**Identifying Data:**

Full Name: E.U.

Sex: Male

DOB: XX/XX/1999

Race/Nationality: African American

Primary Language: English

Address: Queens, NY

Date & Time: 11:00AM 09/09/22

Location: CitiMed JFK

Source of Information: Self

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** Right knee pain

**HPI:**

E.U., 18 y/o male, denies PMHx presents with right knee pain after being involved in a car accident three days prior. Patient states that he was in the passenger seat when his vehicle rear ended another vehicle going approximately 20mph causing his right knee to hit the dashboard, at which point he felt a sudden, throbbing pain rated 7/10 worse with movement that has been constant since the incident. Airbags were deployed and window glass remained intact. Patient was then immediately brought to Jamaica Hospital by EMS. During that time he received 5 stitches for a laceration over the right knee and was given Ibuprofen 600mg and an ice pack with mild relief. X-rays of his cervical, thoracic, lumbar spine and right knee were negative for acute fracture. Patient was discharged the same day. Today he admits to 3/10 neck pain. Denies head trauma, LOC, vision changes, headache, dizziness, numbness/tingling, weakness, nausea/vomiting, abdominal pain, changes in urine/stool, SOB, or chest pain.

**Past Medical History:**

* Denies PMHx

*Immunizations*

* Up to date on childhood vaccinations
* SARS-CoV-2 (3 doses)

**Past Surgical History:**

* Denies PSHx

**Current Medications:**

* Denies any prescription or OTC medications

**Family History:**

* Mother – Prediabetes, Hypertension
* Father – healthy
* Sister – healthy

**Social History:**

* Habits – No alcohol use. Never smoker. No reported illicit drug use
* Travel – Denies recent travel
* Occupation – Student at trade school
* Marital History – Single
* Diet – No dietary restrictions. Reports eating standard American diet
* Sleep – Denies snoring. Sleeps 8-9 hours per night. Feels well rested
* Exercise – Plays pick-up basketball twice per week
* Sexual History – Denies sexual activity

**Review of Systems:**

* General
	+ Denies weakness, fatigue, weight loss, loss of appetite**,** fever/chills/night sweats
* Skin, hair, nails
	+ **Admits to laceration of the right knee**
	+ Denies rash, pruritis, excessive sweating, pigmentations, moles, change in hair distribution.
* Head
	+ Denies headache, vertigo, or new head trauma
* Eyes
	+ 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
	+ **Admits to neck pain**
	+ Denies swelling/lumps, stiffness, or decreased ROM
* Pulmonary System
	+ Denies dyspnea, cough, 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, 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
* Nervous System
	+ Denies weakness, loss of strength, changes in cognition/mental status, changes in memory, seizures, headache, loss of consciousness, & ataxia
* Musculoskeletal System
	+ **Admits to swelling/redness/pain of right knee**
	+ Denies deformity
* Peripheral Vascular System
	+ Denies intermittent claudication, coldness/trophic changes, varicose, or color change
* Hematologic System
	+ No Hx of DVT/PE, anemia, or lymph node enlargement
* Endocrine System
	+ Denies polyuria/polydipsia/polyphagia, heat/cold intolerance, excessive sweating, or hirsutism
* Psychiatric
	+ Denies Hx of depression/anxiety, or other psychiatric illnesses

**PHYSICAL EXAM**

Vital Signs:

BP: 116/64mmHg – sitting, L arm RR: 16 breaths/min Pulse: 68 bpm

T: 98.7F(oral) O2 SAT: 100% on room air

Height: 5’10 inches Weight: 240 lbs BMI: 34.4 kg/m2

General Appearance: Alert and oriented to person, place, and time. No acute distress. Not diaphoretic. Appears reported age and well groomed. Obese body habitus. Ambulating with crutches with ace bandage noted on right knee

Head: normocephalic, atraumatic.

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

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: No goiter. Trachea midline. No 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. regular rate/rhythm. 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. Clear to auscultation bilaterally. No adventitious sounds appreciated.

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

Skin: **Ace bandage wrap and gauze pad noted over the right knee, upon removal four lacerations were noted: lateral superficial laceration 0.5cm x 1cm, proximal superficial laceration 1cm x 1cm, and distal superficial laceration 1cm x 1cm all with pink granulation tissue, and medial 1cm deep laceration 3cm in length with 5 stitches noted, skin well approximated. No erythema, puss, drainage, increased warmth, or foreign body noted. Mild tenderness, ecchymosis, and non-pitting edema over the right knee.** Non-icteric. No tattoos noted. No visible moles. No other visible wounds, ecchymosis, or erythema to other body parts.

Hair: Average quantity, quality, 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 atrophy or deformities in bilateral upper and lower extremities.

**Cervical:** ROM flexion 50/50, extension 50/60, right lateral flexion 40/45, left lateral flexion 40/45, right rotation 80/80, left rotation 80/80. Non-tender to spine and paraspinal muscles

**Right knee:** ROM flexion 100/135, extension 0/0. Generalized tenderness. **Joint stability (valgus/varus stress test & anterior/posterior draw) deferred at this time due to multiple open wounds around the joint.**

**Left knee:** ROM 135/135, extension 0/0, nontender

**Right ankle/foot:** No ecchymosis, non-tender. Full ROM. Able to wiggle all toes

**Left ankle/foot:** No ecchymosis, non-tender. Full ROM. Able to wiggle all toes.

Peripheral Vascular: Warm to touch bilaterally. 2+ pulses throughout. No LE edema or ulcerations. Calves equal in circumference. No palpable cords bilaterally. No palpable epitrochlear adenopathy.

Neurological: Peripheral sensations intact on feet bilaterally. A&O x 3. Able to follow commands. DTR 2+ throughout.

**Procedure:**

Ace wrap and gauze padding were removed from the right knee. The wounds were cleansed with normal saline and betadine solution. Steri-strips were applied over the open wounds. A non-woven sponge was placed over the knee with a new ace bandage wrap.

**Differential Diagnosis:**

1. Knee
	1. Knee contusion
		1. Bone contusion
	2. Knee sprain/strain/dislocation
		1. Patellar dislocation/subluxation
		2. Tibiofemoral dislocation
		3. Osteochondral injury
	3. Torn ligament
		1. Medial or lateral collateral ligament tear
		2. Anterior cruciate ligament tear
		3. Meniscus tear
		4. Patellar tendon tear
		5. Posterior cruciate ligament tear
		6. Quadriceps tendon tear
	4. Knee fracture
		1. Intra-articular fracture
		2. Fibular head or neck fracture
		3. Patella fracture
2. Neck
	1. Cervical strain
	2. Whiplash injury
	3. Cervical radiculopathy

**Assessment:**

18 y/o male no PMHx with right knee pain and cervical neck pain secondary to injury from MVA three days prior.

**Plan:**

* Right Knee
	+ Referral for MRI to rule out tendon/ligament injuries
	+ Change wound bandage daily. Cleanse with non-scented soap and water, pat dry
	+ Continue to ambulate with crutches
	+ Referral for physical therapy pending MRI results
	+ Ibuprofen 600mg every 6 hours
	+ Follow up in one week to evaluate wound healing
		- Remove stitches
		- Perform joint stability testing at that time
		- Review MRI results
* Neck
	+ Apply Lidocaine 5% ointment once daily as needed
	+ Re-evaluate pain level and ROM next visit to determine the need of further imaging
	+ Referral for physical therapy
	+ If numbness/tingling/weakness or vision changes occur go to nearest ER immediately