**Identifying Data:**

Full Name: C.B.

Sex: Male

DOB: XX/XX/1942

Race/Nationality: African American

Primary Language: English

Address: Queens, NY

Date & Time: 06:00AM 11/11/22

Location: NYPQ

Source of Information: Self & Medical records

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:**

**HPI:**

C.B., 80 y/o M, PMHx HTN, CHF, BPH, Thyroid Cancer with lung metastasis (2007) s/p thyroidectomy with iatrogenic hypothyroidism, prostate cancer (2000) s/p radiation and perianal abscess with fistula s/p incision and drainage in the OR with a seton placement (2021), and right gluteal abscess (Planned debridement 09/22 with Dr. Satterfield but lost to follow up) who presented with progressively worsening right sided hip pain that radiates to the right knee that worsens when he tries to walk x3 months. He ambulates with cane at baseline but has been unable to secondary to pain for the last week. Pt denies relieving factors or treatments to relieve pain. Admits to malodorous drainage from right buttocks, bowel incontinence, and 4/10 chest pain. Denies shortness of breath, fever, chills, nausea, vomiting, abdominal pain, headache, lethargy, or changes in urination.

*Hospital Course:*

Chest pain present upon admission spontaneously resolved. Troponin T, BNP, EKG were all within normal limits. Patient admitted for right gluteal abscess fistulizing to rectum. On admission, patient had leukocytosis of 18.10 with left shift which is decreased to 13.2 with an overall downward trend upon discharge. Chest x-ray showed no focal consolidations or blunting of costovertebral angels. DRE was positive for fecal occult blood.

Patient underwent surgery for colostomy with seton removal on 11/4/22. Post-operative course complicated by ileus. A nasogastric tube was placed on 11/9 for the ileus and removed on 11/11 after resolution of abdominal distention and pain. Foley was removed 11/10/22 after having trial of void.

**Past Medical History:**

* Prostate Cancer with lung metastasis (2000) s/p radiation
* Perianal abscess (2021)
* Right gluteal abscess (2022)
* Thyroid Cancer (2007)
* Iatrogenic hypothyroidism
* Hypertension
* Congestive Heart Failure
* Benign Prostatic Hypertrophy

*Immunizations*

* Up to date on adult immunization schedule
* Influenza (annually)
* SARS-CoV-2 (3 doses)

**Past Surgical History:**

* Thyroidectomy 2007
* EUA Incision and Drainage of perirectal abscess 2021
* Hernia repair
* “Wrist replacement”

**Current Medications:**

* Ciprofloxacin 500mg PO tablet twice daily for five days.
* Metronidazole 500mg PO tablet three times daily for five days
* Acetaminophen 325mg PO three tablets by mouth every 8 hours as needed
* Amlodipine 5mg PO tablet once daily
* Lenvatinib 20mg PO tablet once daily with dinner
* Levothyroxine 137mcg PO tablet twice per week
* Aspirin 81mg PO tablet once daily
* Calcitriol 0.5mcg PO tablet once daily
* Carvedilol 12.5mg PO tablet twice daily
* Ergocalciferol 1.25mg PO tablet (50,000UT) once daily
* Folic acid 1mg PO tablet once daily
* Tamsulosin 0.4mg PO tablet once daily

**Family History:**

* Mother – No Hx cancer
* Father – No Hx cancer

**Social History:**

* Habits – No current alcohol use. Previously social drinker. Never smoker. No reported illicit drug use
* Travel – Denies recent travel
* Occupation – retired
* Marital History – Widowed
* Diet – American Diet
* Sleep – Sleeps 8 hours per night, denies snoring
* Sexual History – Not currently sexually active. No history STIs. Previous Hx w/ women.

**Review of Systems:**

* General
	+ Denies generalized weakness/fatigue, weight loss, loss of appetite**,** fever/chills/night sweats
* Skin, hair, nails
	+ **Admits to abscess in buttocks**
	+ Denies rash, pruritis, excessive sweating, changes in 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
	+ Denies swelling/lumps, stiffness, or decreased ROM
* Pulmonary System
	+ Denies cough, wheezing, dyspnea, 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 generalized weakness, loss of strength, changes in cognition/mental status, changes in memory, seizures, headache, loss of consciousness, & ataxia
* Musculoskeletal System
	+ **Admits to right hip pain radiating to right knee**
	+ Denies deformity, swelling, redness, pain
* 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 anxiety, depression, obsessive/compulsive disorder, or other psychiatric illnesses

**PHYSICAL EXAM**

Vital Signs:

BP: 132/73mmHg – lying supine, L arm RR: 18 breaths/min Pulse: 63 bpm

T: 36.3C(oral) O2 SAT: 98%

Height: 5”10 inches Weight: 145lbs BMI: 20.8 kg/m2

General Appearance: Alert and oriented x3. No acute distress. Not diaphoretic. Appears reported age and well-groomed in hospital gown. Appropriate body habitus.

Head: normocephalic, atraumatic.

