Emily Lancia H&P 2 Due 10/30/23

History

Identifying Data:

Full Name: BM
Address: Forest Hills, NY
Date of Birth: February 7th, 1979 (44YOF)
Date & Time of Encounter: October 24th, 2023, 11am
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 elbow pain x 1 week

History of Present Illness:

44YOF w/ no PMH presents with L elbow pain x 1 week. Pt first noticed erythematous, warm, tender, and swollen mass lateral to her L elbow, causing reduced ROM and pain of the joint, on 10/17/23. Symptoms worsened to cause constant, sharp L elbow pain 10/10 in severity and radiating distally. Pain was significantly aggravated by flexion and extension, resulting in markedly reduced ROM of L elbow. She presented to NYPQ ED for evaluation on 10/18/23 and was noted to have a swollen, firm but fluctuant area ~5cm in diameter with the center measured ~2cm lateral to her L elbow. Surrounding erythema measured an additional ~3cm in diameter. Pain and swelling markedly inhibited both flexion and extension of the joint. She reported chills and sweats, but denied known fever and presented afebrile. Denied h/o recent illness, h/o recent injury or trauma, h/o recent skin wounds. Denied h/o similar symptoms. Denied paresthesias, anesthesia, or reduced strength of LUE.

Pt underwent I+D of soft tissue abscess on lateral aspect of L elbow without complication and was admitted to IM for empiric abx therapy with vancomycin on 10/18/23. She reported marked improvement of L elbow pain and ROM after I+D and has undergone wound checks with redressing/repacking QD with consistently improving signs of infection. Pain has been controlled with APAP PRN. Pt states she has received morphine PRN for breakthrough pain 2x since her admission, but that it has been d/c after causing her headaches. She denies chills, sweats, fatigue, or fever since admission.

Fluid culture grew staph and abx were narrowed to cefazolin on 10/22/23. Today, Pt reports constant, dull, 4/10 pain in the area of infection. She reports full ROM of L elbow, but says that flexion results in sharp pain 5/10 in severity with accompanying paresthesias from

elbow to distal fingertips. Pt has photographed the area of infection every day since admission, and signs of infection consistently continue to improve. Today, surrounding erythema measures ~3cm from the central I+D puncture wound, which is healing without signs of complication. Denies new rashes or vascular changes. Denies loss of LUE strength or sensation. Denies N/V/D or anorexia. She reports a mild, dry cough beginning 3 days ago, denies nasal/sinus congestion, SOB, sore throat, or ear pain. She has no other complaints at this time and says she hopes to be d/c on PO abx in the next 48 hours.

Past Medical History:
Present chronic illnesses – Denies chronic illnesses
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 – Last pap smear 2023 without abnormal findings.
Last mammography 2022 without abnormal findings. Pt has never undergone colonoscopy.

Past Surgical History:
Denies past surgical history.
Denies past injuries or transfusions.

Medications:
Prior to admission: None

Scheduled Meds:
Cefazolin IV 2g q8h
Pantoprazole 40mg PO QD

PRN Meds:
Acetaminophen 600mg q4-6h

Vitamins and Supplement – Generic women's multivitamin daily

Allergies:
Penicillins – Reaction: Delayed onset rash on chest and upper extremities.
Dairy – Reaction: Delayed onset rash on chest and upper extremities.
Denies environmental allergies.

Family History:

Maternal/paternal grandparents – Deceased at unknown age from natural causes
Father – 68, alive and well
Mother – 66, alive and well
Sister – 41, alive with well
Daughter – 8, alive and well
Daughter – 5, alive and well
Denies family history of HTN, cancer, or DM2.

Social History:
BM has been married to her husband for 17 years. They live together with their two children.
She works full-time as an assistant principal at a secondary school.
She reports infrequent alcohol intake, 3-4 drinks/month.
She denies smoking cigarettes/cigars, or using illicit drugs.
She has 4-5 cups of coffee daily.
She denies recent travel.
She reports a diet rich in mostly white meats and vegetables. She says she does not follow any one specific diet, but tries to remain cognizant of the nutritional content of the food she eats.
She reports an active lifestyle, weight-lifting 4-5 days a week and running 2-3 days a week.
She reports getting 7-8 hours of sleep each night. She notes the quality of her sleep has worsened since hospital admission.
She is currently sexually active with only her husband. Denies history of sexually transmitted diseases. Reports last STD testing was 5 years ago.

Review of Systems:
General – Reports chills and sweats last week that have since resolved. Denies fever, fatigue, or recent weight change.

Skin, hair, nails – Reports warm, swollen, tender, erythematous, mass with center ~2cm from L elbow that has been improving since initiation of antibiotic treatment. Denies vascular changes or skin abnormalities on other body areas.

