, stiffness, or decreased ROM.
Cardiovascular: Denies murmurs, angina, palpitations, dyspnea on exertion, orthopnea, or edema.
Resp: Denies shortness of breath, cough, wheezing, or asthma.
GI: Denies abdominal pain, nausea, vomiting, diarrhea, dysphagia, constipation, or bowel movement changes.

GU: Denies dysuria, frequency, discharge, change in color of urine, incontinence or flank pain.
MS: Denies joint/muscle pain, swelling or redness.
Neuro: Denies dizziness, loss of sensation, numbness, or tingling.
Endocrine: **Admits to polyuria, polydipsia**. Denies polyphagia or excessive sweating.

Vitals:

BP	118/67 (RA, Seated upright)	Ht	1.58 m (5' 2.21")
Pulse	73	Wt	86.2 kg (190 lb)
Temp	98.7 °F (37.1 °C) (Oral)	SpO2	98% RA
Resp	18	BMI	34.52 kg/m

Physical Exam:
General: Pleasant older woman seated comfortably eating breakfast on her hospital bed, alert, awake, cooperative in NAD
HEENT: Head normocephalic, without obvious abnormality, atraumatic
Lungs: Clear to auscultation bilaterally, good air entry, with no adventitious sounds heard
Heart: RRR, S1, S2 normal; no murmur, click, rub or gallop were appreciated
Abdomen: Soft, NT/ND, BS present and normo-active
Extremities: No LE edema bilaterally, with 2+ dorsalis pedis pulses palpable bilaterally
Mental status: AAOx4, answering questions appropriately
Neurologic: Moving all extremities, grossly normal. Pt's balance/gait is intact.
Skin: Warm and moist.

Labs: (1/12/21 @1:30pm) Today
CMP: Na 136, K 3.9, Cl 101, **CO2 21**, **BUN 5**, CR 0.81, **Glu 346**, eGFR >60
Phosphorus: 2.6 (resolved from 1.3 on 1/11/21)
Lipid Panel: Cholesterol 140, HDL 34, Triglycerides 307, LDL 44
HgA1C (1/11/2021): **>15.5%**

Imaging:
CXR portable (01/10/21) shows good inspiratory effort, no consolidation, no effusions.
CT head w/o contrast (01/10/21) negative for acute infarct, hemorrhage, or mass effect.
CTA chest w/ contrast (01/10/21) negative for PE.

Assessment:
60-year-old female with a history of poorly controlled diabetes mellitus, hypertension, hyperlipidemia initially admitted to the MICU for DKA management, downgraded to the floor for continuation of care after DKA resolved. Pt also found to have vaginal and oral candidiasis in the setting of poorly controlled DM.

Plan:
#DKA-resolved/T2DM - uncontrolled
- HbA1c >15.5

- Continue with diabetic diet
- Continue with Levemir 20 units
- Continue with lispro 6 units
- Continue with FS monitoring with LISS coverage
- Continue with monitoring K, phos and mag
- Nutritionist referral for diabetic diet teaching
- Start insulin administration teaching
- In preparation for sending patient home, social work to help arrange for home visiting nurse to help with learning safe insulin management
- Pt educated about signs and symptoms of uncontrolled hyperglycemia, is privy to plan, and amenable stating understanding seriousness of tighter control of her diabetes. Pt to follow up with Endocrine for DM management.

#Hypophosphatemia - improving
- Continue with K-phos for 1 more day
- Continue with monitoring phos with additional replenishment as necessary

#Hypertension
- Home meds are: amlodipine 5mg daily and losartan-hydrochlorothiazide 100-25mg daily
- Continue to hold as pt is currently normotensive (100-110s SBP)

#Oral/Vaginal Candidiasis-improving
- Continue with fluconazole (as pt ID adjusted): 100mg daily for 10 days (day 3/10)

 # Hyperlipidemia
- Continue with home pravastatin 10 mg
- Consider increasing to stronger statin

GI prophylaxis: Pantoprazole 40mg daily
DVT prophylaxis: Heparin sub-q
Advanced Directive- Full Code