**Identifying Data:**

Full Name: A.S.

Sex: Male

DOB: XX/XX/1994

Race/Nationality: African American

Primary Language: English

Address: Manhattan, NY

Date & Time: 01:00PM 03/16/22

Location: Metropolitan Hospital

Source of Information: Self & Medical Records

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** dry cough x3 months

**HPI:**

AS, 27 y/o male, PMHx childhood asthma and current smoker ½ PPD presents to the ED for a persistent dry cough x3 months. The cough has the same intensity at all times of the day without any associated aggravating or relieving factors. He has tried OTC Robitussin without relief. Admits to mild intermittent SOB and DOE. No one else in the household has cough or has been sick recently. Denies recent illness or travel, N/V/D, sore throat, fever/chills, night sweats, weight loss, generalized fatigue, chest pain, wheezing, sputum production, rhinorrhea, heartburn, regurgitation of food, facial flushing, or palpitations.

***Previous hospitalizations, or ICU/ETT***

**Past Medical History:**

* Asthma in Childhood – Managed with Albuterol PRN. Denies asthmatic episode since childhood
* Nondisplaced fracture of radial neck – 2019 Managed by ortho with posterior splint

*Immunizations*

* Up-to-date on immunization schedule
	+ Influenza (annually)
	+ SARS-CoV-2 3 doses – Moderna, Moderna, Pfizer
	+ BCG vaccination

**Past Surgical History:**

* No reported PSHx

**Current Medications:**

* No reported prescription or OTC medications

**Allergies:**

* NKDA or environmental/food allergies

**Family History:**

* Mother – living & healthy per pt
* Father – living & healthy per pt
* Grandmother - unknown
* Grandfather – unknown
* Siblings – living & healthy
* No reported family Hx of cancer or endocrine disorders

**Social History:**

* Habits – Social alcohol use. Current smoker ½ PPD x10 yrs. No reported illicit drug use
* Travel – Denies recent travel
* Occupation – unemployed
* Marital History – Single
* Diet – No dietary restrictions. Following American diet.
* Sleep – Sleeps well throughout the night. Cough not waking him up at night.
* Exercise – No exercise routine. Recently has felt mild SOB after walking several blocks and after coughing
* Sexual History – Sexually active with women

**Review of Systems:**

* General
	+ Denies generalized weakness/fatigue, weight loss, loss of appetite**,** fever/chills/night sweats
* Skin, hair, nails
	+ Denies rash, pruritis, excessive sweating, pigmentations, moles, change in hair distribution.
* Head
	+ Denies headache, vertigo, or new head trauma
* Eyes
	+ Denies visual disturbances or photophobia.
* Ears
	+ Denies, pain, discharge, tinnitus, hearing loss, or feeling of fullness
* Nose/Sinuses
	+ Denies epistaxis, congestion, or discharge
* Mouth and Throat
	+ Denies bleeding gums, sore tongue/throat, mouth ulcers, voice changes. Last dental exam unknown
* Neck
	+ Denies swelling/lumps, stiffness, or decreased ROM
* Pulmonary System
	+ **Admits to cough, mild dyspnea on exertion**
	+ Denies wheezing, hemoptysis, cyanosis, orthopnea, or PND
* Cardiovascular System
	+ Denies chest pain, known murmur, palpitations, irregular heartbeat, or syncope
* Gastrointestinal System
	+ Denies decreased appetite, intolerance to specific foods, N/V/Constipation, mild abdominal pain,diarrhea, dysphagia, pyrosis, flatulence, jaundice, changes in bowel habits, hemorrhoids, rectal bleeding/blood in stool.
* Genitourinary System
	+ Denies incontinence, changes in frequency, nocturia, oliguria, polyuria, abnormal color of urine, flank plain, or dysuria
	+ Sexual History – refer to Social Hx
* Nervous System
	+ Denies generalized weakness, loss of strength, change in cognition/mental status, changes in memory, seizures, headache, loss of consciousness, & ataxia
* Musculoskeletal System
	+ Denies deformity, swelling, redness, pain
* Peripheral Vascular System
	+ Denies intermittent claudication, coldness/trophic changes, varicose, or color change
* Hematologic System
	+ No Hx of DVT/PE, anemia, or lymph node enlargement
* Endocrine System
	+ Denies polyuria/polydipsia/polyphagia, heat/cold intolerance, excessive sweating, inability to sweat, or hirsutism
* Psychiatric
	+ Denies Hx of anxiety, depression, obsessive/compulsive disorder, or other psychiatric illnesses

**PHYSICAL EXAM**

Vital Signs:

BP: 128/73mmHg – sitting, R arm RR: 16 breaths/min Pulse: 95 bpm

T: 99.0F (oral) SpO2: 100% on room air

Height: 5’10 inches Weight: 194 lbs BMI: 27.8 kg/m2

General Appearance: Alert & Oriented x3. No acute distress. Not diaphoretic. Appears reported age and well groomed. Appropriate body habitus.

