Nicholas Burney ER H&P #2

Full Name: M.Z.
Age: 29
Sex: M
Marital Status: Single
Race/Nationality: Hispanic
Address: Staten Island, New York
Date of Birth: 10/9/1992
Date and Time: June 21st , 2021, 7:05 AM
Location: Staten Island University Hospital
Source of Information: Self
Reliability: Unreliable (Intoxicated)
Mode of Transport: Ambulance

Chief Complaint: "My face hurts x 1 day".

History of Present Illness

M.Z. is a 28 y/o male of unknown medical history who presents to the ED s/p assault for evaluation of facial trauma. As per EMS, patient was found at 4:30 AM after assault by multiple people. Patient is intoxicated during encounter with interviewer, he is mostly uncooperative and repeatedly attempts to turn over and sleep. Patient admits to head trauma and wounds to left side of the face with unknown loss of consciousness. Denies chest pain, abdominal pain, nausea and vomiting. Patient is unsure of last tetanus booster.

Past Medical History

Unable to be elicited.

Past Surgical History

Unable to be elicited.

Medications

Unable to be elicited

Allergies

Unable to be elicited

Family History

Unable to be elicited

Social History

Patient is clinically intoxicated, unknown drug use or smoking.

Review of Systems

General: Denies fever, night sweats, chills, weight gain or loss.
Head: Admits to trauma, headache, denies vertigo.
Eyes: Admits to changes in vision, eye pain, and photophobia in left eye.
ENT: No deafness, otorrhea or tinnitus. No voice changes or bleeding gums. Admits to blood in nose and mouth.
Neck: No localized swelling, stiffness or decreased ROM.
Breast: No lumps, pain or discharge.
Respiratory: No cough or respiratory distress. No hemoptysis, shortness of breath.
Cardiovascular: No edema. No chest pain with exertion or palpitations.
Gastrointestinal: No nausea, vomiting, diarrhea or abdominal pain.
Genitourinary: No dysuria, frequency or burning. No discharge.
Peripheral Vascular: No varicose veins, coldness or trophic/color changes.
Hematologic: Denies anemia, DVT or lymph node enlargement.
MSK: Some pain in left shoulder. No muscle weakness, back pain.
Nervous system: Confirms headache. Denies loss of consciousness.
Endocrine: Denies polydipsia, polyphagia, polyuria, intolerance to heat or cold.
Skin: Confirms numerous wounds and bruises to face. No skin rash, excessive dryness or sweating.
Psychiatric: Negative for anxiety, depression, stress, memory deficits, or ever having taken psychiatric drugs.

Vital Signs

Height: 5’ 7”
Weight: 170 lb
BMI: 26.6
BP: 119/75
Pulse: 71
RR: 19
T: 97.8 degrees Fahrenheit
O2 Sat: 100% on RA

Physical Exam

General: NAD, non-toxic appearing, well developed and well nourished.
Head: Normocephalic, trauma to head and face, scattered ecchymoses. Hematoma over left scalp.
Eyes: Pupils equal and reactive to light bilaterally, conjunctival hemorrhage with swelling in left eyelid. Able to count fingers in front of face, limitation in upward and downward gaze. Fluorescein stain shows no uptake. IOP in left eye measured 40, 41, 42, 40, 41. 3cm laceration under left eye and complicated laceration through medial canthus of left eye.
Neck: Non-tender, no meningeal signs, supple.

ENT: No discharge, dried blood in nasal cavities, airway is clear.
Pulmonary: Equal breath sounds bilaterally, no wheezes, ronchi or rales. No distress.
Cardiac: S1 S2 distinct, regular rate and rhythm.
Abdomen: Soft, nontender, non-distended.
MSK: Full ROM in all extremities, no edema of lower extremities. No calf pain, radial pulses 2+ B/L
Neurological: A&O x3. No focal deficits. Strength 5/5 with no sensory deficits. Steady gait.
Skin: Warm, dry, no acute rashes. Good turgor.

Labs

CBC:
WBC – 6.25
RBC – 4.11
Hb- 12.9
Hematocrit- 36.5
CMP:
Na – 131
K – 3.1
Cl – 94
CO2 – 23
BUN – 11
Creatinine – 0.8
Glucose – 145
Ca – 9.1
Protein – 7.0
eGFR – 122
Creatine kinase - 150
Urinalysis:
Colorless, clear, negative protein, blood, nitrite, leukocyte esterase.
Lactate: 2.8
Blood Alcohol Level: 340

EKG:

Normal sinus rhythm

Imaging

CT Cervical Spine – No evidence of acute fracture, compression deformity or facet subluxation. Joint space heights are within normal limits.

CT Head – The ventricles and cortical sulci are normal in size and configuration. No acute intracranial hemorrhage or midline shift. Small left scalp hematoma.

CT Maxillofacial – Acute fracture of the left medial orbital wall/lamina papyracea with herniation of orbital fat into the ethmoid sinus. There is a hematoma along the superior aspect of the left orbit with inferior displacement of the superior rectus muscle.

Assessment and Plan

28 year old male with left medial orbital fracture, left scalp hematoma, 3cm laceration under left orbit and elevated left eye intraocular pressure.

Disposition: Transfer

1. Repair left orbital laceration
2. Repeat IOP measurement, administer alphagan and reassess
3. Consult Ophthalmology due to laceration of punctum and medial canthus, transfer to Kings County Hospital for treatment
4. Cardiac monitor bedside
5. Tetanus booster