**Teegarden**

**Good job overall. Really good capture of information and the HPI contains all the needed info. The HPI sequence, though, could make the situation a little clearer – see my comments below. As I noted below, the neuromusculoskeletal exam reads as normal, though he clearly has impairments. How can you communicate the specifics to the next reader? I’ve made some other minor comments to focus the H&P a bit – see below. But strong job for first attempt in the clinical year.**

**Identifying Data:**

Full Name: P.R.

Sex: Female

DOB: XX/XX/1933

Race/Nationality: Hispanic

Primary Language: Spanish

Address: New York, NY

Date & Time: 02:00PM 01/5/21

Location: Metropolitan Geriatric Clinic

Source of Information: Daughter (Primary caregiver), translated from Spanish / medical records

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** “My mother’s rash is getting worse and spreading all over her body” x3 months - daughter

**HPI:**

PR is an 88 y/o female with a PMHx of DM2, HTN, HLD, PVD, longstanding persistent atrial fibrillation, Mobitz Type 1 second degree AV block, osteoarthritis, and mild cognitive impairment that presents to the geriatric clinic for her routine follow up visit with ongoing complaint from her caregiver of persistent rash that has worsened since the last visit 2 months prior on 11/5/21. Pt is living in an apartment with her daughter (primary caregiver), ambulating with a rollator walker, and dependent in both her ADLs and IADLs. There is no home health aide as daughter cares for her mother full-time. Pt requires assistance to rise from chair and while using walker. She is urinary incontinent but maintains control of bowel movements. During her prior visit on 11/5/21, pt was found to have a pruritic rash and was subsequentially treated for mild generalized xerosis with ammonium lactate 12%, and candidiasis of the left inframammary fold and inguinal area with Econazole nitrate 1% cream, Betamethasone valerate 0.1% cream and starch powder. The daughter reports today that the persistent rash has not improvement and there is now breakage in the skin and involvement of the neck, arms (left > right), abdomen, and bilateral thighs (left > right). The itching has progressed and is now keeping her from falling asleep at night. In addition to the treatments described above, she takes daily Cetirizine and has tried changing her laundry soap, switching her body soap to Cetaphil, changing her bed sheets, and applying Vaseline with no improvement. She denies any aggravating/relieving factors. No one in the family/household has rash/itching. The last medications started prior to onset of rash were Apixaban and Januvia on 10/5/21. To me, this is the most important piece of information in formulating the DDx. How can it be made more prominent [Hint: consider whether it might be placed somewhere else in the HPI to make the sequence of events clearer] Pt denies chest pain, SOB, palpitations, N/V/D, constipation, abdominal pain, fever, cough, headache, or recent viral illness.

**Geriatric Assessment:**

* ADLs: Mostly dependent. Needs assistance in transferring, toileting, dressing, bathing, and grooming. Pt can feed herself.
* IADLs: Dependent. Needs assistance with meal prep, household chores, transportation, communication, paying bills, shopping, and taking medications
* Home health aide: No, daughter is full-time caretaker
* Social support: Daughter (Daughter is retired)
* Visual impairment: Yes, has glasses but not wearing at encounter. 20/70 visual acuity of left eye and the right eye?
* Hearing impairment: Yes, bilateral sensorineural. Not using hearing aids. Because?
* Dental: Dentition is primarily intact this needs a little more info – I’m not sure what primarily intact means. Perhaps clearer to note the areas of trouble (if few)
* Falls: One fall within past year In a perfect world, would like to know a little more about this – e.g. “Slip and fall” or falls work-up at the time showed…..
* Assistive devices: Walker with seat (Rollator)
* Gait impairment. Yes, unsteady gait.
* Nutritional concerns: Daughter reports that she is eating well.
* Urinary incontinence: Yes. Wearing adult diapers. Functional – inability to ambulate well & increased urgency from furosemide
* Fecal incontinence: No. Daughter reports pt can control bowels. 2 bowel movements daily.
* Osteoporosis: DEXA scan was unable to be completed due to habitus
* Depression: Pt denies feeling sad/depressed. PHQ9 score 0
* Home Safety issues: None reported.
* Health care proxy: Daughter. MOLST form completed
* Advanced directives: Full code

