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PA Student: Kailin Cheng, March 13, 2018

Pt ID: MV male, Latino, DOB 11/8/68, 49y/o. married.

Informant: Pt himself & his wife, Reliable

Referral Source: ER.

2 CC: "I feel pain every time I pee & it is always Red" x4days

HPI: 49y/o Reliable male w/significant PMH of DM2 for 2yrs, controlled w/Metformin 1500mg QD, presents to the ER complaining of hematuria, dysuria, frequency, & nocturia x4 days ago. He states the pain started suddenly, on the supra pubic area, which radiates to the RLQ & LLQ. Pain appears every time pt urinates & alleviates only when he is not urinating, he describes the pain as a burning sensation, 10/10 on level of severity. Pt reports subjective fever, chills, fatigue, night sweats, which started two days ago; he denies nausea, vomit, diarrhea, recent weight loss, poor appetite, trauma, recent traveling, penile discharge, testicular pain, changes on the diet OR medication. Pt reports last month suffered from pyelonephritis & was treated w/Abx for 10 days & Reports completion of the Abx course.

3D

PMH: DM2 x 2years

Childhood Illness: Hepatitis A.

Immunization: Up to date.

PSH: None; denies past injuries OR transfusions

5 Meds: Metformin 1500mg once a day.

Allergies: Denies drug, environmental OR food allergies

Family Hx: Maternal & Paternal grandparents - Deceased at unknown age & unknown reasons.
Father - Alive, 74 y/o, HTN, CVD
Mother - Alive, 70 y/o.
Brother - Alive, 45 y/o ~~goo~~ KC unremarkable health
Daughter - Alive, 23 y/o unremarkable health
Daughter Alive, 27 y/o unremarkable health
Son - Alive, 27 y/o unremarkable health.

5 Very good!

Social Hx: MR MV is married living w/ wife and youngest daughter only, w/ No pets. He works as truck driver, who has to sit for many hours. He denies drinking, smoking or doing illicit drug. He drinks two cups of coffee every day (morning & afternoon). Pt denies recent travels. Pt reports his diet consits of fried food, take out because he works many hours; pt does not practice physical activities for lack of time & can only sleep around 4 hours per night.

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Review of Systems.

GRal. Reports fever, chills, night sweats, & fatigue. Denies weakness, loss of appetite, Recent weight gain or loss.

Skin, hair, nails: Denies changes in texture, excessive dryness or sweating, discoloration, pigmentations, moles/Rashes, pruritus, or changes in hair distribution.

Head: Denies headache, vertigo, head trauma, unconsciousness, coma, fracture.

Eyes: Reports wearing glasses for hyperopia. Denies visual disturbances, fatigue, lacrimation, photophobia, pruritus. Last eye exam - 2017 - normal visual acuity & pressure.

EARS: Denies deafness, pain, discharge, tinnitus, hearing aids.

Nose/Sinuses: Denies discharge, epistaxis, obstruction.

Mouth & throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures, last dental exam - Don't Remember

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

Breast: Denies lumps, nipple discharge, pain.

Pulmonary System: Denies dysprea, SOB, cough, wheezing, hemoptysis, cyanosis, orthoprea, PND.

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

Gastrointestinal System: Denies changes in appetite, intolerance to foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool, pain in flank.

Genitourinary System: Reports urinary frequency, dysuria, nocturia color of urine is Red. Denies incontinence, urgency, oliguria, polyuria, hesitancy, dribbling. Last prostate exam - December 2017 - normal.

Sexual Hx: Pt is sexually active, his wife, one partner. Denies impotence, STI, or using contraception.

Musculoskeletal System: Denies muscle or joint pain, deformity or swelling, redness, arthritis.

Peripheral Vascular system: Denies intermittent claudication, coldness of trophic changes, varicose veins, peripheral edema, skin color change.

Hematologic System: Denies anemia, easy bruising or bleeding, lymph node enlargement, history of DVT or PE.

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

Nervous System: Denies seizures, loss consciousness, sensory disturbances, ataxia, loss of strength, change in cognition, mental status, memory, weakness.

Psychiatric: Denies depression, sadness, anxiety, obsessive compulsive disorder, suicidal ideation.

Physical Exam.

Gral: 49 y/o male, obese pt well groomed, alert & cooperative, appears in apparent distress. 2

Vital Signs: BP supine Right side 136/92 mmHg → perform 2 sets of BP

RR 16 breaths/min unlabored

HR 88 beats/min regular 4.5

Temp: 98.6 F (oral).

O_2 Sat: 98% room air

Ht: 5'8", wt: 225 lb, BMI: 34.2 obese.