Head: normocephalic, atraumatic.

Eyes: No ptosis or miosis. PERRLA. No strabismus/exophthalmos. Sclera white, cornea clear, conjunctiva pink. No erythema of lacrimal sack.

Ear: Appropriate in size. No lesions/masses/trauma visualized on external ear.

Nose: Symmetrical, no external masses/lesions/deformities/trauma/discharge.

Mouth & Throat:

Lips: Pink and moist. No cyanosis, lesions, or ulcerations

Oral Mucosa: Pink &Moist. No masses/lesions noted. No leukoplakia.

Palate: Pink. No visible lesions/masses/scars.

Teeth: Intact without visible dental carries. All teeth have appropriate shape.

Gingivae: No hypertrophy or recession. Unremarkable

Tongue: Pink, well papillated. Frenulum intact. Appropriate shape/size. No masses/lesions/deviation.

Oropharynx: Hydrated, no exudate/masses/lesions/erythema/postnasal drip/foreign bodies noted. Grade 2 tonsils. Uvula pink, midline with no lesions or edema.

Neck: No palpable goiter.Trachea midline. No lesions/pulsations noted. No stridor noted. No cervical adenopathy. No carotid pulses/thrills/bruits heard on auscultation.

Cardiovascular: PMI located at the 5th ICS in midclavicular line. Carotid pulses are 2+ bilaterally without bruits. RRR. No murmurs. Normal S1 & S2. No splitting of S2 or friction rubs appreciated.

Pulmonary: Chest symmetrical with no deformities or trauma. Lat/AP diameter 2:1. Normal chest expansion and diaphragmatic excursion. No adventitious breath sounds.

Skin: Warm and moist**.** Non-icteric. No tattoos noted. No visible moles.

Hair: Average quality, quantity, & distribution. No seborrhea/lice/dandruff noted

Nails: Capillary refill <2 seconds in bilateral upper and left lower extremities. Appropriate color, shape, and thickness.

Musculoskeletal: No erythema / ecchymosis / atrophy or deformities in bilateral upper and lower extremities.

Peripheral Vascular: Warm to touch bilaterally. Radial pulse 2+ b/l. No edema or ulcerations. Calves equal in circumference. No palpable cords bilaterally.

**Labs:**

CBC w/ differential – pending

Sars-2-Covid swab – pending

**Imaging Findings:**

*CXR* *Impression*: Perihilar mass consolidation process of the right lung extending into the right upper lobe.

**Assessment:**

27 y/o male with PMHx childhood asthma & current smoker complaining of dry cough x3 months without apparent environmental exposures or recent illness found to have large perihilar mass of the right lung on CXR.

**Differential Diagnosis:**

1. Malignancy
	1. Primary vs Secondary
	2. Consider neuroendocrine carcinoid tumor based on age and proximity to bronchus
2. Pneumonia
	1. Unlikely given that patient has no other associated signs/symptoms, reported recent illness, immunocompromised status, or known exposure
3. Foreign body
	1. Unlikely to swallow foreign body given patients age, mental status, and negative history
4. Tuberculosis
	1. Less likely given that there is no apparent cavitation on CXR. No apparent clinical signs such as productive cough, CP, hemoptysis, lethargy, or fever.
5. Cyst
	1. Less likely given that CXR findings not consistent with appearance of pulmonary cyst
6. AV Malformation
	1. CXR does not appear to have typical appearance of AVM such as feeding into the pulmonary vein
7. Chest wall mass
	1. Less likely given that there was no apparent chest wall mass noted on physical exam
8. Benign neoplasm
	1. Highly unlikely based on large size of mass

***Great DDx***

**Plan:**

* Pulmonary
	+ #Chronic cough 2/2 Right lobe mass/consolidation
		- Labs:
			* CBC w/ differential – Evaluate for systemic signs of infection/inflammation
			* Electrolytes – Evaluate possible abnormalities 2/2 malignancy
			* Calcium – Abnormalities should prompt further workup for bone metastasis
			* Alk phos/ALT/AST/Total bilirubin – Abnormalities should prompt further workup for liver metastasis
			* Creatinine & renal function panel – obtain baseline prior to giving contrast
		- Imaging:
			* Chest/abdominal CT scan with IV contrast
		- Consult Heme/Oncology
			* Consult for likelihood of further staging and biopsy
* Other
	+ Diet: oral, no restrictions
	+ Code: Full
	+ Disposition: Admit to internal medicine for further evaluation of CXR findings

***Sad case, good plan for initial evaluation.***