**Past Medical History:**

*Present Illnesses:*

* Allergic rhinitis
* Chronic Dermatitis
* Constipation – Dx 11/5/21
* Mild cognitive impairment – Dx 10/5/21
* Diabetes Mellitus Type 2 Would like to know when diagnosed – helps understand likely status
* Hyperlipidemia
* Hypertension Would like to know when diagnosed – helps understand likely status
* Incontinence – functional
* Longstanding Persistent Atrial Fibrillation need some kind of statement about ventricular rate control/not controlled
* Mobitz Type 1 second degree AV Block
* Osteoarthritis (bilateral knees)
* Peripheral venous insufficiency
* Vitamin D Deficiency

*Past illnesses:*

* Pneumonia – 1/2018 CAP hospitalization
* Childhood illnesses: Unable to recall

*Immunizations*

* 1st dose of Shingrix given 1/5/21
* All other immunizations up to date
  + COVID-19 + booster
  + Prevnar 13
  + Pneumovax 23
  + Td
  + All childhood immunizations

**Past Surgical History:**

* Left knee arthroplasty - 2019

**Current Medications:**

* Acetaminophen 500mg PO PRN q6h
* Amlodipine 5mg PO 1x/daily
* Ammonium Lactate 12% cream 2x/daily (Started 11/5/21)
* Apixaban 5mg PO 2x/daily (Started 10/5/21)
* Azelastine HCL 137 MCG Spray solution 1x/daily (Started 11/5/20)
* Betamethasone Valerate 0.1% cream 2x/daily (Started 11/5/21) applied where?
* Cetirizine 5mg PO at bedtime (Started 6/2/21)
* Cholecalciferol (Vit D) 1000 units PO 1x/daily
* Econazole Nitrate 1% cream topic 1x/daily (Started 11/19/21) applied where?
* Fluticasone Propionate 50MCG spray solution 1x daily (Started 10/2/20)
* Furosemide 40mg PO 1x/daily
* Lisinopril 40mg PO 1x/daily
* Metformin 1000mg PO 1x/daily
* Metoprolol Succinate ER 25mg PO 1x/daily
* Polyethylene glycol (MiraLAX) powder 1x/daily (Started 11/5/21)
* Sitagliptin (Januvia) 100mg PO 1x/daily (Started 10/5/21)
* Starch Powder 3-4x/daily PRN (Started 11/5/21)

**Allergies:**

* NKDA
* No known food or environmental allergies

**Family History:**

* Mother – Deceased of “old age”, denies medical conditions
* Father – Deceased of “old age”, denies medical conditions
* Maternal Grandmother – unknown
* Maternal Grandfather – unknown
* Paternal Grandmother – unknown
* Paternal Grandfather – unknown
* Siblings – none
* Children – Daughter, healthy

**Social History:**

* PR is a single female who lives with her daughter in an elevator apartment building.
* Habits – No current alcohol use, “occasional” alcohol use in the past. Denies ever using tobacco. Denies ever using illicit drugs.
* Travel – Denies recent travel
* Occupation – Retired. Prior occupation unknown.
* Marital History – Widowed. No pets.
* Diet – Soft foods. Daughter reports pt eating 3 meals per day consisting of water, bananas, apple sauce, chicken, rice, and other soft foods. As discussed, might need some probing about protein intake, possible supplements
* Reports recent difficulty falling asleep due to itching. Sleeps 7-8 hours per night.
* Exercise – Walks around the home with walker-assistance, otherwise unable to ambulate.
* Sexual History – Not sexually active.

