Emily Lancia H&P 1 Due 9/26/23

**History**

Identifying Data:

Full Name: VM
Address: Jamaica, NY
Date of Birth: April 19th, 1979 (44YOM)
Date & Time of Encounter: September 19th, 2023, 10:20am
Location: NYPQ IM, Flushing, NY
Religion: Catholic
Source of Information: Self
Source of Referral: None, admitted to ED from home
Reliability: Reliable

Chief Complaint: L knee pain x 2 weeks

History of Present Illness:

44YOM with PMH of DM2 (since 2017) presents with L knee pain for 2 weeks. Pt reports blunt force trauma from a metal baton striking the posterior and lateral aspects of knees B/L on 9/4/23. Pt's L knee became progressively painful and swollen in the days following the trauma, and he developed fever and fatigue on 9/6. Symptoms continued to worsen despite rest and acetaminophen 800mg q6h at home. When symptoms persisted for 4 days, Pt presented to NYPQ ED on 9/10/23 for evaluation.

Upon arrival to ED, Pt presented febrile and diaphoretic and described constant, non-radiating, throbbing pain 8/10 in severity in L knee and 5/10 in severity in R ankle. Pt denies recent head or abdominal trauma. He notes recent travel to Puerto Rico with prolonged outdoor exposure from 9/5-9/9/23. Denies known or insect bites, including ticks. Denies recent exposure to animals. Denies recent open wounds or rash. Denies IVDU. Denies recent sick contacts. Denies recent illness. Denies GU symptoms. Pt notes that his DM2 has been uncontrolled in recent months, denying adherence to lifestyle modifications or pharmacological therapy recommended by his PCP. After orthopedic imaging and workup, Pt suspected to have L knee septic arthritis and underwent arthrocentesis with synovial fluid analysis that confirmed growth of group B beta hemolytic strep. Pt was admitted to orthopedic service and treatment with ceftriaxone as well as pain control with acetaminophen was initiated. Pt also underwent R ankle pain arthrocentesis with fluid analysis, but was negative for infection.

One day after admission, Pt underwent L knee surgical irrigation and washout on 9/11/23. Pt's POD1 labs were found to be consistent with DKA, and he was transferred to ICU for management. DKA resolved with IV fluids and insulin drip without complication. On POD2,

Pt transferred to the internal medicine unit on subq insulin and has remained normoglycemic without evidence of acidosis since. PPx anticoagulation therapy with Enoxaparin was initiated and abx/pain control regimen for septic joint continued. However, Pt remained febrile and complained that L knee pain/swelling did not improve and R ankle pain/swelling worsened to 8/10 severity. After ortho eval, he underwent repeat irrigation and drainage of L knee as well as I&D of R ankle on 9/14/23. Pt states that by POD2, pain of irrigated areas improved to 6/10 severity, managed with acetaminophen. Pt began bedside PT and was encouraged to ambulate and did so successfully, although he reported some transient dizziness moving from supine to standing.

On POD3, Pt complained that L knee pain worsened again to a 10/10 in severity. Ortho consulted and opioid pain management was initiated. Pt's fever broke yesterday (POD4) for the first time since initial presentation to ED, and he has remained afebrile since. Today (POD5), Pt reports constant, dull L knee pain 9/10 severity with an intermittent sharp pain localized to L anterior patellar surface. Pt says the intermittent pain is unprovoked, 10/10 severity, wakes him from sleep, and radiates distally to L ankle. He reports constant, dull, non-radiating, 6/10 pain in R ankle. He believes the swelling in both his L knee and R ankle has improved, although he has not visualized the areas since the procedure due to wound dressings. He reports normal ROM in L knee and R ankle although he has been unable to ambulate since 9/17/23 due to pain.

Today (POD5), he denies diaphoresis or chills. He reports some anxiety surrounding his recovery, but denies depressive mood or any changes in cognition. He denies nausea, vomiting, diarrhea, or constipation and reports normal daily bowel movements. He denies dysuria, urinary frequency, or urinary urgency. Denies dyspnea, palpitations, or chest pain. Denies calf pain or swelling. He reports intermittent paresthesias in LLE that he attributes to diabetic neuropathy. He has continued PT and states he has been performing recommended full ROM movements while in bed. He is hopeful to get up and ambulate again later today.

Past Medical History:
Present chronic illnesses – DM Type 2 x 6 years, uncontrolled prior to hospital admission
Past medical illnesses – Denies past illnesses
Childhood illnesses – Denies childhood illnesses
Immunizations – Up to date, excluding COVID-19 and influenza vaccines this year
Screening tests and results – Pt has never undergone colonoscopy.

Past Surgical History:
L knee I&D, age 44, NYPQ Orthopedics, Flushing, NY. D/t septic effusion, required f/u procedure.
L knee I&D, age 44, NYPQ Orthopedics, Flushing, NY. D/t septic effusion, no complications.
R ankle I&D, Age 44, NYPQ Orthopedics, Flushing, NY. D/t serous effusion, no complications.
Denies past injuries or transfusions.

