**Identifying Data:**

Full Name: R.C.

Sex: Male

DOB: XX/XX/1953

Race/Nationality: Caucasian

Primary Language: English

Address: Queens, NY

Date & Time: 010:00AM 02/16/22

Location: NYPQ

Source of Information: Self and Medical Records

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** B/L leg swelling/redness worsening x2 weeks

**HPI:**

RC, 68 y/o M, PMHx HTN, HLD, Hodgkins Lymphoma in remission x13 yrs presented to ED 2/16 with cc b/l lower extremity swelling, warmth, and erythema that is painful (how many days). He was Tx outpatient with Abx (unsure of which one) by his PMD x1 week without improvement.

PQRST, pertinent +, pertinent negatives

hospital course:

Pt noted to have stable vitals, 2+ pitting edema b/l LE, & probable cellulitis. Workup negative for systemic infection/MRSA/MSSA. ID consulted for Cellulitis & pt started on Vancomycin IV 1250mg q12h x6 days. Cardiology consult recommended stopping home Amlodipine as possible contributor to LE edema & CHF, placed pt on Lisinopril 40mg.

Today 2/22, pt has clinical improvement of Cellulitis – area of swelling/redness decreased & pt denies pain to touch. Pt remains afebrile w/o leukocytosis. Plan to D/C home today w/ de-escalation of Vancomycin to Cefuroxime & Doxycycline PO x6 days. Denies fever, chills, SOB, CP, N/V/D, or recent trauma to the legs.

**Past Medical History:**

* Hodgkin Lymphoma – remission 2009. S/p chemo x2 & stem cell transplant
* HTN
* HLD
* Peripheral Neuropathy 2/2 Chemotherapy
* Anxiety
* Depression

*Immunizations and screening*

* Herpes Zoster (Shingrix 2 doses)
* Tdap
* Influenza (annually)
* SARS-CoV-2 (3 doses Moderna) - last dose
* Prevnar 13
* Pneumovax 23

**Past Surgical History:**

* Stem cell transplant 2009 (where)
* Carpel Tunnel B/L – date unknown

**Current Medications:**

*Outpatient Medications*

* Amlodipine Benazepril 5-20mg PO tablet daily
* Bupropion XL 300mg PO tablet daily
* Atorvastatin 20mg PO tablet daily
* Gabapentin 300mg PO tablet q8h

*Hospital Medications*

* Vancomycin 1250mg IV q12h
* Tylenol 640mg PO tablet q6h PRN
* Atorvastatin 20mg PO tablet daily
* Carvedilol 6.25mg PO tablet 2x/daily
* Furosemide 40mg PO tablet daily
* Lisinopril 40mg PO tablet daily
* Gabapentin 300mg PO tablet q8h
* Bupropion 300mg PO tablet daily
* Zolpidem 10mg nightly PRN
* Enoxaparin 40mg SC injection daily
* Pantoprazole 40mg PO tablet daily

**Family History:**

* Mother – emphysema & asthma, deceased
* Maternal grandmother – Alzheimer Dementia
* Father – unknown
* Children – none

**Social History:**

* Habits – Drinks alcohol socially. Quit smoking at 25 y/o. No reported illicit drug use
* Travel – Denies recent travel
* Occupation – retired
* Marital History – Single, never married
* Diet – Following low sodium, American diet
* Sleep – Difficulty falling asleep and maintaining sleep while in the hospital, pt believes due to anxiety. Sleeps throughout the night at home. Denies snoring.
* Exercise – No exercise regimen. Ambulates without assistance. Denies getting SOB when walking long distances. independent with all ADL:
* Sexual History – Not currently sexually active. Previous Hx w/ women.

