Andres Hernandez
Andrea Pizarro, PA-C
4/8/2024

H&P #3 – Internal Medicine

Identifying Data:
Full Name: Z.Z
Address: Queens, NY
Date of Birth: 7/26/1949
Age: 74
Date: 4/8/2024, 10:00 am
Location: New York Presbyterian Queens
Religion: Unspecified
Marital Status: married
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: daughter

CC: "Rash on face" x 4 days

HPI:
A 74-year-old male, PMHx of left eye glaucoma, presents to the ED with a facial rash x 4 days. The patient first noticed facial rash on Thursday night (4 days ago) however, disregarded it as it wasn't bothersome, since it was contained to the nasal area, and the patient usually gets rashes that resolve within hours. Last Friday (3 days ago), the patient noticed swelling, edema, redness contained to the facial region, just below the eyes but above the mouth. Patient denied any pain or pruritis but admits to dryness and flaking. On Saturday (2 days ago) the patient developed a fever of 38 degrees Celsius, and noticed the rash spreading to his forehead and neck. The patient at that point called his primary care physician but the office was closed. Sunday morning (1 day ago) the patient was advised by his wife and daughter to visit the emergency department, the patient agreed and was transported to the ED by the patient's daughter. The patient admits that although he has gotten rashes in the past, never had an episode this serious before, as previous rashes would resolve spontaneously. The patient denies eating any new foods, taking any new medication/supplements, or applying any new creams to his face recently that might've caused this reaction. Pt. denies using any medication, creams, or treatments in effort to heal his rash. Denies currently denies any chest pain, shortness of breath, palpitations.

Over the course of the past 24 hours, labs show leukocytosis 15.5, lactate 1.4, ESR 38 and CRP 18.78. The patient has been sodium chloride 0.9% infusion 75 mL/hr continuous IV, and dose of ceftriaxone, vancomycin, linezolid in the ED. Blood culture pending.

Past Medical History:
Left eye glaucoma (17 years ago, approx. 2007)
Pt. denies diabetes or hyperlipidemia.
Denies any childhood illnesses.

Past Surgical History:
Cataract surgery (date unknown)
No history of transfusions.

Medications:
Lumigan (bimatoprost), pt. did not know dosage.
Alphagan (Brimonidine tartrate), pt. did not know dosage.
Trusopt (Dorzolamide HCI), pt. did not know dosage.
Supplements: Fish oil, vitamin B, vitamin C, vitamin D. (dosages unknown)

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

Family History:
Father – passed at 99, lymphoma.
Mother – passed 97, unknown cardiovascular issue.

Social History:
Job- retired.
Smoking – Smoked only 1-2 cigarettes per day for 20 years, quit in 2019.
Illicit Drugs – Denies use of drugs.
Alcohol – Denies alcohol use.
Diet – Denies a specific diet.
Exercise – Pt. denies exercise .
Caffeine – Denies coffee.
Sleep – Pt. admits that sleep varies.
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 – Admits to color changes in the face and admits to rash. Denies hair changes. Denies, 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: 110/66
RR: 12 breaths/min, unlabored, regular rhythm breathing
Pulse: 73 beats/min, regular rate & rhythm
Temp: 37.0, oral
Height: 5'5"
Weight: 150 lbs.
SpO2: 97%
BMI: 25.0 kg/m2

Skin: Skin is warm & moist. Good turgor. Non-icteric. The affected area, on the face only, has an erythematous area positive for color change and rash. The skin is red and edematous, which is more pronounced over the left eye. It extends from the cheeks,

mouth, nose, and extends to the left side of the neck. Dryness and flaking noted. Not tender to palpation. No fluctuance or 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: 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:
74-year-old male, PMHx of left eye glaucoma, presents to the ED with a facial rash x 4 days. Saturday (2 days ago) the patient developed a fever of 38 degrees Celsius, and noticed the rash spreading to his forehead and neck. Sunday morning (1 day ago) the

patient was advised by his wife and daughter to visit the emergency department, the patient agreed and was transported to the ED by the patient's daughter. Patient denied any pain or pruritis but admits to dryness and flaking. Physical exam shows that the facial area is erythematous and positive for color change and rash. The skin is red and edematous, which is more pronounced over the left eye. It extends from the cheeks, mouth, nose, and extends to the left side of the neck. Over the course of the past 24 hours, labs show leukocytosis 15.5, lactate 1.4, ESR 38 and CRP 18.78. Pt. is started on ceftriaxone, vancomycin, linezolid in the ED. Blood culture pending.

Differential Diagnosis:
Staphylococcal scalded skin syndrome (SSSS) - is a bacterial toxin-mediated skin disorder that primarily affects young children but can also occur in older children and adults. SSSS occurs when exotoxins produced by Staphylococcus aureus undergo hematogenous dissemination to the skin.

Burns - Chemical, thermal, or sunburn injuries can manifest with erythema, blistering, and skin sloughing, resembling SSSS. A key distinguishing factor is the history of skin insult corresponding to the distribution of skin changes, aiding in differentiating burns from other blistering conditions.

Impetigo - is a contagious, superficial bacterial infection observed most frequently in children ages two to five years, although older children and adults may also be affected. It may be classified as primary impetigo (direct bacterial invasion of previously normal skin).

Stevens-Johnson Syndrome (SJS) - These severe blistering eruptions involve the skin and mucous membranes, often triggered by medications or infections. Additionally, mucosal involvement distinguishes SJS and TEN from SSSS.

Toxic Shock Syndrome - Caused by toxin-mediated systemic bacterial infections. Typical findings include widespread erythema, conjunctival injection, fever, and hypotension. Acral skin peeling may occur several days after symptom onset.

Plan:
Antibiotic therapy: although penicillinase-resistant penicillin is the drug of choice alternatives for initial treatment include a first- or second-generation cephalosporin or vancomycin.

Avoid bathing: during first 48 hours because of discomfort. Once bathing is resumed, use of a gentle, unscented cleanser and abrasive scrubbing of the skin should be avoided. Skin should be patted rather than rubbed dry to minimize skin shearing.

Maintain Hydration: Continue with IV fluids as intravenous hydration is necessary to prevent dehydration and secondary electrolyte abnormalities.

Once patients can tolerate oral intake, oral antibiotic therapy can replace intravenous antibiotic therapy. The total duration of intravenous and oral treatment with an appropriate antibiotic is typically 10 days.

Reassessment: is important to make sure the correct diagnosis is made and make sure to observe if patients have poor responses to therapy.

Patient Education:

Explain to the patient that staphylococcal scalded skin syndrome is a skin disorder that results from infection with a bacterial staphylococcus aureus that produces a toxin that causes skin reactions. This infection often presents skin redness with thick crusting around the mouth, nose, and eyes. Tell the patient that it's important to adhere to the full course of antibiotic treatment to make sure to eradicate the source of infection. The prognosis is usually good, unless the infection becomes systemic, where the bacteria no longer Is only on the skin but makes its way into the blood where it can cause bacteremia or sepsis where infection starts shutting down organs. Mortality, although very low, is usually only related to those cases with complications, related to sepsis, electrolyte imbalance or complications due to comorbidities.