Nicholas Burney LTC H&P #2

Good establishment of patient baseline at the outset and this H&P "ticks a lot of the boxes". However, it does not focus adequately on the chief concerns. There needs to be much more information on her back and leg pain and her neuro issues. The plan has a pretty broad range of tests, but there isn't enough data to support some of them. In real-life practice, that will lead to insurance company denials. As we discussed, the DDx for her LBP and leg pain is also not broad enough – and needed to guide the history and the PE to eliminate or support some of the other potential diagnoses.

Full Name: B.S.
Age: 72
Sex: F
Marital Status: Single
Race/Nationality: Black
Address: East Harlem, Manhattan
Date of Birth: 2/14/1949
Date and Time: 11/17/2021, 2:45 PM
Location: Metropolitan Hospital, Manhattan
Source of Information: Self
Reliability: Reliable
Mode of Transport: Self transport

Chief Complaint: "My leg hurts and I can't sleep".

History of Present Illness

B.S. is a 72 year old Twi-speaking right-handed female living at home with her sister, ambulating without assistance, independent with all ADLs and IADLs without a home attendant, with a PMH of HTN, osteoporosis and chronic left shoulder pain, who presents to the clinic for a follow-up s/p an ER visit (date and which ER) for unilateral 10/10 left sided dull headache one week ago. The headache was associated with blurry vision and imbalance while walking. Need to have the CT result here – otherwise it sounds like they just jumped on the UTI Dx without ruling out more serious issues She was diagnosed with a UTI with trace leukocyte esterase in her urine and was treated with Bactrim. And did symptoms respond to the Tx? Today the patient complains of intermittent 9/10 sharp lower back pain that radiates down the right posterior leg to the right foot for the last 2 years and has been getting worse. Need more about the progression over time. She denies knowledge of aggravating or alleviating factors. She describes a "pins and needles" sensation that appears intermittently. Where? (Dx depends on distribution) She also complains of unintentional weight loss of an undetermined amount. She describes chronic insomnia that has worsened over the last week and may be associated with the back pain. The patient states she is very concerned that she has family in Ohio that she is being asked to look after, but is unable to do so due to the condition of her shoulder and inability to lift objects. The symptom of dizziness she experienced last week has resolved and she does not report feeling dizzy in the clinic.

Patient denies any tinnitus, hearing loss, recent falls, trauma, new medications, fever, chills, chest pain, abdominal pain, dysuria, leg swelling. Denies any attempt at self-treatment for the pain. Need the OLD CARTS info re: her back pain – also questions that might narrow the source – e.g. whether it's better when sitting or leaning forward or worse in certain other positions, what it keeps her from doing etc.

Past Medical History

HTN
Osteoporosis
Chronic joint pain which joints?

Past Surgical History

Denies surgical history

Medications

Alendronate

Calcium Carbonate – Vitamin D

Diclofenac Gel applied to what body part?

Losartan

Allergies

No known drug or environmental allergies

Family History

Parents

Older sister – alive and well

Younger sister – alive and well

Social History

Denies smoking, drinking, illicit drug use past and present.
Need more here than just substance use Hx

Review of Systems

General: Denies fever, night sweats, chills, weight gain or loss.
Head: Denies trauma, headache, vertigo.
Eyes: Positive for blurry vision, negative for eye pain, and photophobia. Is her vision still blurry or is this the old complaint. If active, need details of the blurriness – both eyes, fields involved, constant/intermittent
ENT: No deafness, otorrhea or tinnitus. No voice changes or bleeding gums. In patient with weight loss, want to ask about chewing and swallowing
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, flank pain, frequency, urgency, or hematuria.
Peripheral Vascular: No varicose veins, coldness or trophic/color changes.
Hematologic: Denies anemia, DVT or lymph node enlargement.
MSK: Positive for joint pain (which joints?), back pain
Nervous system: Positive for light-headedness Need more on this (either here or in the HPI), negative for headache
Endocrine: Denies polydipsia, polyphagia, polyuria, intolerance to heat or cold.
Skin: No skin rash, excessive dryness or sweating.
Psychiatric: Positive for anxiety, stress Need to expand on this. Negative for depression, memory deficits or taking psychiatric drugs.