Head – Reports headache that began and resolved yesterday that she attributes to morphine tx. Denies dizziness, 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 2023.

Neck – Denies swelling, tenderness, or stiffness.

Pulmonary system – Reports mild dry cough beginning 3 days ago. Denies wheezing, pleuritic pain, 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.

Menstrual/Obstetrical – G2P2. LMP about 2 weeks ago, exact date unknown. Reports regular menstrual cycle. Reports ob/gyn assessment annually.

Nervous – Reports intermittent paresthesias distal to left elbow. Denies weakness, ataxia, or loss of strength. Denies abnormalities of other extremities.

Musculoskeletal system – Reports L elbow pain and tenderness with painful flexion. Denies decreased range of motion or pain with extension. Denies abnormalities of other extremities.

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 – Denies anxious or depressive mood, denies h/o psychological or psychiatric care.

Physical

Vital Signs:

Wt: 185

Ht: 5’10”
BMI: 26.5
Temp: 36.9°C, oral
Pulse: 67 bpm, regular rate and rhythm
Resp: 17 rpm, unlabored
Sp02: 98 % on room air
BP:

	Right Arm	Left Arm
Seated	121/80	110/74
Standing	106/74	108/70

General:
Well-nourished, neatly groomed white female. She appears dressed appropriately for the weather and for her stated age. She maintains eye contact and answers all questions appropriately.

Skin:
Puncture wound with surrounding ~3cm circle of erythema and tenderness noted on L lateral elbow. Warm & moist, good turgor. Nonicteric, no lesions noted, no scars. No visible tattoos or markings.

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 - 20/30 OS, 20/20 OD, 20/25 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. No hepatosplenomegaly to palpation, no CVA tenderness appreciated.

Breasts:
Symmetric, no dimpling, no masses to palpation, nipples symmetric without discharge or lesions. No axillary nodes palpable.

Genitalia:
External genitalia without erythema or lesions. Vaginal mucosa pink without inflammation, erythema or discharge. Cervix parous (or multiparous), pink, and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. Pap smear obtained. No inguinal adenopathy.

Rectal:

Rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative.

Motor/Cerebellar

Pain reported with active and passive flexion of L elbow, full active/passive ROM of all other extremities without rigidity, spasticity, or pain. Symmetric muscle bulk with good tone. No atrophy, tics, tremors or fasciculation. Strength 5/5 throughout. Rhomberg negative, no pronator drift noted. Gait steady with no ataxia. Tandem walking and hopping show balance intact. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis.

Sensory

Intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally

Reflexes

2+ throughout, negative Babinski, no clonus appreciated

Meningeal Signs

No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Differential Diagnoses:

1. Soft Tissue Abscess of LUE
    a. Pt presents with mild constitutional symptoms potentially indicative of infection and a tender, erythematous, swollen, fluctuant area. The location and fluctuance of the mass leads me to think it's most likely an abscess.
2. L Elbow Septic Arthritis
    a. Pt presents with mild constitutional symptoms potentially indicative of infection and a tender, erythematous, swollen area near the L elbow joint that is causing decreased and painful ROM.
3. Cellulitis of LUE
    a. Pt presents with mild constitutional symptoms potentially indicative of infection and a tender and erythematous area. The swelling/fluctuance of the mass leads me to have a lesser suspicion for cellulitis.
4. L Elbow Traumatic Arthritis secondary to overuse injury

    a. Highly active patient presents with acute joint pain and swelling. Synovial fluid analysis would show presence of RBCs and may appear grossly bloody
5. Soft Tissue Cyst of LUE
    a. Pt presents with soft tissue mass without major constitutional signs of infection. However, presence of pain, warmth, and constitutional symptoms leads me to have a lesser suspicion for a non-inflammatory cause.

Assessment:
44YOF with soft tissue abscess lateral to L elbow has improving signs of infection and improving joint ROM after I+D and initiation of antibiotic therapy. Pt is tolerating treatment well at this time.

Plan
Problem List:
1. Soft Tissue Infection
    a. Continue IV abx regimen and consider transition to PO regimen prior to discharge. Monitor for signs of worsening infection.
2. Reduced ROM of L elbow
    a. Continue to encourage passive and active ROM of L elbow, ensuring return to full ROM without pain as adjacent infection clears. Monitor for and address complications.
3. I+D Wound Care
    a. Continue wound checks with repacking/redressing to facilitate healthy healing and monitor for complications.
4. Pain management
    a. Continue PRN pain control regimen with APAP. Adjust regimen PRN according to Pt's pain levels.