History & Physical

Identification:

Mr. KK | 1/25/2020 – 6:38 AM |Queens Hospital Center ED
Informant: Self and son; Reliable

Chief Complaint:

"I burned my leg"

History of Present Illness:

Pt is a 78-year-old Indian male, with a PMH of HTN, HLD, peripheral neuropathy, BPH and bladder CA in remission. Pt presents to ED by family, after a scald burn to his RLE at home around 1 am. As per pt's son his wife was cooking in the early morning in preparation for guests. Pt was trying to go to the restroom through the kitchen when he lost his balance and reached onto stove. As per Pt's son he accidentally knocked over a pot of boiling water with very little oil. Pt has difficulty with balance and ambulates with a cane inside the house. Pt denies taking any medications or putting any cream on leg after the burn. Pt denies any fever, chills, fatigue, recent weight loss/gain, N/V/D. Pt also denies headache, vertigo, head trauma, loss of consciousness, coma, and fainting.

Past Medical History:

Bladder carcinoma
Hyperlipidemia
Hypertension
Peripheral neuropathy
Benign Prostatic Hyperplasia

Past Surgical History:

Cystourethroscopy x3 at Queens Hospital Center, no complications
Cystoscopy with transurethral resection lesion bladder at Queens Hospital Center, no complications
Bilateral Cataract surgery at Queens Hospital Center, no complications

Allergies:

Denies any drug allergies.

Medications:

Amlodipine 10 mg PO daily
Finesteride 5 mg PO daily
Gabapentin 100mg PO TID
HTCZ 25 mg PO daily
Tamulosin 0.4 mg PO daily

Family History:

Mother: Deceased, old age
Father: Deceased, old age

Social History:
Patient is married and lives with his wife and son.
Pt denies any tobacco, alcohol, or drug use, past and present.
As per pt's son he tries to exercise to strengthen muscle for gait.
Pt ambulates with cane at home and a lightweight walker outdoors.

Review of Systems:
General – See HPI.

Skin, hair, nails – Admits to dry skin. Denies changes in texture, oiliness, or sweating, discolorations, pigmentations, moles/rashes, pruritus, lesions, easy bruising, or changes in hair distribution.

Head – See HPI.

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Denies palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Nervous system – Denies seizures, sensory disturbances, ataxia, tremors, involuntary movements, change in cognition / mental status / memory/insight/judgment.

Musculoskeletal system –Admits to walking with a cane. Denies gout, neck pain, herniated disc.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, blood clots, cramping in legs, ulceration of extremities, hair loss or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

Physical Examination
General survey: A&O x3, well groomed, well dressed elderly man laying on stretcher in no apparent distress, and appears stated age.

Vital Signs:
T-98.5, BP-122/78, P-95 bpm strong and regular, RR-19 breaths/min strong and regular, SpO2 - 97%
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. No adventitious sounds.

Heart: RRR, normal S1, S2, grade I diastolic murmur

Abdomen: ventral hernia, soft, non-tender, no distention, no masses, BS present in all quadrants

Extremities: Palpable posterior tibial and dorsalis pedis pulses bilaterally, RUE (forearm) with a 3 x 2 cm 1st degree burn. RLE (anterior and posteromedial aspect of right lower leg) and R lateral foot, with 2nd degree, partial thickness burn wound, with 8% TBSA, and serous drainage from open blisters and some blisters intact.

A: Pt is a 78-year-old Indian male, with a PMH of HTN, HLD, peripheral neuropathy, BPH and bladder CA in remission. Presents with 2nd degree, partial thickness burn to RLE, 8% TBSA, and serous drainage from open blisters and some blisters intact.

P:

- Open blister debrided, intact blisters left in place
- Wound cleaned and thoroughly irrigated
- SSD and dry dressing applied
- IVF resucitation, Parkland formula…
- Administer tetanus toxoid vaccine
- SW consult for wound care. Pt will require daily dressing changes with bacitracin ointment.
- Schedule f/u appt with burn clinic at Jacobi Burn center. Pt is previously planned travel out of country on 2/5 so needs to be scheduled before that time.
- Fall risk assessment

Case discussed with Dr. Morel and Dr. Robinson. Patient agrees with tx plan.

