



# **FLORENCE BLACKMAN IHUMAN**

## **Case Study 66-Year-Old Female – Chest Pain**

Nursing  
Walden University  
25 pag.

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## VERSION 1

### Florence Blackman (66 y/o female) – Chest Pain

- CC: Intermittent squeezing chest pain
- **MSAP: Exertional “squeezing” mid-chest pain radiating to left arm, relieved by rest, worse with cold**
- Associated dyspnea on exertion
- History: HLD, HTN, previous smoker, family hx of heart disease
- Stressful work

#### **History Questions:**

- How can I help you today?
- Any other symptoms we should discuss?
- Do you have any allergies?
- Are you taking any OTC or herbal medications?
- Any new or recent changes in medications?
- What does the pain / discomfort in your chest feel like? (squeezing, pressure, crushing, burning, stabbing, aching, tingling, suffocating)
- How severe (scale 1-10) is the pain in your chest?
- Does anything make the pain in your chest better or worse?
- What are the events surrounding the start of your chest pain?
- Is there a pattern to your chest pain?
- Have you had any trauma to your chest?

- Does the pain in your chest radiate someplace else? Where?
- Do you have unusual heartbeats (palpitations)?
- Does the pain get worse with breathing?
- Does your pain awaken you from your sleep?
- Is your pain affected by what, when, or how much you eat?
- Do you presently have heartburn, a food or acid taste in your mouth?
- Do you drink alcohol? If so, what do you drink and how many drinks per day?
- Do you have any of the following problems: fatigue, difficulty sleeping, unintentional weight loss or gain, fevers, night sweats?
- Do you experience: SOB, wheezing, difficulty catching breath, chronic cough, sputum production?
- Does anything make your shortness of breath better or worse?
- How long does your SOB last?
- Do you have any of the following: heat or cold intolerance, increased thirst, increased sweating, frequent urination, change in appetite?
- Do you have any of the following: dizziness, fainting, spinning room, seizures, weakness, numbness, tingling, tremor?
- Do you have problems with: N/V, constipation, diarrhea, coffee grounds in your vomit, dark tarry stool, bright red blood in your BM, early satiety, bloating?
- How is your overall health?

- Tell me about your work.
- Tell me about daily exercise or sports that you play.

**Physical Exam:**

- Vitals: pulse, BP, respirations
- Examine skin
- Neck: measure JVP (jugular venous pressure) - Neck: auscultate carotid arteries - Chest wall & lungs:
  - o Visual inspection of anterior & posterior chest
  - o Palpate anterior & posterior chest
  - o Auscultate lungs - Heart:
    - o Palpate for PMI (Point of Maximal Impact)
    - o Auscultate heart - Abdomen:
      - o Auscultate abdominal/femoral arteries
      - o Palpate abdomen
- Extremities: Visual inspection of extremities

**Assessment note:**

- F.B. is a 66 y/o Caucasian female presenting with 2-week h/o new onset, intermittent, stable chest pain which radiates to the L arm, occurs with SOB, is worse with cold temperatures and exertion, and improved by rest. On physical exam she is pain free with stable vital signs. PMH risk factors include: distant history of smoking (5 pack/years), a history of HTN, and high cholesterol, and a family history of coronary vascular disease.

- Stress test: 2-mm ST segment depression in inferior leads, 2, 3, and aVF and V3-6 **Diagnosis: Coronary artery disease:**

### **stable angina**

#### **Plan:**

- Determine need for coronary angiography based on stress test results and ECHO. Her Duke score of 10.5 is slightly above moderate risk, and arguments could be made for both a trial at medication intervention since the pt needs improvement on both HTN and HLD
  - o Augment management of preexisting HTN and HLD with a BB (metoprolol 25 mg XR daily); a statin (atorvastatin 40 mg daily); and ASA 81 mg daily - Continue use of HCTZ 25 mg daily - Encourage lifestyle modification:
    - o Decrease intensity of aerobic workouts for next 3 months
    - o D/c alcohol for next 2 months as starts a statin
- f/u in 3-4 weeks

## Ben Kapinsky (18 y/o male) – Fever

- CC: Fatigue, SOB, productive cough with yellow/green sputum
- **MSAP: Hypoxia**
- Tachypnea, dyspnea
- Fever and chills
- Fatigue and myalgia
- Right-sided chest wall pain aggravated by coughing
- Productive cough
- Right middle and lower lung crackles
- Bilateral cervical lymphadenopathy
- Tachycardia
- Previous hx of the flu 2 weeks ago, but got better
- Childhood asthma per history