**Review of Systems:**

* General
  + **Admits to generalized weakness/fatigue.** Denies weight loss, loss of appetite, fever/chills/night sweats
* Skin, hair, nails
  + **Rash, Pruritis**. Denies excessive sweating, pigmentations, moles, change in hair distribution.
* Head
  + Denies headache, vertigo, or new head trauma
* Eyes
  + Denies visual disturbances, abnormal lacrimation, photophobia, or pruritis
  + Last eye exam 1 year prior. Visual acuity 20/70 OS. Unknown OD acuity Why not?. Wears glasses for reading.
* Ears
  + **Hearing loss**. Denies, pain, discharge, tinnitus, hearing aids, or feeling of fullness
* Nose/Sinuses
  + Denies epistaxis, congestion, or discharge
* Mouth and Throat
  + Denies bleeding gums, sore tongue/throat, mouth ulcers, voice changes, or dentures. Last dental exam 1 year prior.
* Neck
  + Denies swelling/lumps, stiffness, or decreased ROM
* Breast
  + **Itching, rash under folds.** Denies lumps, nipple discharge, or pain. Breast cancer screening not indicated at this age.
* Pulmonary System
  + Denies SOB, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, or PND
* Cardiovascular System
  + Denies chest pain, known murmur, HTN, palpitations, irregularly irregular heartbeat, edema/swelling of ankles/feet, or syncope
* Gastrointestinal System
  + Denies changes in appetite, intolerance to specific foods, N/V/D, constipation, dysphagia, pyrosis, flatulence, abdominal pain, jaundice, changes in bowel habits, hemorrhoids, rectal bleeding/blood in stool.
* Genitourinary System
  + **Functional incontinence**
  + Denies changes in frequency, nocturia, oliguria, polyuria, abnormal color of urine, flank plain, or dysuria
  + Sexual History – refer to Social Hx
  + Denies hesitancy/dribbling
* Nervous System
  + **Admits to progressive changes in cognition/mental status/memory**
  + Denies seizures, headache, loss of consciousness, ataxia, loss of strength, or weakness
* Musculoskeletal System
  + **Admits to chronic muscle/joint pain. Hx of osteoarthritis**
  + Denies deformity, swelling, redness
* Peripheral Vascular System
  + Denies intermittent claudication, coldness/trophic changes, varicose veins, peripheral edema, or color change
* Hematologic System
  + Denies anemia, easy bruising/bleeding, lymph node enlargement, or history of DVT/PE
* Endocrine System
  + Denies polyuria/polydipsia/polyphagia, heat/cold intolerance, goiter, excessive sweating, or hirsutism
* Psychiatric
  + Denies depression/sadness, anxiety, or obsessive/compulsive disorder. Never seen a mental health professional. Never taken psychiatric medications

**PHYSICAL EXAM**

Vital Signs:

BP: 159/64mmHg – sitting & supine, R arm

RR: 18 breaths/min, unlabored

Pulse: 86 bpm, irregularly irregular

T: 36.3C (oral)

O2 SAT: 96% on room air

Height: 58 inches Weight: 135 lbs BMI: 28.15 kg/m2

General Appearance: alert & oriented x3, no acute distress. appropriate development and body habitus, well nourished, appropriate posture, appears stated age, well groomed

Head: normocephalic, atraumatic

Eyes: Symmetrical OU. No strabismus/exophthalmos/ptosis. Sclera white, cornea clear, conjunctiva pink. No erythema of lacrimal sack. PERRLA. EOM intact with no nystagmus. Able to read the chart or a sign with both eyes? In older people also want to comment on the lens and its clarity/opacity (cataracts)

Ear: Appropriate in size. Ear and tragus nontender AU. No lesions/masses/trauma visualized on external ear. No discharge/foreign bodies in external auditory canals AU. TM pearly white/intact with cone of light in appropriate position AU. Non-obstructing cerumen bilaterally.

