Progress Notes

Medicine Note

Admission Date: 8/29/2015 8:00 PM
Hospital Day: 1

Summary:

67 year old male with history of BPH, nephrolithiasis in past, Lyme Disease treated many years ago, cervical spondylosis, and prior hernia repair, who presented on 8/29/15 due to cyclical fevers, cough, and mid epigastric abdominal pain. Collateral was obtained from patient and family members including

Around July 2015, patient started experiencing mid epigastric abdominal pain and was seen by GI at the time who performed a colonoscopy and endoscopy which showed some polyps in colon and H. Pylori. Per family report, patient was started on quadruple therapy which he took for one month. About one month later, patient developed persistent mid epigastric abdominal pain as well as cyclical fevers where he would spike to 101-103 around 2PM in the afternoon and slowly defervesce. Patient was treated with amoxicillin due to concern for Lyme Disease but he did not improve. One week later, he developed cough and was subsequently treated with doxycycline along with medrol dose pack without relief of his symptoms. Due to persistent cough and mid epigastric pain along with cyclical fevers, he was brought to hospital where he was subsequently admitted. During these cyclical fevers, he develops sweats and tremors but subsequently defervesces. He denies any CP, nausea, vomiting, diarrhea, constipation, or any new urinary changes. Review of systems positive for cough and dyspnea when taking a deep breath, mid epigastric abdominal pain, and chronic urinary symptoms with BPH.

Other History:
- **PMH:** BPH, nephrolithiasis in past, Lyme Disease treated many years ago, cervical spondylosis, and prior hernia repair
- **Meds (reviewed all medictation bottles):** alendronate weekly, has recently used medrol dose pack, doxycycline, and amoxcillin
- **Allergies:** NKDA
- **SH:** born in Italy, moved at the US upon time of marriage, cuts lawns and works in garden but does not go to wooded areas though there is a wooded area in the back, no travel history

Review of Allergies/Meds/Hx:

Allergies: Review of patient's allergies indicates no known allergies.

Medications:

Scheduled Medication:

heparin (porcine)	5,000 Units	Subcutaneous	Q8H
pantoprazole	40 mg	Oral	Daily
tamsulosin	0.4 mg	Oral	Nightly

Objective:

Vitals:
Temp: [98.1 °F (36.7 °C)-101.8 °F (38.8 °C)] 101.1 °F (38.4 °C)
Pulse: [84-104] 102
Resp: [16-19] 18
BP: (119-144)/(62-95) 135/74 mmHg
SpO2: [93 %-98 %] 93 %

I/O's:

Gross Totals (Last 24 hours) at 08/30/15 1911
Last data filed at 08/30/15 1755

Intake	3192.5 ml
Output	1850 ml
Net	1342.5 ml

Physical Exam
General: Alert and oriented x3, No apparent distress
HEENT: PERRL, EOMI, Mucous membranes moist
CV: S1/S2 nl, RRR, no m/r/g
Pulm: clear to auscultation bilaterally. No wheezing, rales, or rhonchi.
Abd: soft, mid epigastric tenderness, BS normoactive
Ext: DP +2 b/l, no pitting edema
Neuro: A&O to person, place, and time. No focal deficit.
Skin: Skin is warm. No rash noted.

Labs:

Recent Labs

	08/28/15 1941	08/29/15 2115	08/30/15 0855
NA	135	132*	134
K	4.1	4.3	4.1
CL	100	100	103
CO2	19.8*	19.0*	19.0*
BUN	31*	18	15
CREATININE	1.3*	1.0	1.0
GLU	114*	112*	116*
CALCIUM	8.8	8.2*	7.9*

Recent Labs

	08/29/15 2115
PHOS	2.4
MG	1.9

Recent Labs

	08/28/15 1941	08/29/15 0939	08/29/15 2115	08/30/15 0856
WBC	7.6	5.5	5.9	4.7
HGB	12.0*	12.5*	11.4*	10.5*
HCT	36.9*	36.2*	32.1*	30.5*
PLT	151	109*	96*	70*
MCV	89	90	83	84
NEUTROPHILS	64	67	63	63
LABLYMP	20	18	12*	13*
MONOCYTES	16*	14	23*	22*
LABEOS	0	0	0	0
LABBASO	0	0	3*	2

Recent Labs

	08/29/15 2115
INR	1.15*
PTT	31.6*

Recent Labs

	08/29/15 2115	08/30/15 0855	08/30/15 0856
BILITOT	1.7*	1.5*	--
BILIDIR	0.6*	--	--
AST	59*	67*	--
ALT	53*	58*	--
ALKPHOS	87	91	--
LABPROT	11.7	--	--
ALBUMIN	3.2*	cancelled	3.0*

Recent Labs

Lab	08/28/15 1941	08/29/15 2115	08/30/15 0855
GLU	114*	112*	116*

Microbiology:

Lab Results

Component	Value	Date
LABBLOO	No Growth to date All Blood Culture Bottles with growth will be reported	08/28/2015
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Recent Results (from the past 1008 hour(s))

Urinalysis-macroscopic w/reflex microscopic

Collection Time: 08/28/15 7:41 PM

Result	Value	Ref Range
Urinalysis	See Below	
Clarity, UA	CLOUDY (A)	CLEAR
Color, UA	YELLOW	YELLOW
Specific Gravity, UA	1.028	1.005 - 1.030
pH, UA	5.5	5.5 - 7.5
Protein, UA	2+ (A)	NEGATIVE
Glucose, UA	NEGATIVE	NEGATIVE
Ketones, UA	NEGATIVE	NEGATIVE
Blood, UA	SMALL (A)	NEGATIVE
Bilirubin, UA	NEGATIVE	NEGATIVE
Leukocyte Esterase, UA	NEGATIVE	NEGATIVE
Nitrite, UA	NEGATIVE	NEGATIVE
Urobilinogen, UA	0.2	<=2.0 EU/DL

Diagnostics:

CXR (8/28/15):

Findings and impression:

There are low lung volumes.