### **History Questions:**

- How can I help you today?
- Any other symptoms or concerns we should discuss?
- Do you have any allergies?
- Are you taking any prescription medications?
- Are you taking any OTC or herbal medications?
- How high is your fever?
- When did your cough start? – 4 days ago

- Is there a pattern to your cough? – no
- Does anything make your cough better or worse?
- Are you coughing up any sputum? – yellowish green stuff
- What are the events surrounding the start of your cough? – symptoms started without much warning, thought maybe just got tired going to the party, but got worse over time
- What treatments have you had for your cough? – cough syrup, doesn't help
- Do you awaken at night coughing? – yes, can't sleep
- Have you had a cough like this before? – no
- Do you have any pain in your chest? – yes, here on the right side when I cough or take a deep breath (points to right thorax, 6-8<sup>th</sup> intercostal space at midaxillary line)
- How severe (1-10 scale) is the pain in your chest? – 7-8 when cough or deep breathe
- Have you had any contact with other sick people? – no
- Tell me about any current or past medical problems? – none besides mild asthma
- Any previous medical, surgical, or dental procedures? – none besides fillings in teeth - Have you ever been hospitalized? – no
- Do you have any of the following problems: fatigue, difficulty sleeping, unintentional weight loss or gain, fevers, night sweats? – “some of that stuff for sure”
- Do you have any problems with: headaches that don't go away with ASA or Tylenol, double or blurred vision,

difficulty with night vision, problems hearing, ear pain, sinus problems, chronic sore throats, difficulty swallowing?

- Do you experience: chest pain discomfort or pressure; pain/pressure/dizziness with exertion or getting angry; palpitations; decreased exercise tolerance; blue/cold fingers or toes?
- Do you have problems with: N/V, constipation, diarrhea, coffee grounds in your vomit, dark tarry stool, bright red blood in your BM, early satiety, bloating?
- When you urinate, have you noticed: pain, burning, blood, difficulty starting or stopping, dribbling, incontinence, urgency during day or night or any changes in frequency?
- Do you have problems with: muscle or joint pain, redness, swelling, muscle cramps, joint stiffness, joint swelling or redness, back pain, neck or shoulder pain, hip pain?
- Have you noticed: any bruising, bleeding gums, nose bleeds, or other sites of increased bleeding?
- Do you have any of the following: heat or cold intolerance, increased thirst, increased sweating, frequent urination, change in appetite?
- Do you have any of the following: dizziness, fainting, spinning room, seizures, weakness, numbness, tingling, tremor?
- Do you have any problems with nervousness, depression, lack of interest, sadness, memory loss, or mood changes, or even hear voices or see things that you know are not there?



- Do you drink alcohol? If so, what do you drink and how many drinks per day? – occasional beer or wine after studying - Do you use any recreational drugs? – no
- Do you now or have you ever smoked or chewed tobacco? – no, athletic - Are you sexually active? – no
- Do you have HIV?

### **Physical Exam:**

- Vitals: Temp, pulse, BP, orthostatic BP, respirations
- Skin, hair, nails: inspect skin overall – tenting of dorsal hand skin (dehydration)
- HEENT: inspect mouth/pharynx
- Neck: palpate neck
- Lymphatic: palpate all lymph nodes – tender cervical lymph nodes on neck
- Chest wall & lungs: auscultate lungs
- Heart: auscultate heart - Abdomen:
  - o Visual inspection o Palpate
- Extremities: visual inspection -           Genitourinary:           male exam -   Musculoskeletal:
  - o inspect for muscle bulk and tone o test strength -           Neurological:
  - o cranial nerves
  - o reflexes – deep tendon

### **Assessment note:**

- Ben Kapinsky is a 18 y/o college student who presents with a hx of the flu which resolved and then was followed by a 4-day history of sudden onset fevers, chills, SOB, fatigue, pleuritic chest pain, and a productive cough without wheezing. Physical exam is significant for a fever of 103.2 F (oral), tachypnea (24 breath/min), hypoxia, and R middle and lower lobe coarse crackles, and tender anterior cervical lymphadenopathy. He denies known sick contacts and has a childhood hx of asthma, now off therapy without recent attacks.

