Week 6 Episodic SOAP Note

by Nurse Imperial

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Week 6 Assignment 1: Episodic SOAP Note

Identifying Information

Initials: J.K.

Age: 59

Gender: Male

Source of information: Patient interview; collateral information from the medical records

Reliability: The patient appears a reliable historian

Subjective Information

CC: “Chest pain.”

History of Presenting Illness: J.K. is a 59y/o male patient of African American descent with a history of high blood pressure and diabetes mellitus. The patient presents with chest pain that has been moving to his right arm for about four weeks. He endorses exertion as a significant factor in exacerbating his chest pain. He also reports shortness of breath, especially with exertion when the pain occurs. J.K. reports that the pain about one or two minutes and is relieved by rest. In the past three days, the patient has noted that he requires less exertion for the pain to occur, especially when walking out in the cold. J.K. has been using OTC Tylenol 400 mg to relief the pain for the past five days.

Location: Substernal region of the chest

Quality: Dull pressure

Severity: 6 on a scale of 0-10

Timing: Started about four weeks ago; intermittent and lasts for about two minutes

Setting: During activity

Aggravating/Relieving factors: Exertion/rest

Associated manifestations: Shortness of breath

Review of Systems:

General: J.K. denies fever, weight loss, chills, or night sweats; endorses fatigue

HEENT: He denies a history of dizziness, syncope, or headaches, heating loss, ringing in the ears, eye redness, itching, pain, or changes in vision, nasal congestion, nosebleeds, or sinusitis, sore throat, gum bleeding, or voice hoarseness.

Respiratory: Endorses shortness of breath; denies a history of wheezing, coughing, or hemoptysis

Cardiovascular: Reports substernal chest pain, dyspnea, and palpitations; denies edema

Gastrointestinal: No reports of abdominal discomfort, nausea, vomiting, constipation, or diarrhea

Genitourinary: No reports of excessive urination, blood in urine, or changes in water intake

Neurological: No reports of numbness, dizziness, syncope, or vertigo

Musculoskeletal: No reports of muscle pain or crumping, or joint pain or stiffness

Hematologic: No history of hematological conditions

Lymphatics: No history of swollen glands

Endocrine: No reports of dehydration or excessive thirst

Medications/Allergies: Metoprolol 100 mg PO Daily for HTN; Metformin 850 mg PO TID for diabetes; J.K. denies any known food, environmental, or medication allergies

Past Medical History: HTN Stage II diagnosed in 2010; T2DM diagnosed in 2007

Past Surgical History: appendectomy in 1993

Family History: Paternal grandfather (79, deceased, history of HTN and diabetes); maternal grandmother (82, deceased, history of HTN); father (85, alive, history of CAD and diabetes); mother (84, alive, history of HTN and myocardial infraction)

Social history: J.K. is married with two sons aged 22 and 18 living in their family home. He works as a real estate agent. He reports a 30 pack-year history of tobacco use and about four (4) beers per week. He denies using marijuana or other recreational drugs.

Health and Maintenance Practices: He states that he sleeps approximately 6 hours but gets as many as 8 hours of sleep during the weekends. He recently adopted a ketogenic diet for continued control of his diabetes. He has also been reducing the amounts of sodium in his diet gradually but finds it hard. J.K. does not engage in significant physical activity.

Objective Date

Physical exam:

Vital signs: Weight – 159lb; Height – 5ft8"; T – 99.0°F; BP – 133/91; RR – 23; HR – 99

General: J.K. is oriented ×4 and does not show signs of distress but appears anxious. His speech is clear.

Skin: Warm and dry

Neck*:* Thyroid is not palpable

Respiratory: The chest has symmetrical expansion; lungs are clear to auscultation bilaterally; no wheezes, rales, or rhonchi noted

Cardiovascular: Regular rate and rhythm without murmurs, S1S2, mild S3 in the mitral area, 3+ carotid pulse, carotid bruit and thrill on the right side, +2 femoral, radial, and brachial pulses, capillary refill >2 sec, no jugular vein distension, no peripheral edema on the extremities

Gastrointestinal: The abdomen is soft without tenderness or distension. Normal bowel sounds are detected in the four quadrants. Palpation does not reveal hepatomegaly. No guarding observed

Musculoskeletal*:* Chest wall tenderness not detected

Diagnostic results:

