Andres Hernandez

H&P #2 – Emergency Medicine

Chief Complaint: "Face pain, following a fall" x 1 hour ago

HPI:
A 67-year-old female with a past medical history of unspecified lymphoma presents to the ED with facial abrasions following a fall that occurred 1 hour ago. While visiting her mother at a nursing home earlier today, the patient was assisting her mother in the bathroom when she believed she became entangled with her mother's wheelchair. This caused her to lose her balance and fall. Prior to the incident, she was feeling well, had no acute symptoms, and had no recent history of similar incidents or known issues with balance or gait. The patient reports that her face impacted the floor first, and immediately noticed a significant amount of blood on the floor around her. Nursing home staff responded promptly by providing towels and ice packs before calling EMS. Initially, she rated her facial pain as 9/10, primarily on the left side, but after receiving Tylenol, the pain decreased to 7/10. The patient admits striking her head against the floor but denies loss of consciousness. Pt. denies the use of any blood thinners. Pt. denies dizziness, palpitations, weakness, or numbness at the time of the fall. Denies neck pain, chest pain, back pain, or injury to her extremities.

Past Medical History:
Up-to-date on all immunizations
GERD, managed with maloox, prn.

Past Surgical History:
Hysterectomy due to fibroids, 25 years ago

Medications:
Acetaminophen (Tylenol), or Naproxen (Aleve) prn for headaches
Maloox , prn

Allergies:
NKDA
No food allergies
No environmental allergies

Family History:
Mother, alive, has "heart condition" and a past valve replacement
Father, deceased from lung cancer 20 years ago
Brother, decreased from lung cancer 30 years ago

Social History:
Substances: Denies a history of substance abuse. Denies smoking. Denies vaping. Denies drinking alcohol. Denies drinking caffeine.
Travel: denies recent travel
Diet: Not on any specific diet/regimen
Sleep: Averages 5-6 hours per night
Exercise: Occasional walking

ROS:
General – Denies fever, headache, weakness or recent weight loss.

Skin, hair, nails – Other than abrasions on the face. No changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, or changes in hair distribution.

Eyes –Denies visual disturbance, photophobia, lacrimation or pruritus. Last eye exam is unknown.

Ears – Denies ear pain, muffled sound, deafness, discharge, or sensation of fullness.

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies sore throat, bleeding gums, mouth ulcers, voice changes.

Neck - Denies localized swelling/lumps or stiffness/decreased range of motion.

Pulmonary System – Denies shortness of breath, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

Cardiovascular System – Denies chest pain, HTN, irregular heartbeat, edema/swelling of ankles or feet, syncope, or known heart murmur.

Gastrointestinal System – Denies nausea, vomiting, diarrhea, abdominal pain, or jaundice

Genitourinary System – Denies urinary frequency, dysuria, or flank pain.

Endocrine System – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism.

Psychiatric – Denies depression, feelings of helplessness or hopelessness, lack of interest in usual activities, anxiety, or suicidal ideations.

Physical Exam:
Vital Signs:
BP: 138/84 mmHg
P: 82 beats/min, regular
RR: 16 breaths/min, unlabored
T: 98.6 degrees F (oral)
O2 Sat: 98% room air

General: Well-nourished, well-groomed female who appears her stated age. She is awake, alert, and oriented x3. She is sitting comfortably on her bed upon entry and is in no acute distress. The patient has notable facial swelling and abrasions on the forehead, nose, and below the eyes bilaterally. She is very cooperative during history taking and the physical exam. The patient can ambulate without assistance.

Nose: **Abrasion noted at the tip of the nose. Bleeding controlled.** Symmetrical. No masses, deformities, or discharge. Nares patent bilaterally. Nasal mucosa pink and well hydrated. No discharge noted on anterior rhinoscopy. **No epistaxis.**

Eyes: Symmetrical OU. No strabisumus, exopthalmos or ptosus. Sclera white, cornea clear, conjunctiva pink. **Abrasions under both eyes noted.**

Ears: Ears symmetrical. No lesions, masses, or trauma. No Battle's sign. No discharge or foreigns body in external auditory canals. TM's are pearly white and intact with light reflex in good position. Auditory acuity intact.

