Andres Hernandez
Mr. Fahim Sadat
3/2/2024

H&P #3 – Urgent Care

Identifying Data:
Full Name: M.C.
Address: Queens, NY
Date of Birth: 2/24/1982
Age: 42
Date: 2/19/2024, 11:30 am
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: "Right Eye Pain and Swelling" x 2 days

HPI:
A 42-year-old female, with no past medical history, presents with increasing pain and swelling in her right eye. She reports the development of a painful lump in her right upper eyelid that has been progressively worsening. The current pain intensity is rated at 6/10. The patient notes that the swelling is intermittent, resolving at times but returning with increased swelling. The discomfort worsens during blinking and touching the affected area. The patient has been self-medicating with over-the-counter ibuprofen for eye pain, which provides some relief. She denies any recent trauma or injury to the eye, as well as any discharge, loss of vision, or pain with eye movement.

Past Medical History:
The patient has no significant past medical history and denies any chronic medical conditions.
Pt. denies diabetes or hyperlipidemia.
Denies any childhood illnesses.

Past Surgical History:
Pt. denies any surgical history.
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- Office manager where she spends extended hours in front of a computer.
Smoking – Pt. denies smoking cigarettes.
Illicit Drugs – Denies use of drugs.
Alcohol – Denies alcohol use.
Diet – Denies a specific diet.

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 or hair changes. Denies discolorations, pruritus, or moles.
Head – Denies trauma or vertigo. Admits to headache.
Eyes –Denies any recent changes in vision or discharge from the eye. Denies any ocular symptoms such as redness or itching in the unaffected eye. 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. Denies joint pain, 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 – 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: 118/76
RR: 16 breaths/min, unlabored, regular rhythm breathing
Pulse: 72 beats/min, regular rate & rhythm
Temp: 98.6 F, oral
Height: 5'4"
Weight: 150 lbs.
BMI: 25.6 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: The right eye presents an erythematous and swollen upper eyelid with a tender localized lump. The affected area is warm to the touch. There is no discharge or conjunctival involvement. The left eye has no abnormal findings. PERRLA. EOMs are intact and painless 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:
42-year-old female seeks care at urgent care due to increasing pain and swelling in her right eye. She reports the development of a painful lump in her right upper eyelid that has been progressively worsening. She denies any recent trauma or injury to the eye. Denies discharge, loss of vision, or pain with eye movement. Upon physical examination, the right eye presents with an erythematous and swollen upper eyelid with a tender localized lump. The affected area is warm to the touch. There is no discharge or conjunctival involvement. The left eye has no abnormal findings. PERRLA. EOMs intact and painless 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.

Differential Diagnosis:
Hordeolum: acute inflammation of the eyelid that manifests as a localized, painful, and erythematous swelling or nodule. Hordeola can be either external or internal. External hordeola originate from glands in the eyelash follicle or lid-margin (gland of Zeis). Internal hordeola result from inflammation of the meibomian gland, leading to swelling just under the conjunctival side of the eyelid.

Chalazion: typically presents as a painless, localized eyelid swelling. Chalazia and hordeola can have a similar appearance; however, chalazia tend to be painless and exhibit

less erythema. A chalazion grows slowly over days to weeks, in contrast to a hordeolum, which appears over a day or so.

Blepharitis: inflammation of the eyelid margin associated with eye irritation. Hyperkeratinization of the meibomian gland ductal epithelium is an early finding in patients with posterior blepharitis. Altered lipid composition in gland secretions leads to tear film instability. The abnormal secretions also exert a direct toxic effect on the ocular surface. Additionally, the altered lipid composition creates an environment that fosters bacterial growth, perpetuating meibomian gland abnormalities. Long-term inflammation results in gland dysfunction, fibrosis, as well as damage to the eyelid and ocular surface.

Preseptal cellulitis: an infection of the anterior portion of the eyelid, not involving the orbit or other ocular structures. Patients with preseptal cellulitis typically present with unilateral ocular pain, eyelid swelling, and erythema.

Orbital cellulitis: an infection involving the contents of the orbit (fat and ocular muscles) but not the globe. Orbital cellulitis may cause vision loss and even be life-threatening. Findings that should raise concern for orbital rather than preseptal cellulitis include ophthalmoplegia with diplopia, pain with eye movement, visual impairment, and proptosis. This is because orbital cellulitis causes swelling and inflammation of the extraocular muscles and fatty tissues within the orbit, whereas preseptal cellulitis does not.

Plan:
Warm Compress:
Drainage can be facilitated with warm, moist compresses placed on the affected areas frequently (eg, for 5 to 10 minutes four times a day). Massage and gentle wiping of the affected eyelid after the warm compress can also aid in drainage.

Discontinue the use of make-up until symptoms resolve:
Patients should discontinue eye makeup to support healing.

If does not resolve in 2 weeks refer to ophthalmology:
If the lesion does not reduce in size within two weeks, the patient should be referred to an ophthalmologist for consideration of incision and drainage.

For the time being, no topical treatments needed at this time:
There is little evidence that treatment with topical or systemic antibiotics and/or glucocorticoids promotes healing. However, patients who have frequent hordeola in the setting of rosacea-associated blepharitis and who do not achieve adequate improvement with warm compresses and mechanical removal of lid margin debris may respond to a topical antibiotic ointment.