Labs: Na – 126, K – 4.0, Cl – 97, Bicarb – 22, BUN – 21, Cr – 1.1, Glucose – 281, CK – 142, CK-MB – 5.5, WBC – 4.7, Hgb – 12.9, HCT – 38.2, PLT – 203

ECG – Sinus rhythm

Assessment

Primary and Differential Diagnoses

Coronary artery disease: CAD is among the most common cardiovascular diseases in the United States. It is associated with the formation of plaques in the coronary artery walls (atherosclerosis) (National Center for Chronic Disease Prevention and Health Promotion, 2021). Conventionally, intermittent chest pain (angina) is the typical clinical manifestation of CAD. Pain often radiates to the right arm or neck in CAD (Nelson et al., 2019). Other common manifestations include shortness of breath, fatigue, weakness, and nausea. According to Shao et al. (2020), hypertension, diabetes mellitus, obesity, hyperlipidemia, poor diets, a sedentary lifestyle, and smoking increase the risk of CAD. J.K. presents with a range of these risk factors, including T2DM, hypertension, and a long history of tobacco use. In addition, the patient's complaints and history indicates a high likelihood of CAD. As noted by Ghiasi et al. (2020), rest relieves chest pain in CAD, with less exhaustion during the cold weather resulting in more intense and frequent chest pain. Consistently, J.K. reports exertion as the provoking factor, with the recent

weather changes in autumn affecting its intensity. Consistent with the evidence, his chest pain has been radiating to the right arm and shoulder, with additional symptoms such as fatigue and shortness of breath. The ECG findings provide additional evidence supporting the diagnosis.

Angina pectoris/Unstable angina: The condition is associated with a decrease in blood flow into the myocardium. Psychological stress, cold, exposure, and alcohol and tobacco use are known risk for angina (Jewulski et al., 2021). Conventionally, patients with angina pectoris report heaviness, tightness, or pressure in the chest following exertion (Rousan & Thadani, 2019). Angina at rest, worsening angina, and angina lasting more than 15 minutes is considered unstable. According to Song et al. (2018), chest pain without an increase in myocardial oxygen demand indicates angina. While J.K. presents with chest pain, it does not indicate typical angina. As noted by Ghiasi et al. (2020), angina involves radiation of pain to the left arm, while CAD involves ration to the right arm.

Myocardial infarction: The disease involves decrease or failed blood flow into the myocardium. According to Ojha and Dhamoon (2022), many cases remain undetected, resulting in hemodynamic deterioration and death. Typically, MI presents with a tight, squeezing, dull, crushing, or gripping chest pain (Ferry et al., 2019). Patients often report palpitations, dyspnea, nausea, vomiting, excessive sweating, and weakness. Physical examination often reveals abnormal ECG findings, with raised cardiac markers (Andersson et al., 2018). However, with MI, inverted T waves, Q waves, or ST elevation or depression would be detected on ECG. Therefore, the diagnosis is ruled out.

Acute myocarditis: The disease features an inflammatory cellular infiltrate with or without cardiac myocyte injury. It typical age of onset is between 20 and 50 years in most cases (Lampejo et al., 2021). While it may have different clinical presentations that make its identification problematic, some typical ones include shortness of breath, chest pain, and fever (Cooper, 2019), with atypical symptoms such as fatigue, intolerance to exercise, palpitations, and syncope (Lampejo et al., 2021). While J.K. presents with some of the symptoms, he does not report fever and the physical examinations reveals a sinus rhythm. Therefore, the diagnosis is ruled out.

Plan

Pharmacological interventions:

- Start diltiazem 180 mg PO q6-8Hrs – The drug decreases angina attacks and heart rate decline and improves exercise tolerance (Lanza & Shimokawa, 2023; Peng et al., 2021)
- Start propranolol 80 mg PO qAM – The beta-blocker lowers the risk of cardiovascular mortality in patients with CAD (Khan et al., 2023)

Non-pharmacological interventions:

- Initiation of light exercises, including walking or biking to address the risk factors and improve tolerance. The exercises should be started after response to the pharmacological interventions is confirmed.
- Dietary changes to include multi-colored vegetables

Patient education:

- The patient is advised about the importance of medication adherence in preventing disease progression.
- The patient is encouraged to start engaging in light exercises to address the risk factors.
- The patient is educated about medication side effects.

Follow-up:

- Follow-up in four weeks; the patient is given emergency contacts to call in case of an emergency

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