The lungs are grossly clear without focal consolidation or pulmonary edema. There is no pleural effusion or pneumothorax. The cardiomediastinal silhouette is within normal limits.

CT abdomen/pelvis (8/28/15):

FINDINGS:

Bibasilar atelectasis is seen.

No hydronephrosis or intrarenal calculi are seen of either kidney. Too small to characterize hypodensities are seen in the left kidney. No calcifications are noted along the course of the ureters or within the urinary bladder. There is a left-sided bladder diverticulum measuring 2.4 x 1.6 x 1.8 cm containing a 4 mm calculus. There is significant prostatic hypertrophy which causes mass effect upon the bladder base.

The visualized unenhanced spleen, pancreas, and adrenal glands are unremarkable. There is a subcentimeter hypodensity in the anterior right hepatic lobe which is too small to fully characterize. There is no bowel obstruction, free air, or free fluid. What is likely the appendix is visualized and is unremarkable. 2 soft tissue densities are again seen near the region of the inguinal canals bilaterally, correlate for history of bilateral inguinal hernia repair.
No aggressive osseous lesions are seen.
IMPRESSION:
4 mm calculus within a left-sided bladder diverticulum.
No hydronephrosis is seen.
No calculi are seen within either kidney, along the course of the ureters, or within the urinary bladder.
Prominent hypertrophy of the prostate gland.

Assessment:

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67 year old male with history of BPH, nephrolithiasis in past, Lyme Disease treated many years ago, cervical spondylosis, and prior hernia repair, who presented on 8/29/15 due to cyclical fevers, cough, and mid epigastric abdominal pain with labs significant for new anemia (hemoglobin dropped from 12.5 to 10.5) and thrombocytopenia (platelets dropped from 151 to 70) with transaminitis (AST 59, ALT 53, TB 1.7) and proteinuria (2+ protein in urine). Though studies were positive for acute Hepatitis A, this seems unlikely to explain entire presentation so further work up warranted and this is likely a false positive.

Plan:

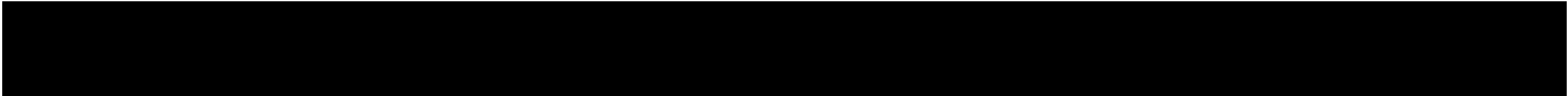
Cyclical fevers: differential includes infectious, connective tissue diseases or autoimmune related, or malignancy-related; presenting signs include cyclical fevers, anemia, thrombocytopenia, mid epigastric abdominal pain; note elevated ESR 91 and CRP 259; could also be lymphoma given cyclical fevers with concern for hemolysis; could also be tick born illnesses but this seems less likely given that he was on doxycycline
- qanterferon-TB; tick born illnesses including rickettsia, babesia, ehrlichia, anaplasma; malaria; monospot; HIV; ANA; RF for other infectious and autoimmune causes
- blood cultures and urine cultures pending
- consider work up for occult abscess pending labs as above and clinical course; can consider CT scan with IV contrast, WBC scan, dopplers to rule out DVT
- monitor with tylenol as needed to bring down fever

Transaminitis: AST 59, ALT 53, TB 1.7 with albumin 3.2 and prolonged INR/PTT (INR 1.15, PTT 31.6); Hepatitis A IgM+ indicating acute hepatitis, though this could be a false positive and certainly does not explain other parts of his presentation (i.e. thrombocytopenia, cyclical fevers)
- RUQ US
- acute and chronic hepatitis including recheck Hepatitis A given possibility of false positive and for concomitant hepatitis infections
- anti-mitochondrial antibodies, ANA, anti-smooth muscle antibodies for autoimmune causes
- trend

Anemia/thrombocytopenia: hemoglobin decreased from 12.5 to 10.5 since hospitalization; platelets down to 70 from 151 with virtually undetectable haptoglobin (which is most likely indicative of hemolysis since virtually undetecable) raising concern for hemolytic anemia; other studies include reticulocyte count (normal), ferritin (elevated at 2730), vitamin B12 (910), folate (normal)
- official manuel smear results pending, but our review of smear today showed roleaux formation with no schistocytes visible
- DAT, LDH (for hemolytic anemia), D-dimer and fibrinogen (for DIC)
- discontinue heparin SC given concern for rapidly declining platelet count
- type and screen sent for need for transfusion; transfuse if hemoglobin<7, platelets<20 and febrile

Cough
- robitussin as needed
- CXR PA and lateral

Mid epigastric abdominal pain
- abdominal CT negative for any acute pathology
- RUQ US
- H pylori stool antigen given recent treatment with H pylori quadruple therapy and to assess clearance (ordered by night team, though realized that patient currently on PPI which will alter results)



Proteinuria
- check protein: cr ratio
- SPEP ordered by night team pending

Chronic medical issues
- GERD: on protonix, but would stop because will need to check H. Pylori stool antigen to assess clearance
- BPH: recent CT scan shows enlarged prostate, following with urology as outpatient but started on flomax

Other
- FEN: regular diet
- Code Status: Full Code
- DVT prophylaxis: SCDs
- Disposition: TBD