Performance Overview for [redacted] on case i-Human Case Week #4

The following table summarizes your performance on each section of the case, whether you completed that section or not.

Time spent: 4hr 11min 26sec
Status: Submitted

Case Section	Status	Your Score	Time spent	Performance Details
Total Score		[redacted]		
History	Done	[redacted]	37min 57sec	[redacted]
Physical exams	Done	[redacted]	46min 42sec	[redacted]
Key findings organization	Done		2min 24sec	[redacted]
Problem Statement	Done		27min 45sec	[redacted]
Differentials	Done	[redacted]	7min 18sec	[redacted]
Differentials ranking	Done	100% (lead/alt score) 0% (must not miss score)	42sec	
Tests	Done	100%	16min 50sec	16 tests ordered, 6 correct, 0 partially correct, 0 harmful to patient, 0 missed relative to the case's list
Diagnosis	Done	100%	12sec	
Management Plan	Done		56min 38sec	706 words long; the case's was 156 words
Exercises	Done	79% (of scored items only)	8min 9sec	0 of 1 correct (of scored items only) 1 partially correct

History Notecard by [redacted] on case i-Human Case Week #4

Use this worksheet to organize your thoughts before developing a differential diagnosis list.

1. Indicate key symptoms (**Sx**) you have identified from the history. Start with the patient's reason(s) for the encounter and add additional symptoms obtained from further questioning.
2. Characterize the attributes of each symptom using **"OLDCARTS"**. Capture the details in the appropriate column and row.
3. Review your findings and consider possible diagnoses that may correlate with these symptoms. (Remember to consider the patient's age and risk factors.) Use your ideas to help guide your physical examination in the next section of the case.

HPI	Sx =	Sx =	Sx =	Sx =	Sx =	Sx =
Onset						
Location						
Duration						
Characteristics						
Aggravating						
Relieving						
Timing / Treatments						
Severity						

Problem Statement by [redacted] on case i-Human Case Week #4

This patient is a 69-year-old, Asian, overweight female with a history of stable grade two systolic murmur diagnosed five months ago, hypertension, CAD, and hyperlipidemia. Denies alcohol consumption. Denies tobacco or e cigarette use. Presents today with complaint of intermittent chest pain x 5 days. Describes chest pain as heavy, pressure, and all over chest, non-radiating, 6/10 on pain scale when in pain, 0/10 on pain scale at time of examination. Denies fever, recent URI, and/or infection. Episodes last less than five minutes. 2-3 minutes in duration. Occurred when going for evening walk. When walking stopped so did the symptoms. Denies diaphoresis, nausea, and vomiting. On physical exam pt is hypertensive, tachycardic, heart rate and rhythm are regular, & faint murmur auscultated immediately after S1. All lung sounds are clear to auscultation anteriorly and posteriorly. Negative for BLE edema. Negative for JVD. FH-Mother Hyperlipidemia deceased at 90 years of age.

Attempt: 3279073

Report generated on 9/22/2024, 1:27:32 PM Asia/Karachi

Management Plan by [redacted] on case i-Human Case Week #4

S: Subjective

The patient is a 69-year-old female with a history of coronary artery disease (CAD), hypertension, and hyperlipidemia presenting with complaints of episodic chest pain for the past 5 days. The pain is described as a pressure-like sensation across the mid-chest, occurring primarily during exertion or stress and alleviating with rest. The patient denies any associated symptoms such as radiation of the pain, nausea, or diaphoresis. She reports that the episodes of chest pain are relieved within minutes of resting and denies any recent changes in pattern, severity, or frequency of the pain. She also notes occasional windedness accompanying the chest pain. There is no history of recent infections, fever, or other systemic symptoms.

O: Objective

Vitals:

Blood Pressure: 142/89 mmHg
Heart Rate: 108 bpm
Respiratory Rate: 16 breaths per minute
Oxygen Saturation: 98% on room air
Temperature: 98.6°F (37°C)
Physical Examination:

Cardiovascular Examination: Regular rhythm with no murmurs, rubs, or gallops detected. No peripheral edema.
Respiratory Examination: Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi.
Abdominal Examination: Soft, non-tender, no hepatosplenomegaly or masses palpated.
Laboratory and Imaging: ECG shows no ST-segment elevations or depressions, regular rate and rhythm.
Chest X-ray PA and lateral views showed no acute cardiopulmonary findings.
Comprehensive metabolic panel within normal limits.
Lipid profile revealed elevated cholesterol levels with LDL at 169 mg/dL and HDL at 43 mg/dL.
Troponin levels were within normal range.

A: Assessment

The patient's clinical presentation and diagnostic findings support a diagnosis of stable angina pectoris. This is corroborated by the typical exertional pattern of her chest pain and her significant history of CAD, hypertension, and dyslipidemia. The absence of acute changes in the ECG and normal troponin levels effectively rule out acute coronary syndrome (ACS) at this time (Buttaro et al., 2021). However, the patient's elevated heart rate and suboptimal lipid control are concerning and warrant further management.

P: Plan

Medication Adjustments:

Increase the dosage of her current statin medication to better control her LDL levels as per the latest atherosclerotic cardiovascular disease (ASCVD) risk guidelines.
Initiate beta-blocker therapy to help manage her heart rate and reduce myocardial oxygen demand (Carey et al., 2018).
Continue current antihypertensive medications and adjust as needed to achieve blood pressure goals.

Lifestyle Modifications:
Reinforce dietary advice focusing on low cholesterol and low sodium intake.

Advise the patient to increase physical activity levels as tolerated, aiming for at least 150 minutes of moderate-intensity aerobic exercise per week.
Encourage weight management strategies to achieve a body mass index (BMI) within the normal range.
Further Diagnostic Testing:

Schedule a follow-up stress test to evaluate for ischemia that might not be apparent at rest.
Arrange for a follow-up echocardiogram to assess cardiac function and structure, particularly looking for signs of hypertrophy or other structural heart disease (Yancy et al., 2017).