Nose: Symmetrical, no masses/lesions/deformities/trauma/discharge.

Mouth & Throat:

Lips: Pink & moist. No cyanosis, lesions, or ulcerations

Oral Mucosa: Pink, well hydrated. No masses/lesions noted. No leukoplakia.

Palate: Pink, well hydrated. No visible lesions/masses/scars.

Teeth: Majority of teeth retained (count them?). No visible dental caries. All teeth have appropriate shape.

Gingivae: No hypertrophy or recession. Unremarkable

Tongue: pink, well papillated. Frenulum intact. No masses/lesions/deviation.

Oropharynx: Well hydrated, no exudate/masses/lesions/erythema/postnasal drip/foreign bodies noted. Grade 1 tonsils. Uvula pink, midline with no lesions or edema.

Neck: Trachea midline. No masses/lesions/pulsations noted. Neck supple, non-tender to palpation. Free range of motion. No stridor noted. No cervical adenopathy. No carotid pulses/thrills/bruits heard on auscultation. Thyroid is non-palpable, unremarkable. No goiter

Lymph nodes: non-palpable, unremarkable preauricular, postauricular, submandibular, posterior cervical chain, anterior cervical chain, supraclavicular, and infraclavicular lymph nodes

Cardiovascular: PMI located at the 5th ICS in midclavicular line. Carotid pulses are 2+ bilaterally without bruits. Irregularly irregular RR If it’s irregular, then it’s not RR. S1/S2 distinct with no murmurs or S3/S4 heard. No splitting of S2 or friction rubs appreciated.

Chest: Symmetrical with no deformities or trauma. No tenderness on palpation. Respirations unlabored, no paradoxical respirations or use of accessory muscles. Lat/AP diameter 2:1.

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion/diaphragmatic excursion symmetrical. No adventitious sounds.

Abdomen: Abdomen symmetric and protuberant. No scars, striae, or pulsations noted. Bowel sounds are normoactive in all 4 quadrants. No aortic/renal/iliac/femoral bruits heard. Non-tender to palpation. No guarding or rebound tenderness. No hepatosplenomegaly to palpation. No CVA tenderness appreciated.

Skin: xerosis and scaling with hyperpigmented pruritic plaques noted over the bilateral proximal anterior thighs (left > right), lower abdomen (left > right), upper and lower back, posterior neck, and the dorsal aspect of the bilateral arm and forearm. Skin breakage on the left abdomen. Erythema and maceration of the inframammary folds under the breast bilaterally. Warm and moist with patches of xerosis. Non-icteric. No tattoos noted. No moles. Skin over the bilateral food was unremarkable without cracking or ulcerations.

Hair: Average quantity and distribution. No seborrhea/lice/dandruff noted

Nails: Capillary refill <2 seconds in bilateral upper and left lower extremities. Appropriate color, shape, and thickness.

Musculoskeletal: No soft tissue swelling / erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Non-tender to palpation.

Peripheral Vascular: 2+ pulses throughout. No ulcerations. Upper and lower extremities have normal skin color and warm to touch bilaterally. No calf tenderness bilaterally, equal in circumference. No palpable cords bilaterally. No palpable epitrochlear adenopathy.

Neurological: Peripheral sensations intact on feet bilaterally. A&O x person/place/time. Able to follow commands. The neuromusculoskeletal exam reads as normal – and yet this patient needs a rollator and has an unsteady gait. How can you reflect the deficits so that the next reader can understand why?

Psychiatric: Appropriate appearance, speech/language, mood, thought process/content. PHQ9 Score = 0. Mini Cog or similar in a patient with mild dementia?

**Labs:**

*12/29/21*

WBC 5.38 K/uL

HGB 11.4 (L)

A1c 7.3% (H)

HCT 36.7% [HCT should = 3xHgb. If it doesn’t, something isn’t right about one of the values]

MCV 89.1

Na 143 K 4.4 Cl 103 CO2 27

Alkphos 79

Total bilirubin 0.3

Creatinine 0.71

BUN 21

EGFR and Hgb A1-c?

