S: Pt is a 68 y/o F with PMH of HTN, DM and HLD c/o a rash under breasts and armpits x 4 days. She states she had a similar rash about one year ago for which she was given a cream, which resolved her symptoms. Patient admits to pruritus for which she used bacitracin and corn starch to help alleviate the itching. She reports it helps a little as the itching returns. She also states that at first is was a small rash but has grown to cover both armpits and across her inframammary fold area. She admits to rash, redness, itching, and the area being moist. She denies any tenderness, change in existing skin lesion, hair loss or increase, breast changes, and malodorous discharge. She denies any fever, chills, night sweats, n/v/d, HA, dizziness, chest pain, sob, abdominal pain, or urinary symptoms. She also denies having any pets at home, sick contacts, plant exposure, or new soaps, detergents and clothing.
plant, pet exposure, new soaps, detergents or clothing.

Medications:
CHLORTHALIDONE (HYGROTEN) 50 MG TABLET Take 1 tablet (50 mg total) by mouth daily.
HYDRALAZINE (APRESOLINE) 25 MG TABLET Take 1 tablet (25 mg total) by mouth 2 (two) times a day.
LOSARTAN (COZAAR) 100 MG TABLET Take 1 tablet (100 mg total) by mouth daily.
METFORMIN (GLUCOPHAGE) 500 MG TABLET Take 1 tablet (500 mg total) by mouth 2 (two) times a day with meals.
PRAVASTATIN (PRAVACHOL) 40 MG TABLET Take 1 tablet (40 mg total) by mouth daily.

O: Vital Signs: BP 163/90 (Right arm, Seated) | Pulse 76 | Temp 98.4 °F (36.9 °C) (Oral) | Resp 18 | SpO2 98% on room air

Constitutional: She is alert and oriented to person, place, and time. She appears well-developed and well-nourished. She is seated in no apparent distress.
Head: Normocephalic and atraumatic.
Neck: Normal range of motion. Neck supple.
Mouth: Oral mucosa pink and moist. No tongue or lip swelling noted.
Cardiovascular: Normal rate and regular rhythm, S1 and S2 normal, no murmurs, rubs or gallops.
Pulmonary/Chest: Respirations unlabored and breath sounds clear to auscultation bilaterally. Non tender to palpation. No adventitious sounds noted.
Abdominal: Soft, nontender, nondistended. Bowel sounds present in all four quadrants.
Skin: Skin is erythematous, warm and moist around inframammary area and axillary region. Capillary refill < 2 seconds. Fungal rash noted under b/l breast and b/l axillary areas. No drainage, vesicles or tenderness. No bullae, pustules,

Glucose Finger stick -

A: Pt is a 68 y/o F with PMH of HTN, DM and HLD c/o a rash under breasts and armpits x 4 days. She states she had a similar rash about one year ago for which she was given a cream which resolved her symptoms. History and examination consistent with a fungal rash noted under b/l breast and b/l axillary areas. Dx: Intertrigo

P: Intertrigo

- Start CLOTRIMAZOLE (LOTRIMIN) 1 % CREAM, Apply topically 2 (two) times a day as needed to affected area.

- Patient advised to keep areas clean and dry by minimizing moisture and friction in the involved area by:
    - Daily cleansing affected skin with a mild cleanser followed by drying of affected area with a hair dryer on a cool setting or dry towel
    - Daily application of drying powders (baby powder)
    - Use of absorbent material or clothing, such as cotton or merino wool, to separate skin in folds
    - Placing paper towels between skin folds
- Appropriate treatment of coexisting diabetes mellitus
- Advised to go to ER if sudden change in rash, fever, or other concerning symptoms arise.

Patient was seen and examined with PA Patel

S: Pt is a 23 y/o M with no PMH presents to the ED c/o bilateral eye redness x 1 week. Patient states that both his eyes have been itching, red, and tearing for about a week now. He describes the tearing as mostly a watery discharge but also complains of some mucopurulent discharge from both eyes in the mornings. Patient has been using over the counter Visine drops with no improvement in itching or redness. He denies any trauma or possible foreign body to the eyes. He also states he has allergies to shrimp but no recent sick contacts, travel or pets at home. Patient denies any fever, chills, sore throat, congestion, rhinorrhea, cough, N/V/D, cp, SOB, floaters, flashing vision, changes or loss of vision.