**Review of Systems:**

* General
  + Denies generalized weakness, fatigue weight loss, loss of appetite**,** fever/chills/night sweats
* Skin, hair, nails
  + Denies rash, pruritis, excessive sweating, pigmentations, moles, change in hair distribution.
* Head
  + Denies headache, vertigo, or new head trauma
* Eyes
  + Admits to wearing glasses – last eye exam unknown
  + Denies visual disturbances or photophobia.
* Ears
  + Denies pain, discharge, tinnitus, hearing loss, 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 unknown
* Neck
  + Denies swelling/lumps, stiffness, or decreased ROM
* Pulmonary System
  + Denies cough, DOE, wheezing, hemoptysis, cyanosis, orthopnea, or PND
* Cardiovascular System
  + Denies chest pain, known murmur, palpitations, irregular heartbeat, or syncope
* Gastrointestinal System
  + Denies decreased appetite, intolerance to specific foods, N/V/Constipation, mild abdominal pain,diarrhea, dysphagia, pyrosis, flatulence, jaundice, changes in bowel habits, hemorrhoids, rectal bleeding/blood in stool.
* Genitourinary System
  + Denies incontinence, changes in frequency, nocturia, oliguria, polyuria, abnormal color of urine, flank plain, or dysuria
  + Sexual History – refer to Social Hx
* Nervous System
  + Denies changes in memory, seizures, headache, loss of consciousness, loss of strength, changes in cognition/mental status & ataxia
* Musculoskeletal System
  + Denies deformity, swelling, redness, pain over joints
* Peripheral Vascular System
  + Denies intermittent claudication, coldness/trophic changes, varicose, or color change
* Hematologic System
  + Hx of lymph node enlargement 2/2 Hodgkin’s. No Hx of DVT/PE, anemia.
* Endocrine System
  + Denies heat intolerance, polyuria/polydipsia/polyphagia, cold intolerance, excessive sweating, or hirsutism
* Psychiatric
  + **Admits to Hx of anxiety & depression – treated by PMD**
  + Denies Hx of obsessive/compulsive disorder or psychosis

**PHYSICAL EXAM**

Vital Signs:

BP: 147/72mmHg – sitting supine, L arm RR: 16 breaths/min Pulse: 60 bpm

T: 98.06F (oral) O2 SAT: 98% RA

Height: 5’8 inches Weight: 200 lbs BMI: 30.41 kg/m2

General Appearance: A&Ox3. No acute distress. Not diaphoretic. Appears reported age and well groomed. Sitting at bedside.

Head: normocephalic, atraumatic.

Eyes: PERRLA. No strabismus/exophthalmos/ptosis. Sclera white, cornea clear, conjunctiva pink. No erythema of lacrimal sack. EOM intact with no nystagmus. Wearing prescription glasses.

Ear: Appropriate in size. No lesions/masses/trauma visualized on external ear.

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

Mouth & Throat:

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

Oral Mucosa: Pink &Moist. No masses/lesions noted. No leukoplakia.

Palate: Pink. No visible lesions/masses/scars.

Teeth: Teeth mostly intact with multiple visible dental carries. All teeth have appropriate shape.

Gingivae: No hypertrophy or recession. Unremarkable

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

Oropharynx: 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. No stridor noted. No cervical adenopathy. No carotid pulses/thrills/bruits heard on auscultation.

Cardiovascular: PMI located at the 5th ICS in midclavicular line. Carotid pulses are 2+ bilaterally without bruits.RRR . No murmurs. Normal S1 & S2. No splitting of S2 or friction rubs appreciated.

Pulmonary: Chest symmetrical with no deformities or trauma. Lat/AP diameter 2:1. Normal chest expansion and diaphragmatic excursion. Lungs clear throughout with no adventitious sounds.

Abdomen: Abdomen symmetric and flat**.** No scars, striae or pulsations noted. Bowel sounds are normoactive in all 4 quadrants. No aortic/renal/iliac/femoral bruits heard.

Skin: **Erythema extending from foot to distal half of lower leg b/l. Marker lines drawn on proximal 1/3rd of lower leg b/l approx. 3-4 inches above erythema. Area of erythema without increased warmth, minimal swelling, non-tender to touch.** General skin warm and moist. Non-icteric. No tattoos noted. No visible moles.

Hair: Average quality, quantity, & distribution. No seborrhea/lice/dandruff noted

Nails: Capillary refill <2 seconds in bilateral upper and left lower extremities. **Onychomycosis of toenails b/l.**

Musculoskeletal: No erythema / ecchymosis / atrophy or deformities in bilateral upper and lower extremities.