Skin: Warm & moist, good turgor. Nonicteric, no lesions, Rashes noted, no scars, tattoos, no cyanosis.

Hair: Average quantity & distribution.

Nails: No clubbing, capillary refill < 2 sec throughout.

Head: Normocephalic, atraumatic, non tender to palpation throughout.

Eyes: Symmetrical OU, no evidence of strabismus, exophtalmos, ptosis, sclera white, conjunctiva pink & cornea clear.

Visual Acuity: uncorrected 20/20 OS, 20/20 OD, 20/20 OU.

Visual Fields: Full OU, EOMs full w/ No nystagmus

Fundoscopy: Red reflex intact OU, cup: Disk ≤ 0.5 OU, no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, neovascularization OU.

Ears: Symmetrical & normal size; no evidence of lesions, masses, trauma on external ears. No discharge, foreign bodies in external auditory canal AU. TM is pearly white

intact with light reflex in normal position billaterally
Auditory acuity intact to finger rubbing ALL.
Weber midline, Rinne AC > BC ALL.

Nose: Symmetrical, no evidence of masses, lesions, deformities, trauma, discharge. Nares patent bilaterally, nasal mucosa pink & well hydrated
No discharge noted on anterior Rhinoscopy.
Septum midline without lesion, deformities, injection, perforation. No evidence of foreign bodies

Sinuses: Non-tender to palpation over bilateral frontal, ethmoid & maxillary sinuses.

Lips & mucosa: Pink, well hydrated; no masses, lesions noted, non-tender to palpation. No evidence of leukoplakia.

Palate: Pink, well hydrated. Palate intact with no lesions, masses, scars. Non tender to palpation.

Teeth: Good dentition, no obvious dental caries noted

Gingivae: Pink, moist. No evidence of hyperplasia, masses, lesions, erythema, discharge. Non tender to palpation.

Tongue: Pink, well papillated; no masses, lesions, deviation noted. Non tender to palpation

Oropharynx: Well hydrated, pink; no masses, lessions, foreign bodies; No evidence of injection, exudate; tonsils present with no evidence of injection or exudate.
Uvula pink, no edema, lesions.

Neck: Trachea midline. No masses, lessions, scars, pulsation noted. Non tender to palpation. No stridor noted
@ carotid pulses, no thrills, bruits noted billaterally, no palpable adenopathy noted.

Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.

Chest: Symmetrical, no deformities, no evidence of trauma. Respirations unlabored, no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter: 2:1. Non tender to palpation.

Lungs: Clear to auscultation & percussion bilaterally. Chest expansion & diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious sounds.

Heart: JVP ≃ 3.0 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS, is mid clavicular line. Carotid pulses are 2+ bilaterally without bruits. S_1 & S_2 unremarkable. No murmur or extra heart sounds. RRR.

Abdomen: Flat, symmetrical, no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits noted over aortic, renal, iliac, femoral arteries. Tympany to percussion throughout. Tender to percussion and to deep palpation on LLQ & RLQ. CVAT noted bilaterally.

Negative Murphy's sign; No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness.

Anus, Rectum: No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses.

Prostate: Prostate smooth & non-tender with palpable

median sulcus. Stool brown + Hemocault negative.

Peripheral Vascular: The extremities are normal in color, size & temperature. Pulses are 2+ bilaterally in upper & lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally. 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.

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Assessment: Mr MV, 49 y/o Latino male with significant PMH of DM2, presents to the ER c/o hematuria, dysuria, frequency & nocturia x 4 days. R/O malignancy.

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Plan.

- Continue taking Metformin daily
- urine culture - check for bacteria
- urinalysis - urine test that can explain why urine is red.
- PSA blood test & Digital rectal exam - to check if the prostate is enlarge.
- BUN & creatinine to check on kidney functioning
- CBC - To check for calcium, uric acid, phosphorus, sign of stones.
- Blood glucose - check for DM is controlled.
- Urethral smear & culture to check for STDs.

Very good plan!

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DDx:

1) Hemorrhagic cystitis - sudden onset of hematuria w/supra pubic pain.
2) Recurrent UTI - Subjective fever, burning when urinate frequency, ~~had pyelonephritis last month~~ started here KC
3) Pyelonephritis - CVA positive, had pyelonephritis last month, frequency, subjective fever, hematuria.
4) Prostate hyperplasia. - frequency, nocturia, may cause hematuria
5) Stones - can irritate the urinary tract & cause bleeding, severe pain, CVA positive.

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6) STD - Gonococcal urethritis would cause dysuria