

GERIATRICS HOSPITAL CONSULTATION: MODEL EXAMPLE

CC/HPI We were asked by Dr. Hospitalist to consult on a patient of Dr. Keller's who was admitted last evening. Mrs. Jones is an 82-year-old woman who was brought to the E.D. by her daughter because of three days of worsening fatigue, exertional dyspnea, and a new need for help from family with bathing and dressing. She was able to attend the state fair where she ambulated on the grounds two weeks ago, so this is an acute change. She has mild dementia and is a little confused at baseline, but according to her daughter, she has been quite a bit more so for two days. The daughter says her mom just can't focus as well as usual, and is now almost unable to follow a conversation. Mrs. Jones has no dyspnea at rest; has a chronic cough productive of scant amounts of yellow sputum; denies fevers or chills; sleeps on two pillows but denies PND; and has occasional palpitations, though she can't say how often. Her appetite is a little reduced this week, though she has had no nausea, vomiting, or change in her bowel habits.

PMH/PROBLEM LIST She has a history of diastolic heart failure; essential hypertension; mild mixed dementia; lacunar infarcts; mild gait impairment due to knee osteoarthritis and cerebrovascular disease; depression; and urge urinary incontinence.

MEDICATIONS Her outpatient medications include furosemide 20 mg a day, lisinopril 10 mg a day, a baby aspirin daily, atorvastatin 20 mg a day, citalopram 20 mg a day, and acetaminophen, which she takes 3 or 4 times a week. Her daughter directly administers the medications from a mediset, and the patient misses fewer than a dose each week.

The admitting physician continued her outpatient regimen, and added ceftriaxone 1 gram daily, azithromycin 500 mg daily, prophylactic enoxaprin 40 mg daily, and lorazepam 0.5 mg at night as needed for sleep.

FAMILY HISTORY Her brother died of lung cancer two years ago, and both parents died of heart disease in their 70s. Her daughter, who is her only child, is in good health aside from hypertension and occasional migraines.

SOCIAL HISTORY Mrs. Jones is retired from work as a high school librarian, and has been widowed 10 years. She lives with her daughter in a house in South Omaha. She has a sister in Lincoln whom she sees monthly. She never smoked, and she quit drinking wine about 3 years ago (she never drank heavily). At baseline, before this acute illness, she was independent in her ADLs, aside from urinary incontinence. Her daughter manages her medications and finances, and helps with shopping and cleaning house. Mrs. Jones has designated her daughter as her surrogate decision maker, and would like us to take measures to prolong her life if we can, although she is DNR/DNI in the event of arrest. She feels well cared-for and safe at home.

ROS She feels unsteady on her feet, but has not fallen in over a year and a half. She feels she sees OK when wearing her glasses, but has trouble hearing when she and her daughter go out to certain restaurants. She denies depressed mood or feeling that she has lost interest in the things in life she enjoys. At baseline, she knows she is forgetful, and she often repeats questions or comments. Her appetite is good, and her weight is stable. Review of systems is otherwise negative.

PHYSICAL EXAMINATION Vital signs were temperature 37.8 degrees, heart rate in the 90s, blood pressure 158/78, respiratory rate 24, and O2 saturation 91% on room air. She is a thin, frail-appearing elderly Caucasian woman, breathing rather rapidly, and confused – we had to repeat or rephrase our questions several times. She coughed after drinking 20 mL of orange juice. Her skin was flushed and dry, but without a rash. There was blanching erythema over her coccyx, but no other worrisome skin areas over bony prominences. She had temporal wasting. Her vision was 20/40 when wearing her glasses. She could not hear a whisper in either ear, and there was minimal cerumen. Her dentures appeared loose, and her oral mucosa was dry. She had globally diminished neck range of motion, and her jugular veins were almost to the angle of the jaw; there was no thyromegaly or cervical lymphadenopathy. Her heart was irregularly irregular and borderline tachycardic, but I appreciated no adventitious heart sounds. There were crackles on the lower 1/3 of the left lung field, and minimal breath sounds at the right base. Her abdomen was scaphoid, but otherwise completely benign. There is a Foley catheter that drains dark, amber urine. She had loss of intrinsic muscle bulk in her hands, and pretibial pitting edema half-way to both knees. Both knees showed bony enlargement and crepitance with passive flexion and extension. She required three tries to arise from a chair without using her arms, and her gait was slow, wide-based, and appeared to favor her right leg. MMSE was 21/30, with points missed for date, day, month, recall of three words, and ability to follow a 3-step command.

LABS Her white count this morning is 14.8 (81% neutrophils). Hematocrit, platelet count, and electrolytes are all normal. BUN is 28, creatinine is 1.9. Total protein, albumin, coagulation studies, liver function tests, and calcium are all normal. UA showed mod LE, nitrite negative, and no red or white cells. Her first troponin was negative. CHF-peptide is pending.

A chest film showed a consolidation at the right base with pleural effusion, with cardiomegaly and venous cephalization.

ECG showed atrial fibrillation at 96 beats per minute, with normal axis and intervals, and evidence of LVH. There were no Q waves or ST segment changes.

IMPRESSION:

1. Community-acquired pneumonia.
2. Diastolic heart failure, probably exacerbated by pneumonia.
3. Acute metabolic encephalopathy, multifactorial (infection, heart failure, renal dysfunction).
4. Gait impairment, with risk of nosocomial mobility decline.
5. Acute renal failure, suspect dehydration.
6. Possible undernutrition.
7. Possible dysphagia.
8. Polypharmacy.
9. Depression history, mood currently stable.

RECOMMENDATION:

1. Check blood and sputum cultures, continue current ceftriaxone and azithromycin, and O2 to maintain saturation over 91%.
2. Stop enoxaparin (for renal function) and lorazepam (as it aggravates delirium).
3. Trial of holding ACE inhibitor and furosemide; monitor BMP and UOP daily. Consider pulling Foley after 1-2 days.
4. Continue citalopram.
5. Frequent reorientation.
6. Attempt tid ambulation with assistance; PT and OT evaluations. Will confer with PT regarding recommended discharge venue and arrangements.
7. Speech Therapy for swallowing assessment.
8. For now, Boost tid between meals, pending ST's dietary consistency recommendations. Will monitor oral intake.
9. Glasses are with her; consider outpatient Audiology appointment.
10. Monitor sacrum daily. Will notify Nursing of our concern; low threshold to involve Wound Care Nursing for additional measures, alternative bed surface.
11. DNR/DNI order written.
12. Will contact PMD (Dr. Keller) as discharge approaches. We will assume inpatient primary care from Dr. Hospitalist.

(/signed/) Consulting Geriatrician, M.D.

CC: Dr. Hospitalist
Dr. Keller