SUBJECTIVE DATA:

New Patient Visit (continuing care from inpatient hospital stay)

September 9, 2014

SM is a 68 year old married white male.

Informants: Patient, SM, and his wife, TM.

Chief Complaint (CC):

Patient’s wife states, “He has that pressure ulcer on his bottom that just won’t get well.”

History of Present Illness (HPI):

SM presents to the clinic with an open wound on his sacrum. It has been present for approximately 2 months and first began during an extended hospital stay. There is a malodorous, pus filled discharge from the wound. The tissue surrounding the wound is warm, red, and tender. SM complains of aching and burning pain 8/10 when pressure is applied to the area. Repositioning and keeping pressure off of the affected area alleviates the pain.

Past Medical History (PMH):

SM has no food or drug allergies. He has been diagnosed with Type II Diabetes for about 5 years. He was diagnosed with HTN and CHF 4 years ago. He was diagnosed with atrial fibrillation 1 year ago. He was diagnosed with acute kidney injury and GI bleed 3 months ago. He has had a decubitus ulcer in the sacral region for about 2 months. His primary care physician is Dr. Ingram in Jacksonville, AL. His last TB skin test was in April and it was negative. Immunizations include flu and pneumonia in November 2013. His last tetanus was 3 years ago. He had chicken pox as a child but denies any other major childhood illnesses.

Current medications include:

Lantus Flexpen 10 units SQ at 2100 for FSBS >200 (2 years)

Novolog Flexpen SQ TID (0700, 1100, 1600) per sliding scale (3 years)

 <200 – 0 units

 200-250 – 2 units

 250-300 – 4 units

 350-400 – 6 units

 >400 – 8 units

Amiodarone 200 mg PO daily (1 year)

Amlodipine 5 mg PO daily (2 years)

Furosemide 20 mg PO daily (4 years)

Ferrous Sulfate 325 mg PO daily (3 months)

Docusate 200 mg PO daily PRN constipation (3 months)

Norco 10/325 mg PO every 6 hrs prn pain (3 months)

Surgical / Hospitalizations:

Cholecystectomy in May 2014 complicated by acute kidney injury. A Vascath was placed in the right groin and patient was placed on continuous renal replacement therapy (CRRT) and intubated on a ventilator for multiple days. He developed a GI bleed and an EGD and colonoscopy prior to discharge from the hospital confirmed no lesions and no active bleeding.

Family History (FH):

Father had diabetes and HTN and died at the age of 74. Mother had HTN and died at age 73. He has 3 siblings. One brother died at the age of 69 with lung cancer. One sister had diabetes and died at 72 years old. He has one living brother who is 72 years old and has had HTN and CHF for about 112 years. SM has one daughter who is 42 years old with no past medical history.

Social History (SH):

SM has been married for 45 years. He and his wife own their own home. The home has smoke alarms and he wears his seatbelt on a regular basis. The home does has firearms that are not in a locked safe. Before his hospitalization in May he did not exercise but worked a laborious job. He has a 10th grade education and owns a lawn care business and a fruit stand. He and his wife are of the Baptist faith. He denies the use of alcohol or illicit drugs. He smoked 2 packs of cigarettes a day for 50 years but quit when he was hospitalized in May. His wife does smoke but no longer smokes in the car or house. SM has private insurance through his wife’s job and denies any concerns related to food, supplies, or medication.

Review of Systems (ROS):

