Andres Hernandez

H&P#3 – OB/GYN

Chief complaint: "Itchy Rash" x 1 week

HPI:
A 30-year-old G3P2002 female with no significant medical history at 36 weeks and 2 days of gestation (EDD: December 22, 2024) presents to the women's health clinic for a routine prenatal visit with rash that has caused significant discomfort prompting her to seek evaluation. She reports the onset of a pruritic rash that developed one week ago. The rash initially appeared as small, red, erythematous plaques with pustules at the edges, located within the stretch marks on her lower abdomen, sparing the area around her umbilicus. Over several days, the plaques have enlarged with central crusting and erosion, and the rash has spread to her thighs and upper arms in a symmetric distribution. The pruritus is described as severe, particularly at night, disrupting her sleep. She rates the itchiness as 8/10 in intensity. The patient states that the rash worsens after prolonged periods of standing or when wearing tighter clothing, though applying cool compresses provides temporary relief. She has tried over-the-counter hydrocortisone cream and an oral antihistamine (diphenhydramine) with minimal improvement. There is no involvement of her face, palms, or soles, and she denies any drainage, vesicles, or systemic symptoms such as abdominal pain or contractions. She denies prior similar episodes during her first two pregnancies or at any other time. There are no associated fever, chills, or malaise, and she denies any changes in diet, new medications, or recent illnesses.

Past Medical History:
None

Immunizations:
Up-to-date

Past Surgical History:
None

Medications:
None

Allergies:
Denies

Family History:
Mother: Alive, 62 years old, history of hypertension, controlled on medication.
Father: Alive, 65 years old, history of type 2 diabetes.
Sibling: One sister, 35 years old, in good health.

Social History:
Living Situation: The patient lives with her spouse and two children.

Occupation: Homemaker, focused on caring for her children and managing household responsibilities.

Substance Use: Denies tobacco use, recreational drug use, or alcohol consumption. Drinks one cup of tea daily and avoids caffeine otherwise.

Travel History: No recent travel, domestically or internationally. Denies exposure to endemic areas or infectious diseases.

Diet: Follows a balanced diet, incorporating fresh fruits, vegetables, whole grains, and lean proteins. Occasionally consumes sweets or fast food, especially when managing a busy schedule. Drinks approximately 6 glasses of water daily.

Sleep: Reports sleeping 6-8 hours per night, often disrupted by pruritus from her rash and care for her young children.

Exercise: Engages in light physical activity, such as walking or stretching, a few times per week, but has reduced activity recently due to fatigue and abdominal discomfort.

Sexual History: Sexually active with her spouse in a monogamous relationship for the past 10 years.

ROS:

General: Admits to fatigue and mild malaise. Denies fever, headache, weakness, or recent weight loss.

Skin, Hair, Nails: Admits to a pruritic rash on the abdomen and spreading to the extremities. Denies changes in texture, excessive dryness, sweating, discolorations, pigmentations, lacerations, moles, 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: Admits to dry mouth. Denies sore throat, bleeding gums, mouth ulcers, or voice changes.

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

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

Cardiovascular System: Denies palpitations, chest pain, hypertension, syncope, or known heart murmur.

Breast: Denies lumps, nipple discharge, or pain.

Gastrointestinal System: Admits to mild nausea but denies vomiting, diarrhea, abdominal pain, or jaundice.

Genitourinary System: Denies urinary frequency, nocturia, urgency, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate, or flank pain. Urine is yellow/clear.

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

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

Physical Exam:

BP: 128/82 mmHg, right arm sitting

P: 84 beats/min, regular

RR: 16 breaths/min, unlabored

T: 98.6 degrees F (Oral)

O2 Sat: 98% room air

Weight: 180 lbs

Height: 5’5”

BMI: 29.96 kg/m²

General: The patient is a 30-year-old G3P2002 female, 36 weeks and 2 days of gestation, awake, alert, and oriented to person, place, and time. She is seated comfortably on the exam table, cooperative and responsive during the history and physical exam. The patient appears well-nourished and is in no acute distress.

Skin: The skin is warm and moist with good turgor. There is no icterus, and no lesions, scars, or tattoos are noted. The patient has a pruritic rash located within the stretch marks on her lower abdomen, sparing the

umbilicus. The rash is symmetric and has spread to her thighs and upper arms. No other rashes or lesions are observed on the face, palms, or soles. No signs of infection, vesicles, or drainage are noted.

Hair: The hair is of average quantity and distribution. No alopecia, seborrhea, or lice are noted on examination.

Nails: The nails are normal with no clubbing, cyanosis, or lesions. Capillary refill is less than 2 seconds in both the upper and lower extremities.

Head: The head is normocephalic and atraumatic, with no evidence of contusions, ecchymoses, hematomas, or lacerations. The head is nontender to palpation throughout.

HEENT: Eyes: PERRLA, EOMI, no conjunctival injection or scleral icterus. No visual disturbances are noted. Ears: External auditory canals clear, no discharge or tenderness. Nose: Nasal mucosa pink, no discharge or obstruction. Throat: Mucous membranes moist, no erythema, exudate, or tonsillar enlargement.

Cardiac: Regular rate and rhythm. S1 and S2 are distinct without murmurs, gallops, or rubs. No jugular venous distension or hepatojugular reflex noted.

Pulmonary: Lungs clear to auscultation bilaterally. Respirations unlabored, with no use of accessory muscles. No crackles, wheezes, or rhonchi. No clubbing or cyanosis noted.

Abdomen: Soft, gravid, and non-tender. Nontender to palpation in all quadrants. Tympanic throughout. No guarding, rebound tenderness, or masses palpated. No evidence of hernias.

