SAMPLE VERBAL PATIENT PRESENTATION

Lia Pierson Bruner, MD
Assistant Professor, Department of Family Medicine
Augusta University/University of Georgia Medical Partnership

Mr. P. is a 68-year-old retired chef with a history of coronary artery disease (CAD) who presents with a chief concern of "my chest hurts."

(HPI) Mr. P. was in his usual state of health until 5 days prior to admission when he developed intermittent chest pain. He describes the pain as a 5/10 burning sensation in the middle of his chest that sometimes radiates to his throat. It usually happens once a day after dinner and lasts for about 30 minutes. Today the pain was more severe, so he came to the emergency department. The pain is non-exertional, worse after eating, and improved with drinking milk. It is associated with burping, but no shortness of breath, jaw or arm pain, diaphoresis, nausea, or abdominal pain. Although Mr. P. reports this pain feels different from his previous heart attack, he is concerned about another heart attack. His cardiac risk factors include age, male gender, hypertension, hypercholesterolemia, a personal history of CAD with a 3-vessel coronary artery bypass graft 5 years ago, and a family history of positive for premature CAD in his father, who died of an MI at age 42. Mr. P. has never smoked and does not have diabetes or chronic kidney disease. Of note, he has been experimenting with hot salsa recipes this week and has increased his coffee consumption from 3 to 5 cups daily. He has no history of gastro-esophageal reflux disease (GERD).

Past medical history is significant for a history of prostate cancer treated 2 years ago in addition to those conditions already mentioned.

Medications include:

Aspirin 81 mg PO once daily
Carvedilol 12.5 mg PO twice daily
Lisinopril 20 mg PO once daily
Atorvastatin 80 mg PO QHS
Sublingual nitroglycerin 4 mg PO q3min at onset of chest pain.
Fish oil 2 caps PO TID
Multivitamin 1 tab PO once daily
Epi-pen as needed for allergic reactions

Allergies include shellfish, to which he has had an anaphylactic reaction

Family history is significant for a sister in her 70s with peptic ulcer disease and the CAD already mentioned.

Social history is remarkable for good social supports. Mr. P. lives with his wife who is a retired nurse and who is very involved in his healthcare. Although retired, Mr. P is active on the boards of several charities and is thinking of publishing a cookbook of Southern cuisine. He drinks 1-2 beers a week and does not use tobacco or drugs. His exercise consists of walking three times a week for 30 minutes.

The **review of systems** did not reveal other pertinent positives or negatives besides those noted in the HPI.

On **physical exam**, Mr. P. appears in mild discomfort and appears somewhat anxious.

He is afebrile with stable vital signs including RR 16, HR 72, BP 136/82, and O_2 sat 97% on room air. BMI is elevated at 30.

Skin and HEENT exams are within normal limits.

Lungs are clear to auscultation bilaterally without crackles.

JVP is 7 cm. Carotids 2+ with no bruits. A well-healed midline scar is present on his anterior chest. No tenderness to palpation over the chest wall. Apical impulse is tapping and located 7 cm lateral to the mid-sternum in the 5^{th} intercostal space. Normal S1, S2. No murmurs, rubs, or gallops.

Abdomen is soft and non-tender with positive bowel sounds. No masses, hepatosplenomegaly, or abdominal bruits.

Extremities are warm and without edema.

Musculoskeletal and neuro exams are unremarkable.

Relevant **testing** shows:

The admission troponin I was not elevated. CBC and CMP were within reference ranges.

EKG shows evidence of an old anteroseptal MI. No ST-segment elevation or depression and no changes compared to his EKG from 6 months ago.

(Assessment): In summary, this is a 68-year-old man with a history of CAD who presents with chest pain. The differential diagnosis includes myocardial infarction, unstable angina, GERD, and esophageal spasm. GERD is most likely given the association with spicy food, the timing after meals, and the lack of exacerbation with exertion. However, given his extensive cardiac risk factors, we need to rule-out an MI.

I will present the **plan** by system:

For cardiovascular:

- Admit to rule out MI
- Start aspirin 325 mg PO once daily
- Monitor on telemetry
- Continue lisinopril, carvedilol, and high-dose statin
- Repeat troponin I
- Cardiac diet

For GI:

- Counsel patient on signs/symptoms of GERD
- Recommend lifestyle changes that can improve GERD including weight loss, not laying down right after eating, and avoiding triggering foods, alcohol, and caffeine
- Start a daily oral proton pump inhibitor and monitor symptoms

In terms of disposition, if there is no evidence of an MI, we will plan to send Mr. P. home with follow-up with his cardiologist, treatment for possible GERD, and follow-up with his primary care physician.

What questions do you have?