1. Constitutional Symptoms: Weight loss of approximately 25 lbs since May. Denies fever, recent, or repeated infections. Often fatigued and unable to complete activities of daily living without assistance.
2. Eyes: He has glasses but rarely wears them. Denies double or blurred vision. Denies using any medications for his eyes. Denies redness, excessive tearing, pain, or trauma to the eyes. Last eye exam was 9 months ago.
3. Ears, nose, mouth, throat: Difficulty hearing. Has been exposed to high noise levels such as lawn mowers and tractors for most of his life. Denies tinnitus, infection, pain, vertigo, or the use of assistive hearing devices. Denies difficulty smelling. Denies discharge, obstruction, epitaxis, or sinus problems. Denies the used of oral tobacco. Smoked 2 packs of cigarettes a day for 50 years and quit in May. His last dental exam was 7 months ago and he has no issues at that time. He has upper plate dentures that he wears without difficulty. He brushes with fluoride toothpaste at least once per day but does not floss regularly. Denies bleeding of gums, mouth odor, ulcers, or sores on the tongue. Has noticed a change in his sense of taste since he quit smoking. Denies sore throat, hoarseness, or difficulty swallowing.
4. Cardiovascular: Does not exercise on a regular basis but has always worked laborious jobs. Has a history of atrial fibrillation controlled with medication. Denies history of murmurs. Has experienced chest pain and palpitations in the past, but not recently. Currently experiencing activity intolerance and dyspnea upon exertion. History of high blood pressure controlled with medication. Last EKG was normal a few weeks ago. Denies high cholesterol. Denies claudication or the presence of varicose veins. Occasional bilateral lower extremity edema.
5. Respiratory: Occasionally exposed to passive smoke. Denies history of upper respiratory infections or usual treatments. Has a chronic productive cough mostly in the mornings with penny size amount of tan sputum. Last chest x-ray was before his release from the hospital a few months ago. It did not show signs of pneumonia but the lungs were “over inflated and the diaphragm was flat”. He has never been exposed to TB and his last TB skin test was negative in April. Has some difficulty breathing with activity and wheezing. Denies hemoptysis or night sweats.
6. Gastrointestinal: Eats a diet low in sugar and starches. Denies use of nutritional supplements, heartburn, epigastric pain, nausea, vomiting, food intolerance, flatulence, or diarrhea. Reports occasional constipation relieved with Docusate. Usual bowel movements every day. Stools have become more solid since taking Norco. Denies hemorrhoids or jaundice.
7. Genitourinary: Gets up two times per night to urinate. Sometimes has a hard time getting stream started and it is not as strong as it used to be. Denies any pain. Has occasional incontinence especially when he takes his Lasix. Denies discharge or history of sexually transmitted diseases. Denies history of kidney stones. Is not currently sexually active.
8. Musculoskeletal: Denies regular physical activity. Uses seatbelt on a regular basis. Denies neck pain or stiffness, joint pain or swelling, incapacitating back pain, paralysis, deformities, changes in range of motion, or back injury.
9. Integumentary: Uses sunscreen, large rim hat, and long sleeves when outdoors. Skin is dry overall with no rashes, itching, hair loss, moles, or bruising. Has an open wound on his sacrum that has a malodorous drainage. Currently cleansing the wound two times per day with normal saline and covering with gauze and tape.
10. Neurologic: Has overall muscle weakness. Denies syncope, stroke, seizures, paresthesias, involuntary movements or tremors, loss of memory or headaches.
11. Psychiatric: Feel likes he has the blues or down in the dumps recently. Denies nightmares, mood changes, anxiety, nervousness, insomnia, suicidal thought, or potential for exposure to violence.
12. Endocrine: Type II Diabetic controlled with medication and diet. Denies thyroid problems, cold or heat intolerance, polydipsia, polyphagia, polyuria, changes in skin, hair or nail texture, changes in facial or body hair, or change in hat or glove size.
13. Hematologic/lymphatic- Denies bruising or unusual bleeding. Had a GI bleed a few months ago and had to have 8 blood transfusions. HCT was 29 about a month ago.
14. Allergic/Immunologic: Denies seasonal allergies or previous allergy testing. No potential for exposure to blood or body fluids. Not immunized for Hepatitis B. No immunosuppression in self or family members. Denies use of steroids.

OBJECTIVE DATA:

1. Constitutional: SM is an overweight, well-developed 68 year old male. He appears older than his stated age. He is in no acute distress.

a. VS: temp 98.5, BP 124/68, Pulse 82, O2 Sat 91% on RA, Height 6’4”, Weight 224 lbs, BMI 27.26

1. Eyes: Pupils are equal, round, reactive to light and accommodating at 5mm bilaterally. No redness or drainage from the eyes.
2. ENT/Mouth: Hearing is below adequate. No drainage from the ears. Tympanic membranes clear. No redness or drainage, wax present. Nose: Mucosa pink, septum midline. No nasal drainage or congestion. No tenderness of the frontal or maxillary sinuses. Throat: Oral mucosa moist and pink. Oropharynx clear, no redness. Tonsils present. No evidence of bleeding gums or foul odor. No ulcers or sores.
3. Cardiovascular: Normal S1, S2. No S3, S4. Regular rate and rhythm. No clicks, gallops, or murmurs. No carotid bruits. No varicose veins. Bilateral lower extremities with 1 + pitting edema.
4. Respiratory: RR even and unlabored. Wheezes auscultated bilaterally with decreased sounds in the bases. Decreased diaphragmatic excursion. No tactile fremitus, egophony, or whisper pectoriloquy. Clubbing of the nails on bilateral upper extremities.
5. Gastrointestinal: Bowel sounds normal in all four quadrants. Soft, non-distended, non-tender.
6. Genitourinary: No costovertebral tenderness present.
7. Musculoskeletal: No tenderness or swelling to the joints. No abnormal curvature of the spine. Bilateral upper and lower extremities equal with weakness present.
8. Integument/Lymphatic: No cyanosis, ecchymosis, or petechiae. No swollen or tender glands or lymph nodes. No discolored or uneven moles. Sacral wound measures 1 cm x 1 cm x 2 cm with 1 cm undermining from 11 to 7 o’clock. There is a moderate amount of purulent drainage with a strong odor present. The tissue surrounding the wound is warm and red.
9. Neurologic: No tremors or involuntary movements. Alert and oriented to person, place, time, and situation. Able to answer all questions appropriately.
10. Psychiatric: Patient calm and cooperative. No anxiety or nervousness. Somewhat flat affect.
11. Hematologic/Immunologic: No evidence of bruising or bleeding. No swollen or tender glands or lymph nodes.