Vital Signs

Height: 5'5
Weight: 121 Would be good to add previous weight here since that's a complaint
BMI: 20.1
BP: 129/69 orthostatic BP?
Pulse: 85
RR: 18
T: 97.8 degrees Fahrenheit
O2 Sat: 99% on RA

Physical Exam

General: NAD, non-toxic appearing, well developed and well nourished. **Weight appears unchanged from last visit.**
Head: Normocephalic, no signs of trauma.
Eyes: PERRL, sclera and conjunctiva clear.
Neck: Non-tender, no meningeal signs, supple.
ENT: No discharge, no epistaxis, airway clear.
Pulmonary: Equal breath sounds bilaterally, no wheezes, ronchi or rales.
Cardiac: S1 S2 distinct, regular rate and rhythm.
Abdomen: Soft, non-distended abdomen, nontender.
Genitourinary: No CVA tenderness.
Neurologic: Horizontal nystagmus when eyes are directed laterally to the left, upwards rotating nystagmus without vertical nystagmus. No facial asymmetry or dysarthria. No sensory deficits. Romberg and pronator drift negative. Reflexes intact bilaterally. Strength 5/5 RUE, 4/5 LUE 2/2 to shoulder pain, 5/5 lower extremities bilaterally. Sensation intact to light touch bilaterally. Babinski negative bilaterally. Given the MRI findings, what else should be tested?
MSK: **Ambulating in the clinic with antalgic gait favoring the left side Clearer to describe the direction of leaning – there is not always agreement about what "favoring" means. Lower back pain elicited with straight leg raise on right side (at what angle of elevation). No focal tenderness to spine or**

paravertebral muscles, or the right hip. Focal tenderness to left shoulder/acromion, ROM of left shoulder diminished due to pain, positive Hawkins Kennedy test in left arm, inability to abduct left arm against resistance. No deformities of the feet, dry skin noted, DP pulses 2+ bilaterally, no onychomycoses.
Skin: Warm, dry, no acute rashes. Good turgor.

Labs + Imaging

CBC- Done 11/10/2021

WBC – 5.48

RBC- 4.58

HGB – 14.2

HCT – 41.8

MCV – 91.3

BMP - Done 11/10/2021

Na – 143

K – 3.9

Cl – 106

CO2 – 26

Glucose – 89

Ca – 9.5

CT Head w/o contrast – Done 11/10/2021

No intracranial hemorrhage or acute large territory infarcts are seen. Increased bifrontoparietal and moderate cerebellar atrophy noted.

EKG – Done today 11/17/2021

Normal sinus rhythm

Assessment and Plan

Plan:

#Dizziness
Currently not taking any medications due to symptoms subsiding.
Exam positive for horizontal nystagmus and the rotational nystagmus which is much more unusual

PLAN
Holter monitor
EKG and echocardiogram
Cardio referral
ENT referral for VNG and audiology
Advised to increase water intake
Advised to lay flat if symptoms reoccur and to go to the ED if they do not resolve

#LE pain
Predominantly in right lower extremity, described as cramping and pins and needles
Likely radiculopathy vs. what other etiologies we discussed?
Plan
MRI lumbar spine
Pain and palliative referral
Rehab referral
Tylenol OTC
Voltaren gel PRN applied to what area?
Will hold stronger medications like opioids and gabapentin due to vertigo as side effect

#Chronic joint pain
Affecting primarily the left shoulder
Described as stiff in the morning
Also reporting weight loss but weight is unchanged from last visit
R/o rheumatologic condition
Plan
Tylenol OTC PRN
ANA, RF, ESR, CRP
Rehab referral
Continue voltaren gel PRN

#Insomnia
Depression screening PHQ2/9 negative – should be mentioned in PE/objective data. Never want to be presenting new data in the plan
Mainly due anxiety and pain in lower extremity
Contributing factor may also be anxiety over family member obligations and belief of weight loss
Plan
Pain management
Pain clinic referral
Melatonin at night
Offer to speak to patient's family members and advise not to travel out of state

#Health care maintenance
Hep C screening – Never done
DEXA Scan – Done 6/6/2021
AP spine L1-L4 = -2.9 Dual femur -2.1
Zoster 2/2 – Will complete 11/29/2021
Colerectal cancer screening – will complete 04/17/2022
Mammogram – will complete 10/4/2023

TDAP – 10/16/2027
Influenza vaccine – completed 10/28/21
Pneumococcal 65+ - completed
Hepatitis B immunization – aged out
Covid immunization?
Geriatrics assessment:

ADLs : Independent in all
IADLs: Independent in all
Visual impairment: None documented
Hearing impairment: None documented
Falls in the past year: None documented
Assistive devices: None documented
Gait impairment: - antalgic gait at current visit due to RLE pain
Urinary Incontinence: None documented
Fecal incontinence: None on file
Osteoporosis – Yes
Dexa input: AP spine L1-L4 = -2.9 Dual femur -2.1
Cognitive impairment: None documented
Depression: None documented, PHQ 2 negative
Home safety issues: None documented
Health Care Proxy : Her son M. reachable at XXX XXX XXXX