S: 16 y/o male with no significant PMH. Patient presents to orthopedic clinic with father in a Velcro splint for f/u of minimally displaced left ulnar styloid fracture. His date of injury was 11/18/19 from a wrestling fall. Pt had x-ray on 1/23/2020, prior to visit. Pt reports FROM, fingers normal sensation, skin color, and temperature. Pt denies any fever, chills, night sweats, weakness, fatigue, weight loss, chest pain, shortness of breath, or palpitations. Denies any muscle/joint pain or discomfort with movement, no deformity or swelling, redness. Pt denies any sensory disturbances (numbness, paresthesia, dysesthesias).

O: Vitals – T: 98.7, BP - 122/82, P - 80, R – 16
General: seated, well-groomed and good hygiene, in no apparent distress
Skin: Warm and dry, no erythema, masses, or lesions.
Chest/Lungs: Respirations unlabored, nontender to palpation, clear to auscultation bilaterally.
Heart: Regular rate and rhythm, S1, S2 normal, no murmur.
Extremities: Velcro splint removed from left wrist, no tenderness over ulnar styloid Fx site, no edema, erythema, swelling or deformities noted. FROM of wrist and fingers with no pain, capillary refill <2secs.

A: 16 y/o male with no significant PMH. Patient presents to orthopedic clinic for f/u of minimally displaced left ulnar styloid fracture; with routine healing and doing well. Clinically healed Fx of left ulnar styloid. X-ray completed and final report and images pending.

P: Continue activity restrictions, no contact sports and weight lifting. Discontinue use of splint, Normal activity as tolerated. RTC 2/20/2020 for x-ray f/u and sports clearance.

Patient was seen and examined with PA Link.

S: 52 y/o F with PMH of HTN, HLD, PVD, and obesity, presents to surgery clinic for evaluation of umbilical hernia that has been gradually growing for 3 years. Pt had a hysterectomy in 2016 d/t fibroids at Brookdale Hospital, through a midline incision. Pt denies any fever, chills, night sweats, weakness, fatigue, weight loss/gain, nausea, vomiting, diarrhea, constipation, dysphagia, flatulence, jaundice, hemorrhoids, and blood in stool. She also denies any headaches, chest pain, shortness of breath, or palpitations. Pt is tolerating a regular diet and has normal bowel function.

O: Vitals – T: 98.6, BP - 136/78, P - 84, R – 16
General: seated, well groomed and good hygiene, in no apparent distress
Skin: Warm and dry, no erythema, masses, or lesions
Chest/Lungs: Respirations unlabored, clear to auscultation bilaterally.
Heart: Regular rate and rhythm, S1, S2 normal, no murmur.
Abdominal: Large reducible ventral hernia. No signs of incarceration or strangulation. Abdomen is soft, non-tender, BS present in all quadrants.

CT Impression (12/09/2019):

> Multiple periumbilical hernias noted containing mesenteric fat and nonobstructing loops of large bowel.

A: 52 y/o F with PMH of HTN, HLD, PVD, and obesity, presents with large reducible umbilical hernia that has been gradually growing for 3 years.

P:

- Pt is schedule to have a RFA of RLE on 03/12/2020.
- Discussed with patient need for surgery of hernia. Pt agrees and will RTC about two months after RFA to schedule an open ventral hernia repair with mesh.
- Advised on diet and exercise to optimize patient for surgery.

Patient was seen and examined with Dr. Morel and PA Sakaria.

S: 67 y/o F with PMH of HTN, HLD, DM, and GERD presents to surgery clinic c/o intermittent RUQ pain >2 years which she states it radiates to the back. Pts states it is a pinching/squeezing pain and does not take anything to alleviate the pain. Pt rates the pain about 7 out of 10 and says it comes mostly after fatty meals. Pt admits to some nausea and diarrhea sometimes but with no blood. Pt denies any fever, chills, night sweats, weakness, fatigue, weight loss/gain, vomiting, constipation, dysphagia, flatulence, jaundice, hemorrhoids, and blood in stool. She also denies any headaches, chest pain, shortness of breath, or palpitations. Pt states she has normal bowel function and no urninary symptoms.

