Date: 6/9/2023
Full Name: M.M.
Date of Birth: 03/21/1980
Admitted date: 6/8/23
Location: Woodhull Hospital
Source of Information: Self
Reliability of patient: Reliable
Mode of Transport: Uber

Chief Complaint: Headache x 1 day

History of Present Illness:

43 y/o G2P1011 s/p c-section on 6/4/23 due to failed medical induction of labor on 6/03/23 presents to triage with persistent throbbing 6/10 generalized headache since last night. Pt notes 1 episode of vomiting and described it as "yellow fluid and her breakfast" 1 hour after eating this morning. Pt also notes chills since this morning for which she took tylenol. On arrival to hospital, patients BP was 158/76, 169/81 and 135/82 after cycling BP for 1 hour. Pt given magnesium sulfate and nifedipine and is currently being monitored. Pt denies abdominal pain, blurry vision, palpitations, hx of HTN, seizures chest pain or SOB.

Past Medical History:
Uterine fibroids

Past Surgical History:
C - section 6/4/23, no blood products were transfused

Allergies: None

Medications:
Nifedipine - 60mg, once daily starting - HTN
oxycodone, acetaminophen 5,325 - every 4 hours as needed maximum of 7 days - headache -

Family History:

Grandmother: Deceased at 82 y/o, unknown cause of death
Grandfather: deceased at 85 y/o, unknown cause of death
Mother: 72 y/o, alive and well, no known medical hx
Father: 74 y/o, alive and well, no known medical hx

Son - 15 y/o, alive and well
Sister - 38 y/o, alive and well, has hx of gestational diabetes

Social History:

M.M is 43 y/o F who works for a cleaning service with undisclosed religion. Patient notes she has never used tobacco products, denies illicit drug use and had 1 alcoholic drink per week before pregnancy, since then she had not drank. Pt notes her diet consists of rice, chicken and food from the deli.

Review of Systems:

General – Denies fever, night sweats, loss of appetite, weight loss/gain, or weakness/fatigue

Skin, hair, nails – Denies changes in texture, excessive dryness or sweating, pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head – Denies vertigo or head trauma.

Eyes – Denies using reading glasses, other visual disturbances, photophobia, lacrimation, or pruritus.

Ears – Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or use of dentures.

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion

Pulmonary system – denies cough, wheeze, hemoptysis, SOB

Cardiovascular system – Denies chest pain, palpitations, irregular heartbeat, syncope, edema/swelling of ankles or feet, known heart murmur

Gastrointestinal system – Pt notes nausea, vomiting this morning after eating breakfast. Pt has regular bowel movements daily. No intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructations, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, vaginal bleeding, awakening at night to urinate

Musculoskeletal system – Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Nervous – Pt % 6/10 generalized headache that started this morning. Denies seizures, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE

Endocrine system – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter.

Psychiatric – Denies depression/sadness, anxiety, OCD or ever seeing a mental health professional.

Physical Exam

BP: 138/88

Pulse: 82

Temp: 99.0

Resp: 18

Wt: 153lb

SpO2: 96%

BMI: 25.46

General: Pt appears in mild distress. Appears stated weight and age, neatly groomed.

Skin: Pt's skin appears slightly pale, nonicteric, no lesions noted, no scars, no tattoos.

Ears: Symmetrical and appropriate in size. No lesions/masses / trauma on external ears. No discharge / foreign bodies in external auditory canals AU.

Nose: Symmetrical / no masses / lesions / deformities / trauma / discharge. Nares patent bilaterally / Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions / deformities / injection / perforation. No foreign bodies.

Sinuses: Non tender frontal, and maxillary sinus palpation.

Lips: Pink, moist; no cyanosis or lesions.

Mucosa: Pink; well hydrated. No masses; no lesions noted.

Palate: well hydrated. Palate intact with no lesions; masses; scars.

Teeth: Good dentition. No dentures, no other dental caries noted.

Gingivae: Pink; moist. No hyperplasia; masses; lesions; erythema or discharge.

Tongue: Pink; no masses, lesions or deviation.

Oropharynx: Well hydrated; no injection; exudate; masses; lesions; foreign bodies. Tonsils present with no injection or exudate. Uvula pink, no edema, lesions

Neck: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation.

Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted.

Lungs: Clear lung sounds B/l, no adventitious breath sounds

Heart: Regular rate and rhythm (RRR). Carotid pulses are 2+ bilaterally without bruits. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdomen: Abdomen slightly distended. Linea nigra and c-section incision scars are noted. C-section incision healing well with no discharge, sutures and steri-strips intact. Pt has diffuse striae around the abdomen. Bowel sounds normoactive in all four quadrants. Uterus is non tender and feels hard on palpation. No guarding or rebound noted, no CVA tenderness appreciated.

Neurological: Patient is alert and oriented to person, place, and time.

Differential diagnosis:

Preeclampsia - Patient is 4 days s/p c-section and returns % 6/10 generalized headache. Pt's blood pressure is elevated on multiple readings. This is classic for preeclampsia. Patients should be admitted and treated with IV magnesium sulfate (loading dose 4mg). Blood pressure should be cycled every 15 minutes. She also needs blood pressure control which can be done by labetalol, hydralazine, or nifedipine.

CVA - pt presents with multiple elevated BP readings**.** Pt % throbbing persistent headache with nausea and vomiting. Order POC glucose, CBC, CMP. type and screen incase blood transfusion

is necessary. Also order a non contrast head CT to eval for stroke. This diagnosis is unlikely however it is fatal.

HELLP Syndrome - Patient has multiple elevated blood pressure readings and is s/p c-section. Pt also % nausea and vomiting. HELLP usually occurs in third trimester but can occur after birth. Patient is also multipara which is a risk factor. Although this diagnosis is unlikely, treat the patient similar to if they had preeclampsia with magnesium sulfate and BP control. Order CBC to check for low platelets and transfuse if necessary.

Migraine: Patient % of persistent throbbing headache of 6/10 intensity. Pt also notes headache is diffuse. However, nausea and vomiting are cause for concern and other diagnosis should be excluded first.

Assessment - **Plan**

43 y/o G2P1011 s/p c-section on 6/4/23 due to failed induction of labor presents with classic symptoms for preeclampsia. Pt should be started on magnesium sulfate, and admitted to the hospital for monitoring for ecclampsia and further evaluation . Pt's BP must be cycled every 15 minutes. BP control with nifedipine.