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

Neck: Trachea midline, no masses, lesions, scars, or visible pulsation. Supple and nontender to palpation. Full ROM. Non palpable cervical adenopathy. No stridor noted. 2+ carotid pulses, no bruits bilaterally.

Mouth: No cyanosis of lips, white teeth, with no loose, or broken teeth. Gums pink in color, no swelling, bleeding, or pain. Oral mucosa pink. No discoloration, lesions, nodules, swelling. Tonsils visible but not enlarged.

Skin: **Abrasions noted on both upper cheeks, no active bleeding.** Warm, moist, with good turgor. No lacerations, masses, no bruising, or petechiae.

Cardiac: Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, gallops, or rubs. Chest is symmetrical, no derformities, no trauma. Lat to AP diameter 2:1. Nontender to palpation.

Pulmonary: No wheezing, rales, rhonchi, crackles, heard. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. No clubbing noted.

Abdomen: Abdomen flat and symmetric with no scars, striae, or pulsations noted. Nontender to palpation and tympanic throughout, no guarding or rebound noted.

Motor: Good muscle bulk and tone with 5/5 strength on bilateral upper extremities and R lower extremity with decreased strength on L lower extremity. No fasciculations.

Musculoskeletal:
Upper Extremities:
No tenderness, deformities, or swelling in the shoulders, elbows, wrists, or hands. Full range of motion (ROM) in all joints. Strength 5/5 bilaterally.

Lower Extremities:
No tenderness, deformities, or swelling in the hips, knees, ankles, or feet. Full ROM in all joints. Strength 5/5 bilaterally. Gait not assessed due to facial injury and patient discomfort.

Differential Diagnoses:
Head Hematoma: The patient reports hitting her head on the floor during the fall. This impact increases the risk of developing a hematoma (e.g., epidural, subdural), particularly in older patients. While the patient denies loss of consciousness or other immediate neurological symptoms, head hematomas can present with delayed neurological signs. Monitoring new neurological deficits over time is necessary.

Facial Fracture: Given the mechanism of injury and localized pain on the left side of the face, facial fractures such as zygomatic, orbital, or maxillary fractures should be considered. Clinical signs such as facial bruising, swelling, or asymmetry may indicate a fracture.

Concussion: Despite denying loss of consciousness, any fall involving head impact raises concern for a mild traumatic brain injury. The patient's symptoms should be monitored for signs of cognitive dysfunction, confusion, headache, or nausea/vomiting, which could suggest a concussion.

Soft Tissue Injury/Abrasion: It is possible that the patient only suffered a soft tissue injury to the face. These injuries often result in significant pain and swelling but may not involve bone injury.

Syncope: Although the patient did not report dizziness or loss of consciousness, a syncopal episode must be considered as a potential cause of the fall. This requires ruling out any underlying cardiovascular or neurological issues.

Assessment:
67-year-old female with a history of unspecified lymphoma presented the ED following a fall at a nursing home while assisting her mother. The fall resulted in direct trauma to the face, resulting in abrasions to the forehead, nose, and upper cheeks. Patient denied loss of consciousness but reported significant bleeding and pain on the left side of her face. Further evaluation is needed to rule out intracranial hemorrhage and facial fractures.

Plan
Imaging: Obtain CT scan of the head without contrast for intracranial hemorrhage, including CT scan of the face to assess for facial fractures.

Pain Management: Continue with Tylenol for pain control. Consider opioids if pain becomes uncontrolled. Avoid NSAIDS due to previous bleeding.

Wound Care: Clean facial abrasions and apply appropriate dressings with bacitracin or Neosporin cream.

Neurological Monitoring: Perform serial neurological assessments to check for changes.

If imaging results are unremarkable, discharge with pain management instructions. Consider referral to physical therapy for fall prevention and balance improvement if there are ongoing concerns about the patient's gait or risk of future falls.