Eyes: PERRLA. No strabismus/exophthalmos. Sclera white, cornea clear, conjunctiva pink. No erythema of lacrimal sack. EOM intact with no nystagmus. Not wearing 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: Appropriate size. 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 goiter. 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. 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. No adventitious sounds.

Abdomen: **Abdomen symmetric and soft with mild distention. Well healing midline surgical wound with staples intact extending midway between the sternum and umbilicus down to the superior aspect of the pelvis. No erythema, increased warmth, edema, pus, or drainage noted from the surgical wound site. Ostomy site present with pink to red, moist stoma and ostomy bag with semi-solid brown stool. Skin around ostomy bag intact without erythema or blistering. No striae or pulsations present. Bowel sounds are normoactive in all four quadrants. No aortic/renal/iliac/femoral bruits heard.**

Skin: **Right gluteus with open abscess, recently drained and now without pus that fistulizes to the rectum. Stool leakage noted from mucus fistula site.** Warm and moist. Non-icteric. No tattoos noted. No visible moles.

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

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

Musculoskeletal: No erythema / ecchymosis / atrophy or deformities in bilateral upper and lower extremities. 5/5 strength throughout. Decreased ROM of right lower extremity secondary to pain.

Peripheral Vascular: Warm to touch bilaterally. 2+ pulses throughout. No edema or 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:**

*Completed 11/13/22*

134

12.1

112

98

0.87

24

4.4

11.4

18.10

342

34.2

|  |  |  |
| --- | --- | --- |
| Basic Metabolic Panel:Sodium Level 134 (\*)   Potassium Level 4.4   Chloride Level 98   Carbon Dioxide 24   Blood Urea Nitrogen 12.1   Creatinine 0.87    Glucose Level 112 (\*)    Anion Gap 12    Calcium Level Total 8.6   BUN/Creatinine Ratio 14 | CBC w/ Diff:  White Blood Cell 18.10 (\*)   Red Blood Cell 3.38 (\*)   Hemoglobin 11.4 (\*)    Hematocrit 34.2 (\*)    MCV101.2 (\*)    MCH 33.7    MCHC 33.3    Red Cell Diameter Width 12.3   Platelet 342,000  Mean Platelet Volume 9.8   Nucleated RBC Auto 0.00   Absolute NRBC 0.00   | Hepatic Function Panel:  Protein Total 7.0    Albumin Level 3.2 (\*)    Globulin 3.8    Bilirubin Total 1.1    Bilirubin Direct 0.2    Bilirubin Indirect 0.9    Aspartate Aminotransferase 16    Alanine Aminotransferase 12    Alkaline Phosphatase 54 |

PTT/INR:

  Prothrombin Time 15.8 (\*)

  International Normalization Ratio 1.36 (\*)

Fecal Occult Blood Test:

  Occult Blood Stool: Positive (\*)

BNP:

  NT-proBeta-Natriuretic Peptide 190

Lipase:

  Lipase Level 18

Troponin T:

  Troponin-T <0.010

Type & Screen:

  ABORh O Rh Positive

Activated PTT:

  Activated Partial Thromboplastin Time 29.2

Estimated GFR:

  Higher GFR estimate (approximate) >90

  Lower GFR estimate (approximate) 82

SARS-COV-2 NAAT:

  SARS-CoV-2 NAAT Not Detected

*CT Imaging:*

Large 6.6cm collection within the right hemipelvis/right buttock containing air and feces and communicating with the rectum. There is also involvement of the prostate.

**Differential Diagnosis:**

1. Right gluteal abscess w/ Fistula
2. Septic arthritis
3. Osteoarthritis of hip
4. Piriformis syndrome
5. Avascular necrosis of femoral head

**Assessment:**

C.B., 80 y/o M, PMHx HTN, CHF, BPH, Thyroid Cancer with lung metastasis s/p thyroidectomy with iatrogenic hypothyroidism, prostate cancer s/p radiation and perianal abscess with fistula s/p incision and drainage in the OR with a seton placement, and right gluteal abscess who presented with progressively worsening right sided hip pain that radiates to the right knee that worsens when he tries to walk x3 months.

**Plan:**

* Gluteal Abscess with mucus fistula
	+ Initial management with IR drain
	+ Surgical diverting colostomy with sigmoidoscopy
		- Colostomy teaching prior to discharge
		- Diet slowly advanced from clear liquids to solids
		- Postop Abx with Ceftriaxone IV then switch to oral antibiotics for 5 days upon discharge
	+ Seton Removal
	+ Pain control with Acetaminophen PRN
	+ Trend CBCs
		- Downward trend of WBC’s over hospital course
	+ Home care evaluation
* Post-op Ileus
	+ Bowel rest
	+ NG tube placement
	+ Pain Control with Acetaminophen PRN as mentioned above
* Urinary retention
	+ Foley catheter placed, failed trial of void, then subsequently passed before discharge
* Other
	+ DVT PPx: Hep SQ
	+ Diet: advance from clear liquids as tolerated
	+ Code: Full
	+ Disposition: Home with homecare upon improvement and stabilization of condition. D/C date 11/11/22.