### **Diagnosis: Community acquired bacterial pneumonia**

#### **Plan:**

- Admit to the student health center inpatient service
- Oxygen PRN
- IV fluids
- IV antibiotics
- Respiratory therapy as needed if he develops an asthma exacerbation

### **Ramona Frankel (6 y/o female) – Red Right Eye**

- CC: came in with mother complaining of red right eye for past 3 days
- **MSAP: right eye redness**
- Right eye discharge
- Other children at school with similar symptoms
- Congestion

**History Questions:**

- How can I help you today? – mom
- Any other symptoms or concerns we should discuss? – mom
- Does she have any allergies? – mom
- Is she taking any prescription medications? – mom
- Is she taking any OTC or herbal meds? – mom
- What treatments has she had for her eye problem? – mom
- Are there any other people she has had contact with who have a similar eye problem? – mom
- Has she had any trauma to her eyes? – mom
- Does she have any pain in her eyes? – mom
- Has she noticed any blurred vision? – mom
- Does she have a runny nose/nasal congestion? – mom
- Does she have a cough? – mom
- Tell me about any current or past medical problems? – mom
- Any previous medical, surgical, or dental procedures? - mom
- Are her immunizations up to date? – mom

**Physical Exam:**

- Vitals: temp, pulse, BP, respiration
- HEENT:
  - o inspect eyes o test visual acuity o examine pupils o look in ears with otoscope o inspect

mouth/pharynx o

look up nostrils

- Chest wall & lungs: auscultate
- Heart: auscultate

**Assessment note:**

- Ramona is a 6 year old female with right eye redness and purulent drainage for the last 3 days. She was sent home from school today along with other children who had similar symptoms. She has also had some nasal congestion for the last few days. She has not had any fevers or trauma to the eye. Physical exam is significant for right conjunctival redness and purulent discharge. Mother is requesting a clearance to return to school. **Diagnosis: Bacterial conjunctivitis (pink eye)**

**Plan:**

- 7-10 days of antibiotic eye drops
- Instruct patient/parent about handwashing, and educate to not rub eyes to prevent spread of infection
- Children can return to school 24 hrs after starting treatment
- If symptoms worsen or if child has eye pain or blurry vision, return to clinic or ER

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## VERSION 2

**Patient:** Florence Blackman

**CC:** 66-year-old female presents with “intermittent squeezing chest pain”

**HPI:** 66-year-old female presents today with complaints of exertional mid- chest pain that has been occurring for the past 2 weeks. The patient describes the pain as a “squeezing feeling” that radiates to her left arm while she was cross country skiing in extreme cold weather. The patient states that the pain worsens in cold weather and is accompanied by dyspnea that is only alleviated with rest. The patient reports the chest pain to be moderate and reports a 6/10 on a pain scale when episodes occur. The patient reports a history of hypertension and hypercholesterolemia and reports a family history of heart disease. Upon physical examination, the patient is slightly overweight with a BMI of 25.5 but has a normal physical examination.

**Medications:** Hydrochlorothiazide (HCTZ) 12.5mg daily

1/14/21 dws

**Allergies: (medication, environmental, food)** The patient denies any medication, environmental or food allergies

**PMH:** Hypertension and hypercholesterolemia. Denies other chronic medical conditions.

**LNMP/OB History (if indicated):** The patient has no living children.

**PSH:** Denies any surgical or dental procedures.

**Sexual History (if indicated):** Deferred for this exam.

**Hospitalizations:** None.

**Health Maintenance:** Reports going to primary care provider every 4 months to monitor her cholesterol and blood pressure.



**Immunizations:** Immunizations are up to date. Completed all childhood vaccines.

**Family History:** Paternal history of stroke. Maternal history of heart disease. Her sister had open heart surgery at age 58.

**Social History:**

**Substances (Tobacco, alcohol, illicit drugs, caffeine):**The patient denies illicit drug use. The patient was a history smoking cigarettes (5 pack a year) and quit 15 years ago. Reports mild caffeine intake and reports drinking 1-2 glasses of wine a day. Denies history of alcohol abuse or excessive alcohol consumption.

**Home environment:** The patient lives alone in a loft and reports a safe home environment.

**Employment type:** Currently a marketing executive with her own firm. Reports work hours and “long and demanding.”

**Diet:** Eats fast food and goes out to eat at restaurants regularly.

**Sleep:** Sleeps adequately and denies chest pain or dyspnea during sleep.



**Exercise:** Active lifestyle. Performs aerobic exercises three times a week.

**Safety:** Reports feeling safe at home. Denies history of physical or verbal abuse.

**ROS:** (Perform an appropriate ROS based on the C/C and HPI; documented in i-Human assignment; performed in final focused exam)

**General:** Reports usual state of good health in addition to hypertension which is controlled with medication and exercise. Denies fever, chills, recent weight gain or loss, weakness, or fatigue. Eye contact is appropriate with clear speech. Reports the need to lose weight due to being slightly overweight, evidenced by a BMI of 25.5. Reports her weight has stated consistent.