O: Vital Signs: BP 130/71 (Left arm, seated) | Pulse 74 | Temp 98.7 °F (37.1 °C) (Oral) | Resp 16 | SpO2 99% on room air

Physical Exam:
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No acute distress.
Eyes: EOM are intact. Pupils are equal, round, and reactive to light. Right eye exhibits discharge. No foreign body present in the right eye. Left eye exhibits discharge. No foreign body present in the left eye. Right conjunctiva is injected. Left conjunctiva is injected. Right eye exhibits normal extraocular motion and no nystagmus. Left eye exhibits normal extraocular motion and no nystagmus. Right pupil is round and reactive. Left pupil is round and reactive. Pupils are equal.
+ watery discharge b/l
+ conjunctival injection b/l
Visual acuity: Left eye--> 20/30
Right eye--> 20/40
Tonometer: left eye--> p - 12
Right eye--> p - 16
No foreign body or abrasion noted with fluorescein staining
Ears: Mild cerumen noted AU, TMs pearly white/intact with light reflex in normal position AU, and hearing intact.
Nose: No external lesions, mucosa non-inflamed, septum and turbinate's unremarkable.
Mouth: Mucous membranes moist, no mucosal lesions.
Pharynx : Mucosa non-inflamed, no tonsillar hypertrophy or exudate
Neck: Supple, without lesions, bruits, or adenopathy, thyroid non-enlarged and non-tender
Cardiovascular: Normal rate and regular rhythm, S1 and S2 normal, no murmurs, rubs or gallops.
Pulmonary/Chest: Respirations unlabored and breath sounds clear to auscultation bilaterally. Non tender to palpation. No adventitious sounds noted.
Neurological: He is alert and oriented to person, place, and time.

A: Assessment: 23 y/o M with no PMHx presenting to ED complaining of b/l eye redness, itching, and discharge x 1 week. Viral conjunctivitis vs. bacterial conjunctivitis

P:
Prescription for Ofloxicin, Sudafed
Follow up with eye doctor
Advised to go to ER if sudden change in vision, fever, worsening symptoms or other concerning symptoms arise.
Patient was seen and examined with PA Ariella.

S: Pt is a 29 y/o Female, denies any significant PMH or surgical hx presents to ED c/o of a Right ankle injury while working out. Pt states she was on a stationary bike where the pedal fell off and she cut herself on the crank arm. She admits to falling off bike but denies any other trauma, hitting her head or loss of consciousness. She rates the pain 10/10 and denies taking any OTC medication for pain. She admits to bleeding from laceration, and swelling around her ankles along with arthralgia. Pt states she received tetanus shot 2 years ago. She denies head injury, LOC, fever, chills, numbness or tingling sensation, weakness, N/V/D, HA, visual disturbances, chest pain, SOB, cough, .

O: Vital Signs: BP 122/77 | Pulse 75 | Temp 98.1 °F (36.7 °C) (Oral) | Resp 18 | LMP (LMP Unknown) | SpO2 98% on room air

Physical Exam:
Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.
Head: Normocephalic and atraumatic.
Eyes: Visual acuity intact, conjunctiva clear, sclera non-icteric, EOM intact, PERRLA
Cardiovascular: Normal rate and regular rhythm, S1 and S2 normal, no murmurs, rubs or gallops.
Pulmonary/Chest: Respirations unlabored and breath sounds clear to auscultation bilaterally. Non tender to palpation. No adventitious sounds noted.
Musculoskeletal: Normal range of motion. Right Leg: about a 3 cm linear laceration to medial aspect of R distal lower leg, bleeding controlled. Sensation and motor strength intact b/l. Positive swelling around right ankle. No deformities, Distal pulses 2+, Capillary refill <2 secs.
Neurological: She is alert and oriented to person, place, and time. She has normal strength. No sensory deficit.
Skin: Skin is warm and dry.

R ankle x-ray - There is no evidence of acute fracture or dislocation. The ankle mortise appears intact on these nonweightbearing views. There is no periostitis or osseous lesion. Soft tissue swelling and soft tissue defect at the medial aspect of the distal calf with associated cortical depression/defect (spanning 1.5 cm in craniocaudad dimension) at the distal medial tibial shaft.

A: 29 y/o Female denies any significant PMH or surgical hx presents to ED c/o of Right lower leg laceration while working out. Case d/w Elmhurst ortho consult, rec appreciated.
- Irrigate laceration with at least 4L fluids
- update tetanus shot
- 1 dose of IV Ancef, followed by 10 days of oral Keflex
- F/U in Queens ortho clinic within 1 wk for wound check
- pain control per ED

P: Right lower leg laceration

- Patient consent: Laceration repair risks and benefits were explained. The patient appears to understand and granted permission to perform procedure. Verbal consent obtained.
- Anesthesia: Local, Lidocaine 1%, 10 mL. Preparation: area cleaned, prepped, and draped using sterile technique, Betadine, Debrided/undermined, Irrigated/washed with saline, Explored, no foreign material found, Draped in a normal sterile fashion. Distal NVT: Neuro and vascular status intact.

