Ling Yi Mei

Rotation 9: Internal Medicine HP#3

**Identification:**

Patient’s name: BT

Gender: F

Age: 33

Race: African American

Location: NYPQ, Internal Medicine

**Informant**: self, reliable

**CC:** “pain”

**HPI:**

33 y.o African American female with PMHx of hemoglobin-SS disease, acute chest syndrome, sickle cell crisis, subclavian tunnel catheter and chronic anemia was admitted to the medicine floor for worsening back and groin pain x 4 days prior to admission. She stated that the pain radiated from her mid back down to bilateral groin area. She was not getting any relief with home pain meds such as oxycodone 30 mg q4h, morphine sulfate IR 5mg 2 tabs q4-q6, and fentanyl patch 100 mcg q72 hrs. She was also using warm compresses to help alleviate some of the pain with minimal relief. She admitted to one episode of non-bilious, non-bloody vomiting. She was last admitted for sickle cell crisis in June 2019. Denies recent trauma, strenuous activity, chest pain, SOB, fever, chills, abdominal pain, or diarrhea.

**PMH:**

Hemoglobin SS disease

Acute chest syndrome

Sickle cell crisis

Chronic anemia

Anxiety

**Past Surgical History:**

Denies surgical history

**Medications:**

Oxycodone 30 mg PO, 1 tab PO q4h

Morphine IT 15mg PO, 2 tab q4-6h, prn

Hydroxyurea 500 mg PO, 2 cap bid

Folic acid 1mg PO, 1 tab qd

Fentanyl 100 mcg/hr transdermal film extended release, q72h

Lorazepam 0.5 mg PO, 1 tab 3 times/week

**Allergies:**

NKDA

Denies food, seasonal, or contact allergies.

**Social History:**

Lives with family. Denies the use of alcohol, tobacco, and illicit drug.

**ROS:**

General: Patient denies recent weight loss or weight gain, loss of appetite, generalized weakness, fatigue, fever, chill or night sweats

Skin, Hair, Nails: Patient denies any changes of texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, or changes in hair condition

Head: Patient denies headache, vertigo, head trauma, or fracture

Eyes: Patient denies visual disturbance, lacrimation, photophobia, pruritus

Ears: Patient denies deafness, pain, discharge, tinnitus

Nose/Sinuses: Patient denies discharge, epistaxis, or obstruction

Mouth and throat: Patient denies bleeding gums, sore tongue, sore throat, mouth ulcers

Neck: Patient denies stiffness or decreased range of motion.

Breast: Patient denies lumps, nipple discharge, pain

Pulmonary System: Patient denies DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea.

Cardiovascular System: Patient denies chest pain palpitations, edema, syncope, or known heart murmur.

Gastrointestinal System: Patient denies changes in appetite, intolerance to specific foods, nausea, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool

**Patient reports vomiting**

Genitourinary System: Patient denies changes in frequency, nocturia, urgency, oliguria, polyuria, dysuria, change in color of urine, incontinence, awakening at night to urinate, or pain

Sexual history: Patient denies hx of STIs.

Menstrual and Obstetrical:

Patient last normal period is 15 days ago, the time of menarche is 13, her menstrual cycle is 28 days with medium flow without clots. Patient denies postcoital bleeding, dyspareunia, G0P0000

Nervous System: Patient denies seizures, headache, loss of consciousness, sensory disturbances, numbness, paresthesia, dysesthesias, ataxia, loss of strength, change in cognition, mental status, memory, or weakness

Musculoskeletal System: Patient denies joint pain, deformity or swelling, redness, arthritis

**Patient reports back pain and bilateral groin pain**

Peripheral System: patient denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes

Hematological System: Patient denies anemia, easy bruising or bleeding.

Endocrine System: Patient denies polyuria, polydipsia, polyphagia, heat or cold intolerance or goiter

Psychiatric: Patient denies depression, sadness, feeling of helplessness, hopelessness, lack of interest in usual activities, anxiety, obsessive or compulsive disorder, seen a mental health professional, or use medications

**Physical Examination:**

General: 33 years old female is alert and cooperative. She is well dressed and appear to be acute distressed and in pain. Obese female, neatly groomed, looks like her stated age of 33 years. Well developed.