Medications:
*Prior to admission:* None

*Scheduled Meds:*
CefTRIAXone, 2 g, Intravenous, Q24 Hrs SCH
Enoxaparin, 40 mg, Subcutaneous, Daily
Insulin glargine, 24 Units, Subcutaneous, Nightly
Insulin Lispro, 2-1 Subcutaneous, 3X Day
Insulin Lispro, 8 Units, Subcutaneous, TID WC
Polyethylene glycol 17 gram, 1 Packet, Oral, Daily
Senna, 17.2 mg, Oral, Nightly

*PRN Meds:*
Acetaminophen, 650 mg, Q6 Hrs PRN
Dextrose, 15 g, Q15 Mins PRN
Dextrose, 25 g, Q15 Mins PRN
Glucagon, 1 mg, Q15 Mins PRN, morphine, 4 mg, Q12 Hrs PRN/u-lh5
Oxycodone-acetaminophen, 1 tablet, Q6 Hrs PRN Vitals:

Vitamins and Supplement – Denies

Allergies:
NKDA
Denies environmental or food allergies.

Family History:
Maternal/paternal grandparents – Deceased at unknown age from natural causes
Father – 69, alive with well-controlled DM Type 2
Mother – 67, alive and well
Brother – 41, alive with well-controlled HTN
Daughter – 24, alive and well
Daughter – 12, alive and well
Denies family history of cancer.

Social History:
MV has never been married. He currently lives in a multi-generational household with his father, mother, brother, and 12yo daughter.

Prior to hospital admission, he was working full-time as a 311 operator.
He reports drinking alcohol approximately once a month, typically 4-5 beers in one evening.
He reports smoking marijuana daily. He denies smoking cigarettes/cigars or using illicit drugs.
He denies drinking caffeine.
He traveled to Puerto Rico last week, from 9/5/23 to 9/9/23.
He reports a diet rich in meats and vegetables, but notes that he often eats fast food. He says that he has followed a strict diet and exercise regimen in recent years that successfully controlled his DM, but he has stopped adhering to it in the past year.
He currently reports a mostly sedentary lifestyle, noting that he goes on occasional walks with his daughter.
He reports getting 7-8 hours of sleep each night. He believes his sleep to be high quality.
He is currently sexually active with one female partner. Denies history of sexually transmitted diseases. Reports last STD testing was 2 years ago.

Review of Systems:
General – Reports 2 weeks of fever, chills, and fatigue that resolved yesterday. Denies recent weight loss or gain.

Skin, hair, nails – Denies vascular changes, discolorations, or new moles/rashes.

Head – Reports dizziness whenever moving from supine to standing position. Denies headaches, syncope, or head trauma.

Eyes – Denies changes in vision, discharge, or erythema. Visual acuity 20/25 OU uncorrected.

Ears – Denies changes in hearing, pain, or discharge.

Nose/sinuses – Denies nasal congestion, sinus congestion or sinus tenderness.

Mouth/throat – Denies sore throat, difficulty swallowing, or voice changes. Last dental exam 2021.

Neck – Denies swelling, tenderness, or stiffness.

Pulmonary system – Denies cough, wheezing, or dyspnea.

Cardiovascular system – Denies palpitations, chest pain, or edema.

Gastrointestinal system – Denies change in appetite, nausea, vomiting, diarrhea, abdominal pain, or blood in stool.

Genitourinary system – Denies urinary frequency or urgency, dysuria, or flank pain.

Nervous – Reports intermittent paresthesias in left foot. Denies weakness, ataxia, or loss of strength.

Musculoskeletal system – Reports L knee and R ankle pain, swelling, and redness. Denies decreased range of motion.

Peripheral vascular system – Denies varicose veins, peripheral edema, or cold extremities.

Hematological system – Denies easy bruising or bleeding, h/o blood transfusions, or h/o DVT/PE.

Endocrine system – Denies heat or cold intolerance, excessive sweating, or excessive thirst.

Psychiatric – Reports some anxiety surrounding his future recovery. Denies depressive mood. Denies h/o psychological or psychiatric care.

**Physical**

Vital Signs:

Wt: 225 lbs
Ht: 5'7"
BMI: 35.2
Temp: 36.8°C, oral
Pulse: 90bpm, regular rate and rhythm
Resp: 18rpm, unlabored
Sp02: 98 % on room air
BP:

| | Right Arm | Left Arm |
|---|---|---|
| Seated | 108/72 | 128/82 |
| Standing | 102/74 | 102/70 |

General:
Well-nourished, neatly groomed Hispanic male. He appears fatigued and slightly uncomfortable, lying supine with his eyes closed. He has intermittent episodes of more severe discomfort evident by facial grimace, but he is attentive and conversational.

Skin:
Warm & moist, good turgor. Nonicteric, no lesions noted, no scars. Visible tattoos of various names and dates in black ink on forearms B/L.

Hair:
Average quantity and distribution.

Nails:
No clubbing, no discolorations, capillary refill <2 seconds in upper and lower extremities.