Peripheral Vascular: **Peripheral IV in place in left forearm.** Warm to touch bilaterally. **2+ pulses throughout.** **Edema on LE b/l**. No ulcerations. Calves equal in circumference. No palpable cords bilaterally. No palpable epitrochlear adenopathy.

Neurological: **Peripheral sensations intact on feet bilaterally**. Able to follow commands.

**Labs:**











-Blood cultures negative x5 days

-SARS-CoV-2 negative x5 days

-Procalcitonin 0.06

*Coags:*

PT 12.7 PTT 29.7 INR 1.10

*Hepatic Function*

Bili 0.5 AST 24 ALT 19 Alk P 94

*Renal Function*

CrCl 69.6 ml/min eGFR >90

*Cardiac/Vascular/Inflammatory*

ProBNP 36

D-Dimer 435 (H)

CPR 3.37 (H)

ESR 35(H)

**Imaging Findings:**

*CXR impression:* No focal consolidation or significant pleural effusions. Chronic lung scarring with mild interstitial edema not excluded.

*TTE:* EF 60-65%. Severe posterior mitral valve annular calcification extending into posterior leaflets limiting its motion. No other valvular abnormalities.

*Venous Doppler b/l LE impression:* No DVT or venous insufficiency

*Arterial US b/l LE impression:* No significant arterial insufficiency

*Xray b/l foot impression:* Soft tissue swelling b/l. Some lucencies are noted in the lateral aspect of the R foot at the level of the tarsal bones/metatarsal bases. There is diffuse generalized osteopenia and bilateral plantar calcaneal and retrocalcaneal spurring.

**EKG Findings:** NSR. Ventricular rate 87bpm

**Differential Diagnosis:**

1. Peripheral LE edema
   1. CCB induced vs 2/2 cellulitis vs acute HF vs bilateral DVT
2. Erythema LE
   1. Cellulitis vs Erysipelas vs b/l DVT vs arterial insufficiency
3. Insomnia
   1. Physical pain vs Anxiety vs depression vs OSA vs irregular sleep schedule vs sleep disorder

**Assessment:**

68 y/o M PMHx HTN, HLD, Hodgkins Lymphoma cc b/l LE swelling, pain, warth, edema 2/2 cellulitis clinically improving with Vancomycin. Peripheral edema 2/2 Amlodipine. No apparent systemic infection. Plan to D/C home with PO Abx. Denies fever, chills, SOB, CP, N/V/D, or recent trauma to the legs.

**Plan:**

* Infectious Disease
  + #Cellulitis
    - No bacterial culture growth x5 days
    - Negative MSSA/MRSA via nasal swabs
    - De-escalate Vancomycin 1250mg IV q12h to outpatient Cefuroxime 500mg PO q12h x6 days & Doxycycline 100mg PO q12h x6 days
    - F/u with PMD within 1-2 weeks
* Cardiovascular
  + #LE edema, #HTN, # HLD
    - DVT r/o on venous doppler VS
    - Stop Amlodipine-Benazepril. Edema likely 2/2 CCB
    - C/w Furosemide qAM – Decrease dose from 40mg to 20mg
    - C/w Lisinopril 40mg daily & Carvedilol 6.25mg PO BID
    - C/w Atorvastatin 20mg PO tablet daily
    - F/u ambulatory cardiology referral
* Heme/Onc
  + #Hodgkin’s Lymphoma
    - Remission x13 yrs not currently on Tx
    - C/w Gapapentin 300mg q8h for peripheral neuropathy 2/2 chemotherapy
* Podiatry
  + #Onchymycosis
    - F/u ambulatory podiatry referral
* Psych
  + #Anxiety & #Depression
    - C/w Bupriopion XL 300mg
    - F/u PMD for continued mental health management
* Other
  + DVT PPx: Enoxaparin SC inj daily. Discontinue upon D/C
  + GI PPx: Protonix PO. Discontinue upon D/C.
  + Diet: oral (type..)
  + Code: Full
  + Disposition: Plan to D/C home today with PO Abx and ambulatory f/u to PMD, podiatry, & cardiology
  + activity: bed rest etc…PT…out of bed at lib etc