Back: No costovertebral angle tenderness.

Pelvic: Deferred at this time due to patient’s stage of pregnancy and discomfort.

Lower Extremities: The extremities are normal in color, size, and temperature. Pulses are 2+ bilaterally in the upper and lower extremities. No bruits noted. No clubbing, cyanosis, or edema noted bilaterally. No stasis changes or ulcerations noted.

Neurological: The patient is alert and oriented, with normal speech and cognition. No focal neurological deficits noted during the exam.

Psychiatric: The patient appears anxious but cooperative. No overt signs of depression or psychosis observed during the exam.

Differential Diagnosis:

- Polymorphic Eruption of Pregnancy (PEP), also known as Pruritic Urticarial Papules and Plaques of Pregnancy (PUPPP): PEP is the most likely diagnosis for this patient based on the presentation of a pruritic rash that began in the lower abdomen within the stretch marks, sparing the umbilicus, and then spread symmetrically to the thighs and upper arms. PEP is a benign, self-limiting disorder that occurs most often in nulliparous women during the third trimester, with a mean onset of 35 weeks. The rash typically starts as erythematous papules within striae and progresses to urticarial plaques with central crusting and erosion. It often spares the face, palms, and soles, which is consistent with this patient's presentation. The severe pruritus and worsening with prolonged standing or tight clothing further supports this diagnosis. The condition resolves postpartum, usually within two weeks, although it can last longer in some cases.

-Pemphigoid Gestationis: Pemphigoid gestationis (formerly known as herpes gestationis) is a rare autoimmune blistering disorder that occurs during the second or third trimester of pregnancy. It typically presents with intense pruritus followed by the development of urticarial plaques or papules around the umbilicus, spreading to other areas, and potentially forming tense blisters. Unlike PEP, pemphigoid gestationis often involves the umbilical area and may also affect the palms and soles. The rash may progress to blisters, which is less typical for PEP. The differentiation can be made through a direct immunofluorescence (DIF) biopsy, which would show deposition of IgG antibodies in pemphigoid gestationis.

- Erythema Multiforme (EM): Erythema multiforme is an acute immune-mediated condition characterized by target-like lesions. The lesions are typically erythematous with concentric rings, and may involve the mucous membranes (oral, genital, ocular). Although the patient's rash includes some target-like lesions, the absence of mucosal involvement (oral, genital, or ocular) and systemic symptoms (such as fever or arthralgia) makes this diagnosis less likely. Additionally, EM lesions tend to be more widespread and often start on the extremities or trunk rather than within striae, as seen in PEP.

-Scabies: Scabies is caused by an infestation of the skin by the mite Sarcoptes scabiei. The pruritus associated with scabies is intense, especially at night, and is typically accompanied by a characteristic rash that includes erythematous papules, excoriations, and serpiginous burrows, often located in the webs of the fingers, wrists, axillae, and genitalia. The distribution of the rash in this patient, which is located on the abdomen, thighs, and upper arms without involvement of the characteristic areas for scabies (such as between the fingers or on the genitalia), and the absence of burrows, makes scabies less likely in this case.

-Drug Eruptions: Drug-induced rashes can present similarly to PEP with erythematous papules, urticarial plaques, or vesicles. However, this patient's rash has a more typical distribution associated with pregnancy and no recent medication changes were reported, making a drug eruption less likely. A history of new drug exposure and the pattern of rash onset would typically point to a drug-induced eruption, which is not present in this case.

Assessment:
30-year-old G3P2002 female at 36 weeks and 2 days of gestation who presents with a pruritic rash that developed one week ago. The rash initially appeared as erythematous plaques with pustules at the edges, localized within the stretch marks on her lower abdomen, and has since spread symmetrically to her thighs and upper arms. The pruritus is described as severe, particularly at night, disrupting her sleep. The patient reports minimal relief with over-the-counter hydrocortisone cream and antihistamines. On physical exam, the patient has a pruritic rash on her lower abdomen, thighs, and upper arms. The rash spares the face, palms, and soles, and there is no involvement of the umbilicus. There is no evidence of infection, drainage, vesicles, or lesions involving the face, palms, or soles. The skin is warm, moist, with good turgor, and no signs of icterus, lesions, scars, or tattoos are noted. There are no systemic symptoms such as fever, chills, or gastrointestinal complaints. Polymorphic Eruption of Pregnancy (PEP), also known as Pruritic Urticarial Papules and Plaques of Pregnancy (PUPPP) is the most likely diagnosis and management will be focused on symptomatic relief.

Plan:
Polymorphic Eruption of Pregnancy (PEP) [Pruritic Urticarial Papules and Plaques of Pregnancy (PUPPP)]
-Check serum bile acids to rule out intrahepatic cholestasis of pregnancy if pruritus becomes extensive or there are no primary skin lesions.
Symptomatic Management:
-Start mid- to high-potency topical corticosteroids (groups 2 to 4) applied once or twice daily to affected areas until improvement occurs.
-Prescribe oral antihistamines for pruritus relief:
First-generation (e.g., chlorpheniramine) for nighttime use.
Second-generation nonsedating options (e.g., loratadine or cetirizine) for daytime use.
-Consider a short course of systemic corticosteroids if symptoms don't resolve: Prednisone or prednisolone 0.5 mg/kg/day for one week, tapered over one to two weeks.
-Reassure the patient that PEP is benign and typically resolves postpartum (within two weeks).

-Follow-Up: Monitor the patient for response to treatment and resolution of symptoms. Advise follow-up if the rash worsens, systemic symptoms develop, or bile acid results indicate intrahepatic cholestasis.