Andres Hernandez
Mr. Fahim Sadat
2/25/2024

H&P #1 – Urgent Care

Identifying Data:
Full Name: D.A.
Address: Queens, NY
Date of Birth: 1/15/1986
Age: 38
Date: 2/07/2024, 5:00 pm
Location: Centers Urgent Care of Middle Village, Queens
Religion: Unspecified
Marital Status: Single
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Self

CC: "Abscess" x 2 days

HPI:
A 38-year-old male with no past medical history presents to urgent care complaining of a worsening abscess at the waistline. The patient, a truck driver, attributes the development of the abscess to irritation from the friction of his pants against the skin throughout the day. Onset occurred two days ago, with the patient reporting severe, throbbing pain localized to the abscess site, rated at 7/10 in intensity. Today, the patient notes an escalation in symptoms, with increased erythema, skin temperature, and swelling compared to previous days. Pt. denies any discharge or bleeding from the site. The patient recalls a similar incident a couple of years ago when he experienced an abscess on his chest that was drained by a dermatologist. Unable to secure a timely dermatologist appointment this time, he sought urgent care. The patient denies any associated fevers, chills, recent insect bites, or shortness of breath.

Past Medical History:
Pt. denies diabetes or hyperlipidemia.
Denies any childhood illnesses.

Past Surgical History:
Pt. denies any surgical history other than I&D for previous abscess.
No history of transfusions.

Medications:
Denies medication use
Supplements: Denies

Allergies:
Denies any allergies to medications.
Denies food allergies.
Denies environmental allergies.

Family History:
Father – unknown.
Mother – unknown.

Social History:
Job- truck driver.
Smoking – Pt. denies smoking cigarettes.
Illicit Drugs – Denies use of drugs.
Alcohol – Denies alcohol use.
Diet – Denies a specific diet.
Exercise – Pt. denies exercise other than work.
Caffeine – Does take coffee at least two cups per day.
Sleep – Pt. admits sleeping varies according to work.
Sexual Hx – Sexually active with one partner and no history of STIs.

Immunizations
Up to date on vaccinations including COVID-19 vaccine and the flu vaccine.

ROS:
General– Denies and fatigue, weight loss or gain, loss of appetite, fevers, chills, night sweats.
Skin, Hair, Nails – Denies skin (other than the formation of abscess) or hair changes. Denies discolorations, pruritus, or moles.
Head – Denies trauma or vertigo. Admits to headache.
Eyes –Does not recall last eye exam.
Ears – Denies ear pain or discharge.
Nose/sinuses – Denies pain, discharge, epitaxies, or difficulty nasal breathing.
Mouth/Throat – Denies sores, sore throat, or voice changes. Pt. does not recall last dentist visit.
Neck – Denies swellings, pain, or neck stiffness.
Respiratory– Denies dyspnea or respiratory changes.
CVS – Denies chest pain, palpitations, irregular HR, or lower extremity swelling.
GI –Denies abdominal pain, diarrhea, constipation, flatulence, bloating, or change in appetite.
GU –Denies burning, urinary frequency, incontinence, and pelvic pain. Patient denies any flank plain.
Peripheral Vascular System – Denies intermittent claudication, edema, skin changes, or varicose veins.
Musculoskeletal – Denies weakness or muscle pain. Admits to osteoarthritis in both hands.

Nervous – Denies loss of strength or any seizures. Denies numbness, ringing, or sensory disturbances. Denies change in mental status. Denies any changes in cognition, mental status, or memory.
Hematologic system – Denies easy bruising. Denies bleeding or anemia. Denies lymph node enlargement. Denies blood transfusions.
Endocrine – Pt. denies cold intolerance, excess sweating, or abnormal hair growth in any region. Denies polydipsia.
Psychiatric – Denies any loss of interest in things patient enjoys. Denies any constant worrying. Denies feeling hopelessness and anxiety. Denies any suicidal thoughts or OCD. Doesn't have a history of taking psychiatric medications. Denies seeing a therapist.

Physical:
General: Appears of age, neatly groomed, alert & oriented x 3, responding to all questions thoroughly without trouble or discomfort.

Vitals:
BP: 128/88
RR: 12 breaths/min, unlabored, regular rhythm breathing
Pulse: 88 beats/min, regular rate & rhythm
Temp: 98.2 F, oral
Height: 5'8"
Weight: 240 lbs.
BMI: 36.5 kg/m2

Skin: Skin is warm & moist. Good turgor. Non-icteric. The affected area, at the waistline, has an erythematous area with a single elevated lesion. It is a fluctuant pustule with no surrounding cellulitis. No lesions, bruising, or scars on the upper extremities, chest or back. No tattoos noted.

Hair: Normal texture, areas of male patterned baldness. No lice. No seborrheic dermatitis.

Nails: No clubbing, cap refill <2 seconds in both upper extremities. No splinter hemorrhages noted. No signs of trauma or swelling. No Beau's lines.

Head: Normocephalic, atraumatic. No lesions or discoloration seen on scalp. Non tender to palpation throughout the head. Face symmetrical, no lesions, or unvoluntary movements.

Eyes: Symmetrical OU. PERRLA. EOMs intact with no strabismus, no nystagmus, no lid lag. Normal convergence. No exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink and clear w/o exudates. Visual fields full OU.
Visual acuity uncorrected - 20/20 OS, 20/20 OD, 20/20 OU.
Fundoscopy - Red reflex intact OU. Cup to disk ratio < 0.5 OU. No AV nicking, papilledema, hemorrhages, exudates, cotton wool spots, or neovascularization OU.

