



CASE REPORT

Application of osteopathic manipulative treatment to a patient with unremitting chest pain and shortness of breath undergoing “Rule-Out Myocardial Infarction” protocol for one week

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Utilization of resources

Abstract Chest pain and shortness of breath are both common complaints of patients presenting to an emergency room (ER) or urgent care facility. A 67-year-old married white female was seen in the ER complaining of chest pain and shortness of breath. Our education and training has us admit these patients where they may be monitored and assessed according to protocols developed to rule-out serious etiologies. Accordingly, the patient was admitted to the cardiac care unit and placed on the “Rule-Out Myocardial Infarction” protocol. The patient’s symptoms persisted despite adherence to rigorous diagnostic and therapeutic regimens and which stymied attempts to arrive at a definitive diagnosis and provide care. The case presented here demonstrates how an osteopathic approach can enable us to provide appropriate care and resolve some problems that appear to be otherwise unremitting. There is potential for savings in terms of actual costs and utilization of resources. The use of an osteopathic structural exam identified an abnormality that could be easily treated with Osteopathic Manipulative Treatment (OMT), which

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completely resolved the patient's presenting complaints. Had this been done earlier in the course of managing this patient, preferably as part of the admission work-up, the patient's confinement would have been drastically reduced, and repeated expensive tests would not have had to have been performed. The application of OMT to reducing patient morbidity is instructive of the efficacy of the osteopathic approach in this case and suggests that further research is warranted. © 2011 Elsevier Ltd. All rights reserved.

Introduction

Chest pain and shortness of breath are both common complaints accounting for 20-40 percent of hospital admissions of patients presenting to an emergency room (ER) or urgent care facility.¹ They are often harbingers of serious or life-threatening medical problems (e.g., myocardial ischemia or infarction, pulmonary embolism, etc.), but they may also be caused by minor disorders (e.g., musculoskeletal overexertion, etc.). Distinguishing the serious from the trivial challenges our diagnostic ability and ability to optimally utilize limited resources. Our education and training has us admit these patients where they may be monitored and assessed according to protocols developed to rule-out serious etiologies. There will be cases where the symptoms persist despite adherence to rigorous diagnostic and therapeutic regimens and which stymie our attempts to provide appropriate care. The case presented here is instructive to demonstrate how an osteopathic approach can enable us to provide appropriate care and resolve some problems that appear to be otherwise unremitting. There is potential for savings in terms of actual costs and utilization of resources.

This case involves a patient seen at a major military hospital in the Washington, DC area. The author first became acquainted with this patient when she was presented to our team when preparing to take over weekend day and overnight on-call responsibilities. At this time the patient had been in the hospital for one week, having been admitted to the cardiac care unit (CCU) from the ER and was still undergoing the "rule-out MI (myocardial infarction)" protocol (ROMI) in the "step-down" unit. We were told that the patient was still complaining of chest pain and shortness of breath, although the etiology did not seem to be cardiac or pulmonary.

History and physical

The author reviewed the patient's chart and then asked if he could perform his own exam. The

patient was a 67-year-old married white female who presented to the hospital ER complaining of chest pain and shortness of breath. She described the pain as being sharp, of sudden onset approximately two hours earlier; the pain was now a chronic "mostly dull" pain, intermittently sharp, varying in intensity from 6/10 to 9/10, and located primarily at the mid-left sternal border and radiating to the back, shoulders, and neck, worsening upon inspiration. The chart revealed that the patient had no history of cardiac, pulmonary, or gastrointestinal disorders. There was no evidence of musculoskeletal trauma or exertion. No family history of cardiac or pulmonary disorders was reported. The physical exam was reported as remarkable only for mild tachycardia, tachypnea with short shallow breathing, slight pallor, and blood pressure of 148/84 mmHg. Electrocardiogram revealed sinus tachycardia, without evidence of any ST-segment or T-wave abnormalities. Laboratory chemistries, including arterial blood gases and Creatine Kinase-Myocardial Band (CK-MB) and Lactate Dehydrogenase (LDH) serum enzymes, were all normal. Chest x-rays were clear and unremarkable; no signs of cardiac or vascular enlargement were seen. Cardiac monitoring was continuous and remained unchanged; on the third day post-admission, the patient was transferred from the CCU to the step-down unit. Laboratory chemistries remained normal. Consultation-Liaison Psychiatry had ruled-out anxiety and psychosomatic disorders as possible etiologies.

At the time of the author's exam on the seventh post-admission day, the author found the patient to be a pleasant, well-groomed, heavysset (but not morbidly obese), married white female, dressed in hospital pajamas, not in acute distress, but still complaining of chest pain and shortness of breath. The patient stated that the pain was still a chronic, mostly dull, pain, varying in intensity from about 4-5/10 to 8/10 "when it became sharp". The patient pointed to the mid-left sternal border as the origin of the pain and described the pain as radiating to the back and shoulders. Patient stated she had been in generally good health except for a recent "cold" which had abated approximately one week prior to

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