O: Vitals – T: 98.8, BP - 134/76, P - 86, R – 16
General: seated, well groomed and good hygiene, in no apparent distress
Skin: Warm and dry, no erythema, masses, or lesions
Chest/Lungs: Respirations unlabored, clear to auscultation bilaterally.
Heart: Regular rate and rhythm, S1, S2 normal, no murmur.
Abdominal: Positive Murphys sign, abdomen soft, non-distended, BS present in all quadrants, no rebound or guarding.

A: 67 y/o F with PMH of HTN, HLD, DM, and GERD presents to surgery clinic c/o intermittent RUQ pain >2 years with symptomatic gallbladder.

RUQ sonogram on 01/03/2020: 3mm echogenic, mobile, focus, along the nondependent surface of the gallbladder may represent a sludge ball.

P:

- Pt scheduled to have a laproscopic cholecystectomy, possible open on 03/19/2020
- Pt should be NPO after midnight prior to surgery, and no NSAID/ASA use one week prior to surgery. Instructions attached.
- Pt educated on low fat diet
- Pt to schedule appointment for PAT prior to surgery.

Patient was seen and examined with Dr. Morel and PA Sakaria.

S: Pt is a 64 y/o F with PMHx of HTN, HLD, DM, bipolar disorder, and newly diagnosed right breast invasive ductal carcinoma & DCIS, ER positive, PR negative, Her-2 negative presents to Breast clinic on POD #7 of right mastectomy with sentinel lymph node biopsy and JP drain placement on 12/30/19. Pt presents to clinic from Creedmore facility without daily JP drain log. Facility was contacted and confirmed output yesterday, 01/06/2020 was about 55cc and this morning 20cc with about 15cc present in bulb currently. Pt complains of pain at JP site but denies any bleeding or draining from incision. Pt denies fever, chills, night sweats, weakness, fatigue, weight loss, nausea, vomiting, headaches, blurred vision. Denies chest pain, shortness of breath, or palpitations.
O: Vitals – T: 98.9, BP - 136/78, P - 84, R – 16
General: seated, well groomed and good hygiene, in no apparent distress
Skin: Warm and dry, no erythema, masses, or lesions
Chest/Lungs: Respirations unlabored, clear to auscultation bilaterally.
Breast: Right breast s/p mastectomy, site is flat with no ecchymosis or hematoma, bleeding, erythema, or signs of infection. Surgical site with steristrips intact, incision healing well, and JP drain output serosanguineous.
Heart: Regular rate and rhythm, S1, S2 normal, no murmur.
Surgical Pathology result (12/30/2019):

A. Right Axillary Lymph Node Sentinel #1: One lymph node negative for tumor
B. Right Axillary Lymph Node Sentinel #2: One lymph node negative for tumor
C. Right Breast, Mastectomy:
   Invasive and in situ ductal carcinoma
   Invasive ductal carcinoma is well differentiated, measuring 2.3 cm in greatest dimension.
   No angiolymphatic invasion is identified
   In situ carcinoma is of cribriform and solid types with intermediate nuclear grade
   All resection margins free of tumor
   Prior procedure site changes and focal fibrosis present

A: 64 y/o F with PMHx of HTN, HLD, DM, bipolar disorder, and newly diagnosed right breast invasive ductal carcinoma & DCIS, ER positive, PR negative, Her-2 negative presents to Breast clinic on POD #7 of right mastectomy with sentinel lymph node biopsy and JP drain placement on 12/30/19, doing well with some pain at JP drain site.
P:

- Continue JP drain care by Creedmore staff and record daily outputs with log and return to clinic with logs
- Onco type to be sent
- Referred to Medical Oncology, scheduled to see Dr. Ferman on 01/31/2020 at 9:40 am
- F/U at clinic next Thursday, 01/16/2020 with Dr. Pescovitz for post op check and JP drain monitoring

Patient was seen and examined with Dr. Pescovitz and PA Shakhmurov.