No diagnostic tests available for this visit.

ASSESSMENT:

CPT Code: 99204

Differential Diagnoses:

1. COPD 496 – associated with shortness of breath, dyspnea on exertion, decreased respiratory excursion, wheezes, decreased breath sounds, chronic cough with sputum production, hyperinflation of lungs, flattened diaphragm, commonly caused by smoking. Spirometry needed to confirm diagnosis.
2. Acute Posthemorrhagic Anemia 285.1 – associated with blood loss, characterized by fatigue and activity intolerance, he is not currently experiencing blood loss but had a GI bleed in the past 3 months and 8 blood transfusions while in the hospital, he also had acute kidney injury which could cause a decrease in erythropoietin but this is more commonly seen in chronic kidney disease, also he has been a smoker and takes diuretics both of which can cause an increase in Hgb/Hct. Need CBC (85025) to evaluate hgb/hct/plts. Iron (82728), TIBC (83540), ferritin (83550), and B12 (82607) to determine the specific type of anemia. Stool for hemoccult (82270,
82272) to help determine if there is an active source of blood loss.
3. Unspecified Local Infection of the Skin and Subcutaneous Tissue 686.9 – patient is afebrile, wound is red, warm, and tender, malodorous, purulent drainage, failure to heal, increased risk due to diabetes. Need CBC (85025) to evaluate WBCs, need wound culture with gram stain (87070, 87205) to determine presence of infection as well as bacteria and susceptibility. Albumin (84155) to determine if nutritional status is delaying healing
4. Osteomyelitis of the Sacrum 730.08 – wound is deep so bone involvement is a concern especially with the failure to heal, patient is afebrile, wound is red, warm, and tender, malodorous, purulent drainage, increased risk due to diabetes. Need CBC (85025) to evaluate WBCs, need wound culture with gram stain (87070, 87205) to determine presence of infection as well as bacteria and susceptibility. Need x-ray (72100) to determine bone involvement.
5. Tobacco Use Disorder 305.1 – characterized by using tobacco products, cannot be considered a nonsmoker until he has quit for 1 year
6. Overweight 278.02 – BMI = 25 – 29.9
7. Chronic Decubitus Ulcer of Sacral Region 707.03 – worsening
8. Type II Diabetes 250.00 – well-controlled
9. Other Benign Secondary Hypertension 405.19 – well-controlled
10. Congestive Heart Failure 428.0 – improved – need BMP (80048) to evaluate electrolytes with the use of Lasix
11. Atrial Fibrillation 427.31 – well-controlled
12. Personal History of Acute Kidney Injury 584.9 – resolved- need BMP (80048) to evaluate BUN/Creat especially since an infection is suspected antibiotics will have to be used with caution.
13. Personal History of GI Bleed V12.79 – resolved

PLAN:

The following plan has been discussed and agreed on by SM and his wife, TM, for the diagnoses including:

1. Unspecified Local Infection of the Skin and Subcutaneous Tissue 686.9
2. CBC to evaluate WBC
3. Wound culture and gram stain to determine bacteria and susceptibility
4. CMP to evaluate albumin level to determine if nutritional status is delaying healing, also to evaluate BUN and creatinine for renal function since anticipating the use of antibiotics
5. Education on proper wound care and offloading of affected area
6. X-ray of the sacrum to determine if there is bone involvement in the infection
7. Acute Posthemorrhagic Anemia 285.1
8. CBC to evaluate hgb/hct/plts.
9. Iron, TIBC, ferritin, and B12 to determine the specific type of anemia.
10. Stool for hemoccult to help determine if there is an active source of blood loss.
11. Tobacco Use Disorder 305.1
12. Education on smoking cessation
13. Education to patient and his wife on the effects of second hand smoke
14. Education on the effects of cigarette smoking on wound healing
15. Overweight 278.02
16. Education on diabetic diet
17. Education on the effects nutrition has on wound healing
18. Education on the effects that blood glucose levels have on wound healing
19. Education on range of motion and strength training exercises
20. Other
21. Referral to pulmonologist for spirometry testing
22. Appointment to follow-up in 1 week to review test results and reevaluate treatment plan