Education and Follow-Up:
Educate the patient on the importance of medication adherence and recognizing signs of unstable angina and potential myocardial infarction.
Schedule a follow-up visit in 1 month to re-evaluate symptom control, medication tolerance, and adherence to lifestyle modifications (Jeemon et al., 2018). Plan for more frequent follow-ups if symptoms persist or worsen.

Referrals:
Consider referral to a cardiologist for further evaluation, given the patient's complex cardiac history and current symptomatology.

References
Buttaro, T. M., Polgar-Bailey, P., Sandberg-Cook, J., & Trybulski, J. (2021). Primary care: Interprofessional collaborative practice. (No Title). https://cir.nii.ac.jp/crid/1131412329605002496
Carey, R. M., Muntner, P., Bosworth, H. B., & Whelton, P. K. (2018). Prevention and Control of Hypertension: JACC Health Promotion Series. Journal of the American College of Cardiology, 72(11), 1278–1293. https://doi.org/10.1016/j.jacc.2018.07.008
Jeemon, P., Gupta, R., Onen, C., Adler, A., Gaziano, T. A., Prabhakaran, D., & Poulter, N. (2018). Management of hypertension and dyslipidemia for primary prevention of cardiovascular disease. https://europepmc.org/books/nbk525163
Yancy, C. W., Jessup, M., Bozkurt, B., Butler, J., Casey, D. E., Colvin, M. M., Drazner, M. H., Filippatos, G. S., Fonarow, G. C., Givertz, M. M., Hollenberg, S. M., Lindenfeld, J., Masoudi, F. A., McBride, P. E., Peterson, P. N., Stevenson, L. W., & Westlake, C. (2017). 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. Circulation, 136(6). https://doi.org/10.1161/CIR.0000000000000509

Electronic Health Record by [redacted] on case i-Human Case Week #4

History of Present Illness

Category	Data entered by Debbie Duffee Persinger
Reason for Encounter	The patient, a 69-year-old female, presents with complaints of episodic chest pain for the past 5 days, characterized as a pressure-like sensation occurring primarily during exertion and alleviated with rest.
History of present illness	The patient reports chest pain that began 5 days ago, described as pressure-like, occurring during exertion such as walking or climbing stairs, and relieved by rest. The pain does not radiate and is not accompanied by nausea, vomiting, or diaphoresis. There has been no change in the frequency, severity, or duration of the episodes, which typically last for a few minutes.

Past Medical History

Category	Data entered by Debbie Duffee Persinger
Past Medical History	oronary artery disease, hypertension, hyperlipidemia
Hospitalizations / Surgeries	Previous hospitalizations include gallbladder removal 20 years ago.

Medications

Category	Data entered by Debbie Duffee Persinger
Medications	Current medications include a statin, antihypertensive, and aspirin.

Allergies

Category	Data entered by Debbie Duffee Persinger
Allergies	No known drug allergies.

Preventive Health

Category	Data entered by Debbie Duffee Persinger
Preventive health	Up-to-date on cardiovascular risk assessments and screenings.

Family History

Category	Data entered by Debbie Duffee Persinger
Family History	The patient's mother had high cholesterol and hypertension and passed away at age 92 from complications of heart disease. Her father had chronic obstructive pulmonary disease (COPD) and died at age 89. She has one son, aged 45, who is in good health.

Social History

Category	Data entered by Debbie Duffee Persinger
Social History	The patient is a retired teacher who lives with her husband. She is a non-smoker and reports occasional alcohol use. She remains physically active within her limitations and enjoys spending time with her grandchildren.

Review of Systems

Category	Data entered by Debbie Duffee Persinger
General	No recent weight loss, fever, fatigue, or weakness reported.
Integumentary / Breast	No rashes, lesions, or itching.
HEENT / Neck	Denies any headaches, dizziness, visual or auditory changes. No reports of neck pain or stiffness.
Cardiovascular	Episodic chest pressure was noted as described. No history of palpitations or edema.
Respiratory	No shortness of breath, cough, or wheezing independent of chest pain episodes.
Gastrointestinal	No abdominal pain, nausea, vomiting, diarrhea, or changes in appetite.
Genitourinary	No dysuria, frequency, or incontinence.
Musculoskeletal	Reports general aches related to age, no specific joint pain or stiffness.
Allergic / Immunologic	No known drug allergies or history of atopic conditions.
Endocrine	No history of thyroid problems or diabetes.
Hematologic / Lymphatic	No enlarged nodes or history of lymphatic diseases.
Neurologic	No syncope, seizures, or focal neurological deficits.
Psychiatric	No reports of depression, anxiety, or mood swings.

Physical Exams

Category	Data entered by Debbie Duffee Persinger
General	No recent weight loss, fever, fatigue, or weakness was reported.
Skin	No rashes, lesions, or itching.
HEENT / Neck	Denies any headaches, dizziness, or visual or auditory changes. No reports of neck pain or stiffness.
Cardiovascular	Episodic chest pressure noted as described. No history of palpitations or edema.
Chest / Respiratory	No shortness of breath, cough, or wheezing independent of chest pain episodes.
Abdomen	No abdominal pain, nausea, vomiting, diarrhea, or changes in appetite.
Genitourinary / Rectal	No dysuria, frequency, or incontinence.
Musculoskeletal / Osteopathic Structural Examination	Reports general aches related to age, no specific joint pain or stiffness.
Neurologic	No syncope, seizures, or focal neurological deficits.
Psychiatric	No reports of depression, anxiety, or mood swings.
Lymphatic	No enlarged nodes or history of lymphatic diseases.