Andres Hernandez
Mr. Fahim Sadat
3/1/2024

H&P #2 – Urgent Care

Identifying Data:
Full Name: S.P.
Address: Queens, NY
Date of Birth: 9/17/2003
Age: 20
Date: 3/28/2024, 4:00 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: "Pain in esophagus" x 5 days

HPI:
A 20-year-old female with an occasional history of acne presents with progressively worsening retrosternal pain that started approximately one week ago. The patient describes the pain as a burning sensation in the chest, particularly behind the sternum. This discomfort intensifies with swallowing, deep breaths, and with pressure on the sternum. Today, the patient had the most severe episode of pain since onset, which peaked at an intensity of 7/10. The pain is accompanied by difficulty in swallowing both solids and liquids. Notably, the patient initiated a course of doxycycline prescribed for acne treatment three weeks ago. However, she discontinued the medication five days ago due to the onset of her current symptoms. The patient denies any history of heartburn, nausea, vomiting, or shortness of breath.

Past Medical History:
Moderate to severe acne vulgaris.
Pt. denies diabetes or hyperlipidemia.
Denies any childhood illnesses.

Past Surgical History:
Pt. denies any surgical history.
No history of transfusions.

Medications:
Doxycycline – 100 mg once daily PO (before discontinuing)

Supplements: Denies

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

Family History:
Father – unknown.
Mother – unknown.

Social History:
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 not drink coffee or any energy drinks.
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– The patient does not describe being in any acute distress. 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. Denies headache.
Eyes –Does not have any ocular symptoms or abnormalities. 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 the 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 – Pt. admits to abdominal pain in the epigastric region but denies diarrhea, constipation, flatulence, or bloating. Slight 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. Denies deformity, swelling, redness, h/o arthritis.
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 – Admits to dealing with more stress than usual. However, 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: 122/82 mmHg
RR: 16 breaths/min, unlabored, regular rhythm breathing
Pulse: 90 beats/min, regular rate & rhythm
Temp: 98.6 F, oral
Height: 5'6"
Weight: 115 lbs.
BMI: 18.1 kg/m2

Skin: Skin is warm & moist. Good turgor. Non-icteric. No lesions, bruising, or scars on the upper extremities, chest or back. No tattoos noted.

Hair: Normal texture and hair distribution. No dryness, sweating, discoloration, pigmentations, moles, rashes, or pruritus. 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. Patient is tender to palation over the sternal region. In the 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.

Abdomen was tender to palpation in the epigastric region only. The rest of the quadrants were 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:
20 year-old female seeks care at the urgent care due to progressively worse retrosternal pain that began approximately one week ago. The patient reports a recent escalation of symptoms associated with difficulty in swallowing both solids and liquids. Pt. admits that the pain is the worst it's ever been since onset today, intensity a 7/10. The patient initiated a course of doxycycline, which was prescribed for the treatment of acne 3 weeks ago. The patient discontinued taking doxycycline after her pain initiated 5 days ago. Pt denies any heartburn, nausea, vomiting, or shortness of breath. Upon physical examination, the patient shows tenderness over the sternal area and epigastric area. Other findings suggest a generally normal physical exam with no overt abnormalities in the systems assessed.

Differential Diagnosis:
Pill Esophagitis: Medications can induce esophageal mucosal injury. The mean age at diagnosis is 41.5 years, with a slightly higher prevalence in females. Antibiotics account for approximately 50 percent of reported cases of pill esophagitis, with tetracyclines being the most common antibiotic class.

Costochondritis: Costochondritis is a condition that causes pain and tenderness in the chest. The pain occurs in an area called the costosternal joints, where the ribs meet the breastbone. It presents with pain and tenderness in the chest, which can be sharp or dull. Pain associated with taking a deep breath or coughing may also occur.

GERD: A condition that develops when the reflux of stomach contents causes troublesome symptoms. Classic symptoms of GERD include heartburn, regurgitation, dysphagia, chest pain, odynophagia, and extraesophageal symptoms such as chronic cough, hoarseness, and infrequently, nausea.

Achalasia: Degeneration of ganglion cells in the myenteric plexus in the esophageal wall leads to the failure of relaxation of the lower esophageal sphincter (LES), accompanied by

a loss of peristalsis in the distal esophagus. Dysphagia for solids and liquids, as well as regurgitation of bland undigested food or saliva, are the most frequent symptoms in patients with achalasia. Other symptoms include chest pain, heartburn, and difficulty belching.

Bulimia nervosa: Binge eating followed by inappropriate compensatory behaviors to prevent weight gain, such as self-induced vomiting. Symptoms may include shortness of breath, chest pain, joint pain, gastrointestinal problems, menstrual problems, and headaches in many individuals.

Plan:
Discontinuation of offending medication: the initial step is to discontinue medication. Most cases heal after just a couple days of discontinuing the medication without any other intervention needed.

Recommending a PPI or alternative acid suppressive medication to aid in the healing process: Use standard dose proton pump inhibitor until symptoms resolved because GERD may make pill-induced injury worse. If not PPI, use a different acid suppressive medication such as antacids or histamine receptor antagonist. The use of surface agents like sucralfate, which create a protected barrier in the esophagus, can also be used in treating pill esophagitis.

Advise patient: Tell the patient that in most cases symptoms usually resolve 7 to 10 days after discontinuing medication, however if the patient has persistent symptoms for one week, then they will require additional evaluation with upper endoscopy.

Take precautions to prevent future episodes of pill esophagitis: provide clear instructions and tell the patient to take all their pills in the upright position, with at least 4 ounces of fluid or preferably 8 ounces of fluid. Remain upright for at least 30 minutes. Tell patients to avoid taking medication associated with esophagitis immediately prior to sleep.