Geriatrics

Subjective Data

Date 9/6/2012

Chief Complaints:

JC a 78 year old male Veteran admitted to VA Nursing Home from West campus (Montgomery VA) after being treated for AMS and UTI. Patient will be admitted for Dementia services

Past Medical History:

Allergies: ASA related medication

Medical Dx: Dementia, Megaloblastic anemia, CKD, COPD, CAD, constipation, hyperlipidemia, HTN

Medication: Acetaminophen 650/20.3 mL q 6 hrs prn, Albuterol/Ipratropium 1 ampule inhalation q 6 hrs prn, clopidogrel 75 mg qd, , folic acid 1 mg daily, lisinopril 20mg qd, metoprolol 12.5 mg bid, MVI/mineral 1 tab daily, simvastatin 20mg qhs, thiamine 100mg qd, Ferrous sulfate 325mg qd, Colace 100mg bid, Senna tab 1-2 tab qhs

New meds: Dipth/pertuss/tet vaccine 0.5 ml IM x1, Pneumococcal vaccine 0.5 ml x 1, , Nystatin cream tid to affected area x 10 days

Immunization: Immunization hx unclear at this time. Will order Pneumovax and Dipth/pertuss/tet vaccine; CXR on 8/25/2012 no signs of TB

Surgeries: CABG, Right inguinal hernia repair

Social Hx: Patient unable to states a clear history he states that he is married and wife lives in AK, but records revealed that he is a widow. Has 1 daughter, worked as a construction worker. He does admitted to smoking 1ppd, but has quit smoking unsure of how long ago he stopped. Denies illicit drug usage. States he drinks a beer from time to time but unsure of the last time he had a beer. Patient records indicate that patient has a hx of alcoholism.

Family History: Patient unable to state family history. Both parents are deceased.

ROS: *** Patient was unable to provide student with a vast amount of subjective information due to confusion related to dementia and extreme HOH****.

Constitutional symptoms: Due to dementia patient unable to provide a clear history

Eyes: patient states he wears glasses. Last eye exam unknown

HEET: Pt. states he has a hx of smoking 1 ppd of cigarettes but stopped years ago. Patient unable to recall last dental

Cardiovascular: Patient denies chest pains; c/o occasional dizziness, Last EKG on 8/25/12. reveled patient was in SR with PACs and 1st degree AV block; Last Lipid panel was 9/01/12 (Trg=74, Chol=125, HDL=33, LDL=77, VLDL= 14)

Respiratory: Smokes 1 ppd patient unable to recall last time he had a cigarette; last CXR 8/25/2012(RESULTS: the thoracic aorta mildly tortous w/atherosclerosis calcification, median sternotomy wires and surgical clips from previous CABG); 9/1/2011 BNP=474

Gastrointestinal: patient denies any issues

Genitourinary: Patient denies issues, 09/04/2011 BUN 27,

Musculoskeletal: Patient was able to state that he uses a walker to ambulate and has frequent falls. last fall was 9/05/12 per patient.

Integumentary: Patient unable to state

Neurological: Patient c/o feeling weak and tired.

Psychiatric: Patient able to state memory is not “the best”.

Endocrine: Patient denies any issues

Hematological/lymphatic: patient unable to state. 09/04/2011 RBC=2.85, Hgb=10, HCT=30 Ferritin=597.7, Iron= 66, TIBC=200, folate= 6.33, B12=>2000, MCV 105.4, MCH=35

Allergic/Immunological: unable to answer

Objective

Constitutional symptoms: 78 year old thin and frail Caucasian male in poor-mid-fair health. V/S109/43, 97.5, 60, 20 wt: 116 Ht: 68in. Patient is awake and alert with confusion. Denies pain or discomfort. Patient states that he lives alone in an apartment. Use walker to ambulates with. Unable to describe living condition or financial status. Unable to state educational level thinks he stopped going to school at the age of 12 per patient. Patient become agitated during interview process and refuses to answer question or yells out inappropriate comment.

