

## COPD Case Study (answer key)

D.Z. a 68-year-old man, is admitted at 3600 to the medical floor, with a diagnosis of acute exacerbation of chronic obstructive pulmonary disease (COPD). His other medical history includes hypertension and type 2 diabetes. He has had pneumonia yearly for the past 3 years and has been a two-pack-a-day smoker for 38 years. His current medications, include amlodipine, hydrochlorothiazide, metformin and fluticasone/salmeterol. He appears a cachectic man who is having difficulty breathing at rest. D.Z. seems irritable and anxious; he complains of sleeping poorly and states that lately he feels tired most of the time. He reports cough productive of copious amounts of tenacious, yellow-green sputum. You auscultate decreased breath sounds, expiratory wheezes and coarse crackles in both lower lobes anteriorly and posteriorly. His vital signs are 162/ 84 mmHg, 124 beats/minute, 36 breaths/minute, 102°F (38.9°C) and SpO<sub>2</sub> 88%.

1) Briefly describe chronic obstructive pulmonary disease (COPD). What pathophysiology is occurring in the lungs of a patient with COPD?

COPD is a preventable and treatable disease, but it is not reversible once lung function has declined. Due to cigarette smoking or long-term inhalation of noxious gases, the lungs become abnormally inflamed and airways become distended. COPD is a combination of emphysema, persistent enlargement of alveoli & alveolar wall destruction, and chronic bronchitis, a productive cough present for long periods of time. What ultimately happens is a loss of elastic recoil in the lungs and an inability to exhale CO<sub>2</sub>. Patients with COPD also have increased mucus production.

2) What assessments (from above scenario) are indicative of D.Z.'s COPD exacerbation?

Irritable and anxious- early sign of possible hypoxia  
Fatigue  
Productive cough w/ copious (large) amounts of tenacious (sticky & thick) yellow-green sputum  
Lung sounds- decreased breath sounds, expiratory wheezes and coarse crackles in both lower lobes anteriorly and posteriorly  
SpO<sub>2</sub> (oximetry) of 88%  
Respiratory rate 36 breaths/minute

3) What other assessments and signs and symptoms would you look for that indicate respiratory distress?

Assess for retractions and accessory muscle use  
Assess speech pattern-speaking in phrases  
Assess level of fatigue  
Assess for use of pursed lip breathing  
Assess effectiveness of cough  
Assess for any cyanosis

4) What other signs and symptoms are common for a patient with COPD?

Intermittent cough in morning with expectoration of sticky mucus  
Progressive dyspnea  
Activity intolerance (related to dyspnea)  
Barrel chest  
Wheezing, chest tightness  
Weight loss, anorexia (cachectic)  
Fatigue  
Prolonged expiration/Pursed Lip breathing  
Hypercapnia  
Clubbing of fingers

The Health Care Provider enters the following admission orders:

Admission Orders
Diet as Tolerated
Out of Bed with one-person assistance
Supplemental Oxygen via venturi mask at 20% concentration with humidification
Intravenous Infusion Device (IV) (one) xox flush q shift
Continuous ECG monitoring
Arterial Blood Gas (ABG) in the am
CBC with differential and Basic Metabolic panel now
Chest radiograph STAT and q AM
Sputum culture obtain ASAP
Albuterol 2.5 mg plus ipratropium 250mcg nebulizer treatment STAT

## 2013 Cpt Case Study Answer Key

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*Good Informatics Practices (GIP) Module: Training and Training Practices* Heidi Bargerhuff, Brenda Beckett, Cindy Breed, Ursula Centers, Stacy Craft, Jane Derman, Cathy Francis, Bryanna Gallaway, Karen Gividen RN, Robert Gividen, Summer Harriff PhD, Jennifer R. Hawkins MS, Gina Ketcherside PHR CPT M. Ed, Maureen Martin, Susan Meineke, Brenda Money LPN CSS CBAP, Bryan Ricke, Juanita Schoen, Margaret Schulte, Linda Speake, Dianna Woodall, **Resources in Education**, 1983

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