- Procedure: Area cleaned and bandaged, patient tolerated the procedure well. Using 11 sutures place, Suture type used: 4-0 nylon.
- Post procedure: Bacitracin placed over laceration, non-absorbable pad covered site and then wrapped with kerlix.
- Patient instructed to clean area every 12 hrs and cover, avoid rubbing and sun exposure. Patient had opportunity to ask questions and presented a good understanding of instructions and follow-up.
- Discharge instructions reviewed with patient
- Start cephalexin (Keflex) 500 mg, Take 1 capsule by mouth 4 (four) times a day for 10 days
- Patient advised to take Tylenol/Motrin as needed for pain and/or swelling.
- Advised patient to follow up at the orthopedic in 1 week.
- Return to clinic in 10 days to remove sutures. Patient was advised to proceed to the nearest Emergency Department if any worsening or concerning symptoms develop, including but not limited to increase pain, swelling, numbness, tingling, fever, or chills.
- Patient ambulated in clinic freely in no acute distress. Patient in good appearance and in no distress at the time of discharge.

S: Pt is a 60 y/o male with PMH of uncontrolled HTN, HLD, DM due to non-compliance w/ medication and active TB (compliant w/ medication) that has disseminated to his knee. He presents to ED c/o elevated glucose, generalized weakness, and knee pain x 1 month. Patient also states he has trouble sleeping at night. Pt was admitted to Queens Hospital Center on 6/4/20 for active TB in lungs and R knee, however pt eloped on 6/27/20, pt states he didn't want to stay in the hospital any longer, but reports taking his TB meds. Pt states that he came from India about 30 yrs ago and denies any recent travelling. He stated that last year, he had some visitors from India. He currently lives with his daughter and denies any sick contacts. Pt reports that he doesn't have a PCP and hasn't been taking medications for his chronic medical conditions for many months. As per daughter Nancy (631-992-2329), a case manager from DOH has been in touch with pt, and he was d/c on TB meds but never given DM meds, and was following up at a TB clinic. He admits to 12 lb weight loss in the past couple of months and few episodes of night sweats but denies any active hemoptysis, productive cough, fever, night sweats, or chills. He also denies any headache, dizziness, and numbness or tingling sensation, visual changes, N/V/D, chest pain, SOB, palpitation, abdominal pain, or urinary symptoms.

Medications:

Pyrazinamide 1500mg, Ethambutol 1200mg, Isoniazid 300mg, Rifampin 600mg, Vitamin B6 50mg, lisinopril 40 mg PO Daily, labetalol 300 mg PO q12h, atorvastatin 40 mg PO Daily, metformin 500 mg

O: Vital Signs: BP: 176/80 (Patient Position: Sitting) | Pulse 70 | Temp 97.7 °F (36.5 °C) (Oral) | Resp 16 | SpO2 98% on room air

Physical Exam:

Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No acute distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple.

Cardiovascular: Normal rate, regular rhythm and normal heart sounds.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. He has no wheezes. He has no rales. He exhibits no tenderness.

Abdominal: Soft. Bowel sounds are normal. He exhibits no distension. There is no tenderness. There is no rebound.

Musculoskeletal:

Right knee: He exhibits bony tenderness. He exhibits normal range of motion, no swelling, no effusion, no ecchymosis, no deformity, no laceration, no erythema, normal alignment, no LCL laxity, normal patellar mobility, normal meniscus and no MCL laxity. Sensation and motor strength intact

Skin: Skin is warm and dry. No rash noted. He is not diaphoretic. No erythema. No pallor.

Labs:

WBC: 8.24, H/H: 14.8/43.5, PLT: 169, Na: 131, K: 4.8, BUN/Cr: 13/0.74, LFT: WNL, VBG - WNL

Glucose poc capillary: 276mg/dL

Pertinent Radiology findings:

DX Portable Chest 1 View

IMPRESSION: Grossly stable diffuse bilateral pulmonary consolidation.

Report Dictated and Signed by Simon Daniel 8/4/2020 6:02 PM

CT Knee without contrast Right
Impression: No acute osseous abnormality.

Report Dictated and Signed by Sumukh Patil 8/4/2020 5:15 PM

A: Pt is a 60 y/o male with PMH of uncontrolled HTN, HLD, DM due to non-compliance w/ medication and active TB (compliant w/ medication) that has disseminated to his knee. He presents to ED c/o elevated glucose, generalized weakness, and knee pain x 1 month. History and exam Impression: Weakness, likely due to TB vs hyperglycemia; Knee pain due to TB.

Plan: Miliary TB with right Knee TB arthritis.

- Admit to Medicine
- Bio Reference COVID-19 PCR
- Start on Rocephin 1000mg and azithromycin 500mg IV in ED.
- Start Metformin 500 mg, two times a day with meals

Patient was seen and examined with PA Patel and discussed with Attending Leslie Julien, MD.