Head:
Normocephalic, atraumatic, non tender to palpation throughout.

Eyes:
Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity uncorrected - 20/25 OS, 20/20 OD, 20/20 OU.
Visual fields full OU. PERRLA, EOMs intact with no nystagmus or lid lag.
Fundoscopy - Red reflex intact OU. Cup to disk ratio< 0.5 OU. No AV nicking, hemorrhages, or exudates OU.

Ears:
Symmetric and appropriate in size. No lesions, masses, or evidence of trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TMs are pearly white and intact with light reflex in a good position AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne reveals AC>BC AU.

Nose:
Symmetrical with no masses, lesions, deformities, or trauma. Nares patent bilaterally. Nasal mucosa is well hydrated. Septum midline without lesions, deformities, or perforation. No foreign bodies.

Sinuses:

Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Lips:
Pink, moist, no cyanosis or lesions.

Oral Mucosa:
Pink, well hydrated. No masses or lesions noted. No leukoplakia.

Palate
Pink, well hydrated, and intact with no lesions or masses.

Teeth
Good dentition with no obvious dental caries noted.

Gingivae
Pink, moist. No hyperplasia or masses.

Tongue
Pink, moist. No masses, lesions or deviation.

Oropharynx
Well hydrated, with no exudates, masses, erythema, or lesions. Tonsils are present with no erythema or exudates. Uvula midline, with no lesions.

Neck:
Trachea midline. No masses, lesions, scars, or visible pulsations noted. Supple and nontender to palpation. No palpable cervical adenopathy.

Thyroid:
Non-tender, no thyromegaly. No palpable nodules noted.

Chest:
Symmetrical, no deformities, no trauma. Respirations unlabored with no paradoxical respirations or use of accessory muscles noted. Non-tender to palpation throughout.

Lungs:
Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.

Heart:

JVP is 3 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdomen:

Abdomen flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated.

GU:

Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes Descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias noted.

Anus, Rectum, and Prostate:

No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate smooth and non-tender with palpable median sulcus. Stool brown.

**Differential Diagnoses:** (*Since Pt already has definitive diagnosis, I am writing these DDx as if it were prior to the results of initial arthrocentesis analysis that grew GBS)*

1. Septic Arthritis
    a. Pt w/ uncontrolled DM2 presents with systemic signs of bacterial infection and acute arthritis. Synovial fluid analysis would show leukocytosis and/or presence of bacteria.
2. Acute Traumatic Arthritis
    a. Pt presents with acute arthritis after recent trauma to the area. Synovial fluid analysis would show presence of RBCs and may appear grossly bloody.
3. Crystal-Induced Arthritis
    a. Pt w/ uncontrolled DM2 presents with fever and acute arthritis. Synovial fluid analysis would show the presence of crystals.
4. Lyme Arthritis
    a. Pt presents with fever and acute arthritis in an endemic Lyme area. Serologic testing would show serum IgG for B. burgdorferi.
5. Reactive Arthritis

a. Pt w/ uncontrolled DM2 who is sexually active presents with acute arthritis. Synovial fluid findings would be non-specific but lab findings and clinical presentation may be consistent with underlying causative infection.

**Assessment:**

44YOM with L knee septic arthritis secondary to GBS is showing improving signs of infection but worsening pain after I&D (POD5) and abx treatment. He requires continued close surveillance with frequent reevaluations for possible complications related to DM2 and PE risk factors.

**Plan**

Problem List:

1. Septic Arthritis of L knee secondary to GBS
    a. Continue antimicrobial treatment with ceftriaxone for 3-4 weeks. Monitor for localized and systemic signs of infection with frequent evaluation and bloodwork. Continue dressing changes and physical therapy. Arrange discharge to SNF to complete abx treatment.
2. Risk of postoperative thrombotic event
    a. Continue ppx anticoagulation and scheduled physical therapy. Continue to encourage ambulation, Pt has no mobility restrictions. Consider pneumatic stockings if tolerated.
3. Previously uncontrolled DM2
    a. Continue scheduled insulin regimen and carb-control diet while monitoring BGL. Monitor labwork for signs of DKA. Refer Pt to endocrinology upon d/c to determine long-term plan to control BGL and lower Ha1C.
4. Pain management
    a. Continue scheduled and PRN pain control regimen. Adjust regimen PRN according to Pt's pain levels.
5. R ankle joint effusion
    a. Continue dressing changes and physical therapy. Monitor for signs of infection or other complications.

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**History and Physical Verification Form**

**Class:** Physical Diagnosis II (HPPA 522)

Student Expectation:

- Obtain medical history and perform physical exam up to the point covered in class.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

**Student:** Emily Lancia

**Clinical Site:** NYPQ IM

**Date of Visit:** 9/19/23

**Activity performed:** H&P

**Supervisor:**

**Name and Credentials:** Erin Faller PA-C

**Supervisor Signature:** Erin Faller

**Supervisor Comments:** Detailed yet concise + thorough presentation :)