**Differential Diagnosis:**

1. Drug Eruption
   1. Dermatitis that does not improve with clinical therapy and distributed along atypical regions such as the back of the neck and lower abdomen with other dermatologic conditions ruled out is suggestive of a drug eruption. Patient is taking multiple medications that could be inciting agent.
2. Atopic Dermatitis
   1. Xerosis, skin breakage, pruritis, and scaling are all common manifestations of atopic dermatitis. However, the distribution of the skin eruptions is inconsistent with atopic dermatitis.
3. Contact Dermatitis
   1. Possible chemical and physical offending agents such as bedding, detergent, soap have been removed without clinical improvement making this diagnosis less likely.
4. Cellulitis
   1. While cellulitis can cause erythema, there are no obvious signs such as swelling or warmth. Furthermore, cellulitis is typically isolated and skin manifestations seen in this patient are diffuse.

**Assessment:**

PR is an 88 y/o female with a PMHx of DM2, HTN, HLD, PVD, longstanding persistent atrial fibrillation, Osteoarthritis, and mild cognitive impairment that presents to the geriatric clinic for her routine follow up visit with ongoing complaint from her caregiver of persistent pruritis rash that has worsened since the last visit 2 months prior on 11/5/21. The last medications added to the patient’s management prior to the rash were Apixaban and Januvia on 10/5/21. Findings consistent with drug eruption. Ruled out atopic dermatitis, contact dermatitis, skin infection. Good synthesis here

**Plan:**

* Drug Eruption
  + Review medication list and remove suspected offending agents
    - Hold Januvia and switch Apixaban to Rivaroxaban
    - Pt previously taking Warfarin but was unable to maintain INR in therapeutic range
* Pruritis
  + Diphenhydramine (Benadryl) 25mg PO at bedtime PRN
* Allergic rhinitis
  + Continue Cetirizine as prescribed
* Intertrigo breasts bilaterally
  + Apply starch powder daily to dry area
  + Use a mild cleanser followed by drying of affected area daily, then apply zinc oxide
  + Aerate the affected area often
  + Patient advised to keep shirt off at home and place cotton cloth between the folds when feasible
  + Continue Econazole Nitrate 1% cream as prescribed
  + Discontinue Betamethasone Valerate 0.1% cream. Do not apply to areas of skin breakage.
* Diabetes Mellitus Type 2
  + Continue Metformin ER 1000mg PO 1x/daily
  + Hold Januvia 100mg PO
    - Possible cause of drug eruption. Need to r/o by elimination Was there some thought toward alternative med for sugar?
* Hyperlipidemia
  + Encouraged health diet/lifestyle
* Peripheral Venous Insufficiency
  + Encouraged low salt diet
  + Compression stockings advised
* Osteoarthritis
  + Acetaminophen 500mg PRN q6h for pain
* Longstanding persistent atrial fibrillation
  + HR today 86bpm
  + Continue Metoprolol ER 25mg
  + Replace Apixaban 5mg PO with Rivaroxaban 10mg as prescribed
    - Possible cause of drug eruption. Need to r/o by elimination
* Primary Hypertension
  + Continue Lisinopril 40mg, Metoprolol ER 25mg, Furosemide 40mg, and Amlodipine 5mg as prescribed
  + Monitor BP daily
* Healthcare Maintenance
  + Administered 1st dose of Shingrix for Herpes Zoster. Up to date with all other vaccines & boosters
  + DEXA unable to be completed due to body habitus
  + Screening mammogram and colonoscopy not indicated at this age
* Vitamin D Deficiency
  + Continue Cholecalciferol Vitamin D3 1000 units as prescribed
* Anemia, unspecified
  + DRE w/ iFOBT (Results: negative for occult blood)