**Skin, Hair and Nails:** Denies any recent lesions, rashes, changes in texture, or moles.

**HEENT:** Denies headaches, blurry vision, or vision changes. Denies ear problems or ear pain. Denies sinus problems or pain. Denies nasal congestion, cough, runny nose, sore throat, or sputum production. Denies difficulty swallowing, pain in the jaw or neck.



**NECK:** Denies pain or stiffness of the neck. Denies swollen glands/lumps in neck.

**Thorax and Lungs:** Reports dyspnea with chest pain that is alleviated with rest. Reports worsening dyspnea and chest pain with exertion. Denies history of lung disease, allergies, or asthma. Denies wheezing, trouble catching her breath. Denies orthopnea, or paroxysmal nocturnal dyspnea.

**Cardiovascular:** Reports a history of mild hypertension that is managed with medication (HCTZ 12.5mg daily) and hypercholesterolemia. Reports “squeezing” chest pain with dyspnea during exertion that is alleviated with rest. Reports the chest pain lasts a few minutes and has been occurring intermittently for the past two weeks, specifically during cross-country skiing. Reports pain is moderate and rates it a 6/10 on a pain scale. Reports chest pain is sometimes precipitated by exercise. The patient denies decreased exercise tolerance. Denies syncope, palpitations, dizziness, or pressure with or without exertion or with getting angry.

**Peripheral Vascular:** Denies upper and lower extremity edema, coldness, leg cramps, skin ulcers or varicose veins.

**Abdomen:** Denies nausea, vomiting, constipation, diarrhea, coffee grounds in vomit, dark tarry stools, bright red blood in bowel movements, bloating or early satiety.



**Genitourinary:** This exam was deferred.

**Metabolic/Hematologic:** Denies thyroid disease, heat/cold intolerance, excessive hunger, thirst, or history of diabetes. Denies history of anemia.

**Psychiatric:** Denies history of nervousness, depression, lack of interest, sadness, memory loss, mood changes, or hearing voices that are not there. Denies difficulty falling or staying asleep. Denies ideas or self-harm or suicidal ideation.

**Musculoskeletal:** Reports chest pain that radiates to left arm during exertion. Reports full range of motion in upper and lower extremities. Denies pain in other extremities. Denies any weakness or muscle wasting of the upper or lower extremities. Denies difficulty walking or performing ADLs without assistance.

**Neurologic:** Denies history of stroke, syncope, seizures, or frequent/incapacitating headaches. Denies tremors, decreased alertness, or loss of sensation.

**Vital Signs:**

**Temperature:** 98.5 F, **Pulse:** 74, **BP:** 132/90,  
**Respirations:** 18 **SpO2:** 96%



## **Physical Exam:**

**General:** Slightly overweight middle-aged female, appears stated age, alert, and oriented x 4. No grimacing, respiratory or emotional distress noted.

**Skin, Hair and Nails:** Skin is warm and dry with no lesions noted.

Thickness and distribution pattern is typical for the patients' gender and age. Capillary refill is less than 3 seconds in fingers and toes.

**HEENT:** The head is normocephalic and atraumatic. The scalp is nontender and has no visible scaliness, edema, masses, lumps, deformities, scars, rashes, nevi, or other lesions. There is no eyelid ptosis, erythema or swelling noted. Conjunctiva is pink with no discharge. Sclerae is anicteric. There is no edema, redness or tenderness noted on the orbital area. Both pupils are brisk and reactive to light. Normal appearing external ears. No deformities, or edema noted. No discharge noted. Normal appearing external auditory canals. Tympanic membrane translucent, non-injected, and pinkish gray in color. No scarring or discharge noted. Oropharynx not injected. Clear mucosa. Tonsils without exudate. Tongue pink in color and symmetrical. No swelling or ulcerations. Intact Gag reflex. No hoarseness noted. No unusual or foul swelling odor of the breath.



**NECK:** No lesions, or edema noted. No stiffness or pain noted. Full range of motion of the neck noted. Thyroid moves with swallowing. No pathologically enlarged lymph nodes noted in the cervical, supraclavicular, or axillary chains.

**Thorax and Lungs:** Anterior and posterior chest: Thorax is atraumatic, without deformity. Normal symmetrical respiratory effort with excursion. No costochondral point tenderness noted. No evident rib fractures. No vertebral tenderness. The anterior lung fields are resonant. The rest of the lung fields are resonant. All lungs fields are clear to auscultation. No wheezing, crackles or stridor noted. Symmetrical expansion and unlabored breathing are also noted.

**Cardiovascular:** Chest is symmetric, with no scars noted. No cardiac heaves or lifts. No edema noted. PMI is nondisplaced and noted at the midclavicular line, in fifth intercostal space. Normal Jugular venous pressure. Normal heart rate and rhythm, normal S1 and S2 without murmur, click, gallop, or rub. No splitting of the heart sounds heard.

