History of Present Illness

Chief complaint:

cough, hemoptysis

HPI:

[redacted] is a 43-year old male, with a PMH of hyperlipidemia, who presents as a transfer from the VA for hemoptysis x 1.5 weeks. [redacted] states that he has been experiencing a very gradually worsening, productive, exertional cough for the past 1.5 years. He cannot identify a precipitating factor for the cough. He was evaluated by an internist outside of the VA, who diagnosed him with possible asthma/allergy. [redacted] states that his symptoms were improved with the aforementioned medication regimen. Just over a week ago, [redacted] was at Vail with his family for Thanksgiving, when he began to notice worsening of his cough. He also noticed pink-tinged sputum and, occasionally, bloody clots. He initially attributed the worsening of his symptoms to high-altitude. He denies fevers or chills, but does admit to several days of inconsistent night sweats. He denies recent travel outside of the U.S.; he has traveled to California within the past 1.5 years. He has traveled to Saudi Arabia and Mexico in the remote past (he served in Saudi Arabia in the 1990s). Denies occupational exposures to respiratory irritants, sick contacts, or recent incarceration. He was started on albuterol, montelukast, a prednisone taper, and Symbicort. At the advice of his internist, he attempted to schedule an appointment with a pulmonologist at the VA. Due to lack of available appointments, he was advised to go to the VA emergency department for further evaluation.

In the ED at the VA, [redacted] had a CXR and a CT of his chest. The chest x-ray was unremarkable,; however, the CT scan showed a cavitary mass in the right lower lung lobe. His vitals were all WNL. He was transferred to PSL for respiratory isolation and sputum cultures to rule out active tuberculosis.

History

Past medical history: hyperlipidemia

Past surgical history: knee (bilateral ACL repairs), humeral rod

Past social history: employed (real estate agent), no drug abuse, no tobacco use, alcohol use (15 drinks/month)

Past Family History:

Relation not specified for:

Family History: Unremarkable

Medications:

Home Medications:

Medication Dose/Rte/Freq Days Qty Entered Last

Reviewed

OMEPRAZOLE (PriLOSEC) 40 MG PO BID 12/10/15

Strength: 40 MG CAP.DR 2352

MONTELUKAST (SINGULAIR) 10 MG PO BEDTIME 12/10/15

Strength: 10 MG TAB 2353

FENOFIBRATE (TRICOR) 145 MG PO DAILY 12/10/15

Strength: 145 MG TAB 2354

PRAVASTATIN (PRAVACHOL) 20 MG PO BEDTIME 12/10/15

Strength: 40 MG TAB 2355

predniSONE 10 MG PO C BK 12/10/15

Strength: 20 MG TAB 2357

BUDESONIDE/FORMOTEROL 2 PUFF INH RTBID 12/10/15

FUMARATE 2358

(SYMBICORT 160-4.5

MCG/ACT)

Strength: 10.2 GM INHALER

Current Hospital Medications:

Blood Formation,Coagulation &

Sig/Sch Start time Last

Medication Dose Route Stop Time Status Admin

Heparin Sodium (Porcine) (HEPARIN SODIUM)	5,000 UNITS SUBQ	Q8HR	12/10 2300 2345	CKD	12/10

Allergies:

Coded Allergies:

No Known Drug Allergies (NKDA 12/10/15)

Physical Exam

VS/I&O

Last Documented:

	Result	Date Time
Pulse Ox	98	12/10 2230
B/P	135/76	12/10 2230
O2 Delivery	RA	12/10 2230
Temp	36.8	12/10 2230
Pulse	71	12/10 2230
Resp	20	12/10 2230

General appearance: alert, awake, no acute distress, pleasant

Head/Eyes: EOMI, PERRLA

Neck: no lymphadenopathy

Cardiovascular: regular rate & rhythm, normal heart sounds

Respiratory: rhonchi (prominent rhonchi @R base)

GI: soft, non-tender, no guarding, no rebound

Extremities: moves all, no peripheral edema, pedal pulses (2+ DP, PT b/l)

Neuro/CNS: normal speech, no motor deficits

Skin: dry, intact

Psychiatry: normal affect, normal mood

Treatment & Prophylaxis

Treatment & Prophylaxis

VTE Prophylaxis

VTE Prophylaxis initiated: Yes

Diagnosis, Assessment & Plan

Free Text A&P:

[redacted] is a 43-year old male, with a history of hyperlipidemia, who presents from the VA with 1.5 weeks of hemoptysis, preceded by 1.5 years of cough of unclear etiology, with a cavitary lung lesion on chest CT.

#Cavitary lung lesion: Differential is broad at this time and includes infectious and neoplastic etiologies. TB is on the differential, although patient lacks risk factors for exposure, including incarceration, sick contacts, and recent travel. Reactivation is possible given the patient's remote history of travel to Saudi Arabia and Mexico; no recent hx of immunosuppression. Fungal etiologies are also on the differential (Cocciomycoides is a consideration in the setting of recent travel to California). Malignancy is a consideration, though lower on the differential with lack of tobacco history and young age of the patient.

- AFB sputum cultures x 3 q8h to r/o TB.

- Consider PPD testing (patient denies recent testing, more sensitive in ruling out TB than sputum cultures)

- Consider ID consult in AM.

- Consider pulm consult for possible bronchoscopy if AFB cultures are negative.

#Cough/hemoptysis: Likely related to cavitary lung lesion (see above differential). PE is very unlikely with no evidence of emboli on CTPE obtained at the VA.

- Workup as above.

#Normocytic anemia: Hgb on VA labs noted to be 13.7, with an MCV of 87.7. Likely 2/2 blood loss in the setting of acute hemoptysis.

- Monitor; would consider iron studies as outpatient if anemia does not resolve in the absence of hemoptysis

#Thrombocytosis: Noted to have platelet count of 422 in the ED at the VA (upper limit of normal is 400). Likely reactive in the setting of acute illness.

- Monitor.

#Hyperlipidemia: Recent lipid panel is unavailable; patient is on fenofibrate and simvastatin at home per an outside provider.

- Continue pravastatin 20 mg qhs.

- Continue fenofibrate 145 mg qhs.

#GERD:

- Continue home omeprazole 40 mg daily.

#FEN:

- No IV fluids.

- Replete lytes prn.

- Regular diet.

#Code status: Full code.

[x] All labs reviewed

[x] X-rays reviewed

[x] EKG reviewed

[x] Meds reviewed

[] Ordered old records

[] Old records reviewed

[] Discussed with Dr [] (consultant), and Note reviewed

[] Time spent with patient at discharge [] less than 30 minutes, [] greater than 30 minutes

[] Critical care time []

~

[x] Discussed with and seen by housestaff. Patient seen and examined. Agree with findings, assessment and plan as outlined in [redacted] note.

Pt has had worsening exertional cough and SOB for 1.5 years and developed hemoptysis over the last 1.5 weeks. Cavitary lesions noted in RLL. Has been on long steroid taper for this, initiated by his internist, a few weeks ago with hemoptysis occurring while on steroids. Currently getting 3 sputum samples to r/o TB. Will ask pulmonary to see patient and provide recommendations on additional work up and whether pt would benefit from a bronch. Currently not toxic in appearance and I do not think he needs any urgent antibiotic coverage at this time. Will also ask ID to consult on the patient as well.

On day of admission, 12 points ROS reviewed with pt and were negative with exception of that stated in the HPI.

Pt does not report any family hx of lung disease or malignancy.