NU 627 Week 3 Case Study

C.C. "I fell and have shoulder pain"

HPI: 85-year-old M was brought by his son to the HU clinic with complaints of falling 2 days ago at home alone. Now having L shoulder pain described as dull and non-radiating, rating it a 4 out of 10 which developed after the fall. He reports increase unsteadiness for the last month, was able to use a rolling walker but has been using his rolling wheelchair instead with the exception of this fall. Two days ago, he was using the rolling walker to get to the bathroom when wheel hit corner of bed and caused him to fall. Landing on his left side. He denies hitting his head or loss of consciousness. But since the fall he has been sore all over and hasn't been moving much since. Reports most of the pain is in his left shoulder but still is able to move it and hasn't notice any deformities. He has some bruising on his shoulder, arm, hip and lower leg. He also reports decrease appetite over the last couple of days. Denies fever, chills, cough, SOB, N/V/D or GU sx.

PMH: HLD (2007), HTN (2006), CAD (2007), COPD (2006), Dementia (2018), BPH (2011)
Past Surgical History: CABG (2007)
Allergy: No known allergy.
Medications
Atorvastatin (LIPITOR) 40mg tablets, 1 Tab PO QID. Hydrochlorothiazide 12.5mg Tablet, 1 Tab PO BID. Amlodipine 5 mg tablet, 1 tab PO daily. ASA 81 mg tablet PO daily. Plavix 75 mg tablet PO daily. Tamsulosin 0.4 mg PO daily. Spiriva 18mcg inhalation daily.
Social History: He is widowed and lives with the family of his 53-year-old son. Son states that he quit smoking and drinking alcohol in 2007. Smoked about a pack of cigarettes for > 50 years. Denies illicit drug use. He is retired. Family History (FH): His parents are deceased and history unknown. Son no has no medical history.

ROS:
General: He denies fever, chills, nor sleep abnormalities. Appetite has been decreased over the last two days. Overall feels generalized weakness and soreness.
HEENT: He denies nasal discharge, sore throat, earache, and headache. He denies visual or hearing abnormalities.
Respiratory: He denies shortness of breath, cough, and wheezing.
CV: He denies chest pain, palpitations, dizziness, lightheadedness and diaphoresis.
GI: He denies nausea, vomiting, diarrhea, and blood/dark tarry stool.
GU: He denies hesitancy and hematuria. Urination frequency is normal.
Musculoskeletal: He has non-radiating dull discomforting pain in the left shoulder. He has not taken anything to alleviate the pain. He reports able to move shoulder without difficulty but does make the pain increase.

Neuro: No headache, numbness or tingling. Reports all over weakness. Hasn't noticed increase weakness in one particular area. Reports issue with memory at times, which is confirmed by son.
Skin: He denies rashes, new lesions, and diaphoresis. He reports some bruising to shoulder, hip and left leg. Psych: He denies depression, anxiety and insomnia, as well as suicidal and homicidal ideations.

Objective Data

BP 104/62mmHg, 76 BPM, 16 RR, 98.6 degrees Fahrenheit, 99 % RA
Height - 70 inches. Weight - 125 pounds. BMI – 17.9.

Constitutional: Frail , cachectic and appears stated age. He is well groomed, cooperative, alert and oriented. His speech is clear, and he answers questions appropriately.

HEENT: Eyes: Eyelids, eye lashes, and eye orbits are normal and unremarkable. Conjunctiva is not injected, and there is no discharge. PERRLA. Extraocular movements are intact bilaterally. Normocephalic head. No trauma noted. External ears normal bilaterally. Nose is normal and there is no visible nasal discharge. Oral and oropharynx mucous membranes are moist, pharynx is normal, and there is no visible tonsillar exudate.
Neck: It is supple and non-tender with normal range of motion (ROM). No lymphadenopathy. Trachea is midline and there are no other palpable masses. No thyromegaly.
Resp: No deformities nor respiratory distress noted. Chest region is clear to auscultation bilaterally. No wheezing, rhonchi, nor rales. No finger clubbing nor cyanosis
CV: Heart rate is regular, and its rhythm is normal. No murmurs, rubs, nor gallops. S1 and S2 sounds are normal. Normal jugular venous pressure. Distal pulses are intact/normal +2. No edema observed.

GI: Abdomen is soft, non-tender, non-distended, and no masses are palpable. There is no organomegaly. BS present and active in all 4 quadrants.
MS: Active range of motion of lower extremities are within normal limits. Muscle strength 5/5. Gait unsteady utilizing rollator. Get up and go test great than 10 seconds. Left shoulder no swelling but ecchymosis noted deltoid area. Ecchymosis also present over greater trochanter area and lateral malleolus but no visible skin tears. No crepitus noted with passive ROM. Negative empty can test. Able to perform Apley scratch test without difficulty. Positive cross arms test. No spinal tenderness.

NS: Alert. Oriented to place, person, and situation. CN II-XII intact. Finger-to-nose and rapid alternating hand movements are WNL. Sensation is intact. Deep tendon reflexes +2. Negative pronator drift.

Skin: see documentation in MS.
Psychiatric: Mood and judgement are normal. Affect is congruent with mood. No suicidal or homicidal tendencies.