Vital Signs:

BP (seated): 119/90

HR: 107 BMP, regular

RR:  19

Temp: 98 F oral

O2 sat: 98% room air

Skin: Warm & moist, good turgor. Nonicteric, no lesions noted

Hair: Average quantity and distribution

Nails: No clubbing, capillary refill <2 seconds throughout.

Head: Normocephalic, atraumatic, non-tender to palpation throughout

Eyes: Symmetrical OU; no strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. EOMs full with no nystagmus.

Ears: Symmetrical and normal size. No lesions, masses, trauma on external ears.

Nose: Symmetrical with no masses, lesions, deformities, or trauma.

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses

Lips: Pink, dry, no cyanosis or lesions

Mucosa: Light pink, dry, no masses, lesions, or leukoplakia

Tongue: Pink, no masses, lesions, or deviations noted

Oropharynx: Hydrated, no injection, exudate, masses, lesions, or foreign body. Tonsil present with no injection or extrudate, uvula light pink, no edema or lesions

Neck: No lesions, mass, or scars. Trachea midline, pulsation noted. Supple nontender to palpation.

Thyroid: Nontender, no palpable masses, no thyromegaly

Chest: Symmetrical, lat to AP diameter 2:1, no deformities, no trauma. Respirations unlabored. Nontender to palpation.

Lungs: Clear to auscultation and percussion bilaterally. No wheezing, crackles, rales

Heart: S1, S2 without murmur, no gallops, S3 or S4. RRR.

Abdomen: Flat, symmetrical, no scars. Bowel sounds in all 4 quadrants. No bruits. Tympany to percussion throughout. Nontender to percussion or to light and deep palpation. No organomegaly, guarding, or rebound tenderness. No CVAT bilaterally

Female genitalia: exam deferred. **+ tenderness to palpation in b/l groin.**

Rectal: exam deferred.

Peripheral vascular: The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities.

Neurological:

Mental status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted

Cranial nerve:

II- Visual fields by confrontation full.

III-IV-VI- PERRLA, EOM intact without nystagmus.

V- Facial sensation intact, strength good.

VII- Facial movements symmetrical and without weakness.

VIII- Hearing grossly intact bilaterally.

IX-X-XII- Uvula elevates midline. Tongue movement intact.

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar: Full active and passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout).

Sensory: Intact bilaterally

Musculoskeletal System/Upper extremities and lower extremities: No soft tissue swelling, erythema, ecchymosis, atrophy or deformities in bilateral upper and lower extremities. Full range of motion of all upper and lower extremities bilaterally. No spinal deformities. **+ tenderness to palpation from thoracic region down to lumbar region.**

**Lab/Imaging:**

CMP: wnl

Anion Gap: wnl

Ca2+: wnl

CBC: Hb 7.6 MCV 90.8, Hct 22.7, WBC 17.48

CXR: mild left basilar atelectasis. No focal consolidation or significant pleural effusion. Skeletal sequela of sickle cell disease.

Lumbar Spine XR: Chronic diffuse endplate depressions, consistent with sequela of sickle cell disease. Normal vertebral body height and alignment.

**Assessment/Plan:**

Patient is a 33yo F from home with PMHx of hemoglobin-SS disease, acute chest syndrome, sickle cell crisis, subclavian tunnel catheter and chronic anemia presenting with 4 days over worsening back and groin pain. She is being admitted for pain crisis.

#Pain crisis secondary to sickle cell anemia

* 3 doses of dilaudid 4mg IV given. Continue with dilaudid 4mg IV Q4H and titrate up if needed for pain.
* ordered dilaudid 2mg Q2H PRN for severe pain and discontinued lorazepam
* continue with hydroxyurea 500mg BID and fentanyl 100mcg patch
* incentive spirometer and fluid maintenance NS at 100cc/hr
* f/u CPK level
* pain management consult

Chronic anemia

* keep type and screen active.
* Monitor Hgb/Hct

#DVT ppx

* Heparin sq