Ears: Symmetrical and appropriate in size. No lesions or trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TM's pearly gray, intact, cone of light in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne AC>BC AU.

Nose: Symmetrical nares; no masses, lesions, trauma, discharge, or deviated septum. Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. No foreign bodies or polyps noticed B/L. Septum is midline without lesions, deviation, perforation, or inflammation.

Sinuses - Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Mouth/Throat: Lips- Pink and dry; no lesions.
Oral Mucosa - Pink, moist mucosa. No masses, lesions, erythema.
Palate - Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation; continuity intact.
Teeth- Presence of cavities. Otherwise, good dentition for age, no loose teeth.
Gingivae and Tongue -Pink; moist. No hyperplasia, masses, lesions, erythema, or discharge.
Oropharynx- Well hydrated; no exudate; masses; lesions; foreign bodies. Uvula pink and midline, no deviations, no edema, lesions. Tonsils present, grade 1, with no erythema or exudate.

Neck: Trachea midline. No masses, lesions, scars; pulsations noted. Supple; non-tender to palpation. No carotid artery bruit. No cervical adenopathy noted.
Thyroid- Non-tender, no palpable masses, no thyromegaly.

Chest and Lungs: Symmetrical, no deformities, no trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout. Lungs- CTAP bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.

Heart: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, no S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdomen: Abdomen flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated

Rectal: Rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative.

Male Genitalia: Circumcised male. No penile discharge or lesion. No scrotal swelling or discoloration. Testes descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias noted.

Mental status exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to name, date, time and location. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.

Cranial Nerve: CNI correctly identifies coffee and mint odors bilaterally.
CNII visual fields full by confrontation, visual acuity 20/20 OD, OS, OU, uncorrected, red reflex present, cream color discs with sharp borders, no hemorrhages, no exudates or crossing phenomena.
CN III, IV, VI extraocular movements intact, pupil size and shape equal, and reactive to direct and consensual light and accommodation, no ptosis.
CN V face sensation intact bilaterally, corneal reflex intact, jaw muscles are string without any atrophy.
CN VII facial expressions intact, clearly enunciates words, strong eye muscles that hold against resistance.
CN VIII patients can hear hair rubbing between fingers, Weber – no lateralization, Rinne – AC>BC.
CN IX and X uvula midline with elevation of soft palate, gag reflect intake, no difficulty swallowing.
CN XI full range of motion at the neck with 5/5 strength and strong shoulder shrug.
Cn XII tongue midline without fasciculation, good tongue strength.

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Symmetric muscle bulk with good tone. No atrophy, tics, tremors, or fasciculation. Strength 5/5 throughout. Rhomberg negative, no pronator drift noted. Gait steady with no ataxia. Tandem walking and hopping show balance intact. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis

Sensory: Intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally

Reflexes: 2+ throughout, negative Babinski, no clonus appreciated

Meningeal Signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Extremities: No soft tissue swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. Non-tender to palpation, no crepitus noted throughout. Full range of motion of all upper and lower extremities bilaterally. No evidence of spinal deformities.

Peripheral Vascular: The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy.

Assessment:
A 38-year-old male seeks care at urgent care due to a developing abscess at the waistline. The patient reports a recent escalation of symptoms, characterized by heightened redness, swelling, and increased warmth to the touch at the affected site. The patient denies concurrent fevers, chills, insect bites, or respiratory symptoms. Upon physical examination, the affected area at the waistline displays an erythematous zone housing a solitary, elevated lesion. Notably, the lesion is fluctuant, consistent with a pustule, and there is an absence of surrounding cellulitis.

Differential Diagnosis:
Folliculitis: Inflammation of the superficial portion of the hair follicle (superficial dermis). Inflamed papule around a hair follicle without any areas of fluctuance. Most caused by S. aureus, although infections can be caused by other bacterial, fungal, viral, parasitic. Presents with follicular pustules and follicular erythematous papules. Can happen in any hair-bearing area, however the scalp, face, upper trunk, buttocks, legs, and axilla are common areas.

Furuncle: Erythematous area of skin with fluctuant pustule or nodule on the deeper subcutaneous space involving a hair follicle. Does not involve surrounding cellulitis.

Carbuncle: Clusters of multiple, erythematous, subcutaneous fluctuant pustules or nodules with purulent drainage. It is a cluster of furuncles that connect in subcutaneous space, therefore it has an area of fluctuance greater than furuncle and there might be clusters. There might be cellulitis surround the area.

Cellulitis: Infection that affects the deeper layers of the dermis and the subdermal tissues. Most often caused by Group A Strep, MRSA and Strep pyogenes. Presents as macular erythema, swelling, warmth, and tenderness. May have signs of abscess and necrotizing soft tissue. Can sometimes present with or without systemic symptoms. Systemic symptoms includes fever, chills, regional lymphadenopathy, myalgias.

Hidradenitis Suppurativa: Also known as acne inversa. Chronic inflammatory skin condition and found in areas of the skin with high concentrations of apocrine sweat glands such as the armpits. Intertriginous area are most commonly affected. Develops sinus tracts and draining tracts. Relapsing and Chronic.

Plan:
Incision and drainage: Make sure to open and drain all pus pockets to ensure complete evacuation of the infection trapped underneath the skin.

Place sterile gauze over the area: without packing to help soak up any additional pus and blood.

Oral Antibiotics: Clindamycin (450 mg every eight hours)

Reassess: Advise patient to follow-up with dermatologist or return to urgent care in 48 to 72 hours of therapy especially if symptoms worsen. Such as area if fluctuance is still present or becomes larger. If there is an adequate response to I&D and antibiotics, then therapy is considered complete.