HEENT: PERRL, opacity to left eye, no sclera redness/yellowing. no ocular edema, nares patient, turbinated non-boggy, oral mucosa pink and moist, no oral lesion, edentulous, no thyromegaly. HOH. Will consult audiology and eye clinic

Cardiovascular: normal S1/S2, Heart rhythm irreg, no S3/S4 noted, no JVD, no carotid bruits, radial and pedal pulse +2, no edema or calf pain . Will order EKG and consult Cardiologist

Respiratory: lung sounds clear to auscultation, expansion symmetrical, no SOB noted

Gastrointestinal: BS active x4, abd soft, non-tender, and non-distended, no organomegaly, DRE completed rectal vault full of soft stool, no external hemorrhoids noted. Patient incont. of stool. noted to wear adult briefs. Last BM today

Genitourinary: Patient incont. of urine; wears adult briefs. hx of UTI within past 14 days, no renal bruits

Musculoskeletal: Patient able to move all extremities without difficulty, crepitus noted to bilateral knee, equal hand grasp, muscle weakness and atrophy. consult restorative nurse and PT, fall precaution

Integumentary: warm and dry, mid chest incision scar, right inguinal incision scar, erythematous buttocks that blanches with red satellite lesion. 2 stage II areas to right (0.5x0.5x0.1cm) and left buttocks (0.8x0.5x0.1 cm)w/ no s/s of infection, long toenails, bunion to lt great toe, resolving scabbed abrasion on 2nd digit of lt foot (1x0.2x0.1 cm). pinpoint open area to lt outer ankle

Neurological: awake, oriented to person. disoriented to place, time, and season, muscle weakness. scores 6/30 on SLUM exam which indicated Dementia.

Psychiatric: Patient has history of dementia and alcohol abuse per patient's records

Endocrine: no evidence of endocrine disease

Hematological/lymphatic: patient has an hx of megaolblastic anemia

Allergic/Immunological: no issues noted

Assessment:

1. **Dementia**
    - chronic

- Patient will not start on Dementia medication until Geri-psych evaluates patient on next rounds.
- **textbook symptoms**: inability to focus; alteration in memory, agnosia, apraxia, decrease functioning ability/inability to perform ADLs, impairment judgment, personality, and affect; disorientation; language disturbance; disturbance in sleep wake cycle; anxiety, fear, depression
- **patient symptoms**: disorientation to place, time, season, difficulty forming words, decrease focus, short and long term memory deficits, freq. falls, easily agitated, inability to perform ADLs, poor judgement
- **Differential Dx**: adverse side effect to medication, depression, metabolic issue (B12 deficiency or hypothyroidism), ear or eye impairment, tumors or mass, infection, anemia

2. **Atrial Fibrillation**
    - paroxysmal, vs. acute, vs. chronic unknown at this time but patient has hx of MI
    - **Textbook symptoms:** Decreased blood pressure, weakness, lightheadedness, confusion, shortness of breath, chest pain
    - **Patient symptoms:** irregular heart rhythm, B/P109/43, confusion
3. **Megaloblastic Anemia**
    - chronic
    - well controlled with current medication thiamine 100mg qd, Ferrous sulfate 325mg qd, , folic acid 1 mg daily
    - **textbook symptoms**: weakness, dizziness, sore, red shiny tongue, numbness and tingling to arms and/or legs, edema of lower extremities, anorexia, diarrhea, DOE, fatigue, angina, palpitation, organmegaly, dementia and spinal cord degeneration.
    - **patient symptoms**: dementia and weakness
    - **Differential Dx:** folic acid deficiencies, Vitamin B12 deficiencies, chronic alcoholism
4. **Candida dermatitis**
    - acute
    - **textbook symptoms:** bright red rash with well-demarcated lesions advancing to pustules
    - **Patient symptoms:** erythematous buttocks that blanches with red satellite lesion, patient noted scratching area
    - **Differential Dx**: contact dermatitis, bacterial infection
5. **Constipation**
    - chronic
    - welled controlled with current medication regimen Colace 100mg bid, Senna tab 1-2 tab qhs

- **Differential Dx**: intestinal obstruction, hypothyroidism, fecal impaction, cancer, and diabetes

Plan

1. Daily reorienting, add to geri-psych rounds for medication initiation
2. EKG, monitor B/P trends, refer to cardiologist continue Metoprolol/lisinopril
    a. EKG results showed that patient was in Afib→Cardiologist informed of results from today's EKG and previous EKG. No new orders obtained states he will see patient in his clinic tomorrow. patient information given to MD.
3. Anemia profile for next lab draw, last CBC reviewed, continue on MVI/thiamine/folic acid/ferrous sulfate.
4. Nystatin cream tid to affected area x 10 days, clean buttocks with soap and water and pat dry prior to applying cream.
5. Continue current plan of Colace and senna tabs

Other Plans

1. consult dental clinic
2. consult eye clinic
3. consult restorative nurse and PT, fall precaution
4. educated patient on room, call light system, oriented patient to location in nursing home.
5. Dipth/pertuss/tet vaccine 0.5 ml IM x1dose
6. Pneumococcal vaccine 0.5 ml x 1dose
7. TSH