**Peripheral Vascular:** Extremities are warm and dry. Carotid pulses 2+ bilaterally. Radial pulses 2+ bilaterally. No peripheral edema, varicosities, or ulcerations noted.



**Abdomen:** Abdomen is soft to palpation. Nontender to upper quadrant and epigastric palpation. The patient's symptoms cannot be produced with applied epigastric pressure. Bowel sounds normoactive in all 4 quadrants. No masses or bruits noted. Rectal examination was deferred.

**Genitourinary:** Deferred for this exam.

**Psychiatric:** Affect and speech is clear and appropriate. Calm emotional state. Concentration, activity level and attention are appropriate. No increased activity or agitation noted during examination.

**Musculoskeletal:** No asymmetry or deformity of the back noted. No tenderness or spasm noted of the paraspinal muscles. Steady gait with a normal posture noted. Test strength is 5/5 bilaterally. Full range of motion of the upper and lower extremities. No pain noted during ROM.

**Neurologic:** Alert, oriented to person, place, time, and situation. Pupils equal to light and accommodation. Facial movements are symmetrical. Head turning and shoulder shrug are intact to resistance. Tongue is midline with normal movements and no atrophy. Speech is fluent and clear. Deep tendon reflexes of the triceps, biceps, brachioradialis, and patella have a brisk response (2+).



**Differential Diagnoses:** (3-5 with brief rationale for I-Human assignment; 3 with brief rational for final focused exam)

**Myocardial infarction:** The patient reports with intermittent chest pain with exertion and dyspnea that radiates to the left arm for the past two weeks. The patient reports that when the chest pain occurs, the pain is moderate and reports a 6/10 on a pain scale. The recurrent chest pain may imply it is not an MI, since most MI's present with constant chest pain but the possibility of an MI may still need to be ruled out.

**Stable Angina:** The patient reports with intermittent chest pain with exertion and dyspnea that radiates to the left arm for the past two weeks. The patient reports the chest pain lasts a few minutes and is alleviated with rest. Chest pain with exertion is a common finding with stable angina, especially when episodes last a few minutes.

**Unstable Angina:** The patient reports with intermittent chest pain with exertion and dyspnea that radiates to the left arm for the past two weeks. The patient reports the chest pain lasts a few minutes and is alleviated with rest. Unstable angina occurs without exertion, and during sleeping or resting. Since the patient reports alleviation with rest, it may not be unstable angina, but still needs to be ruled out.



**Anxiety attack:** The patient reports with intermittent chest pain with exertion and dyspnea that radiates to the left arm for the past two weeks. The patient reports the chest pain lasts a few minutes and is alleviated with rest. The patient states she has a high-stress career and enjoys cross country skiing to alleviate the stress of her job. However, anxiety attacks can occur during exertion, along with dyspnea and chest pain. It is unlikely that the patient has anxiety attacks that causes intermittent chest pain and dyspnea, but it may also be ruled out.

**Most Likely Diagnosis: Stable Angina** evidenced by intermittent chest pain with exertion and dyspnea that radiates to the left arm that lasts a few minutes and is alleviated with rest. ECG was normal sinus rhythm. Troponin levels were within normal limits. Chest Xray was normal. The patient was also diagnosed with **Coronary artery disease**. Cholesterol was high, at 245mg/dl. LDL was moderately elevated at 140mg/dl and Triglycerides were also elevated at 175 mg/dl.

**Health Promotion:** (appropriate screening, disease prevention, and health promotion according to the patient's age, gender, and identified risk factors...not diagnosis specific)



- ✓ **Wellness Check-** Continue to get lipid panel screening every 4 months to maintain and lower Cholesterol, Triglycerides, and LDL.
- ✓ Lose weight to lower cholesterol and blood pressure.
  
- ✓ Refrain or reduce intake of salty, fast foods, or restaurant meals. Try to cook or prepare healthy meals to lose weight and reduce sodium intake.

### **Screening**

- ✓ Diabetes screening (women with HTN, CAD, overweight and the over age of 45 have increased risk for DM)
- ✓ Cancer screening- Cervical cancer screening (Pap smears every 3 years) Breast cancer (yearly mammogram)

### **Immunizations**

- ✓ Seasonal Flu vaccine
- ✓ Covid-19 vaccine



## References

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**FLORENCE BLACKMAN**  
**IHUMAN Case Study**  
**66-Year-Old Female -**  
**Chest Pain 2 Different**  
**Versions Of the Answer**  
**Expert Reviewed 2024.**

