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HPI – #2

CC: "Congestion" x 8 days

HPI: 81 y/o F accompanied by daughter with a PMH of HTN and DMII presenting to urgent care due to right ear clogging sensation, nasal congestion, sore throat and post nasal drip for the past 8 days. She states that the nasal congestion is always present since it began and has been getting worse. The patient also reports a strong pressure-like sensation around the front of her face and reports that blowing her nose makes the congestion worse with a 5/10 on severity. Patient states that when they have been blowing their nose, they see greenish-yellow nasal mucus on the tissue paper. She reports having a history of sinus infections and states that it feels like one. Patient has been using Claritin over the counter and flonase for symptom relief and has been mildly helping. She denies any fever, cough, chest pain, SOB, abdominal pain or N/V/D.

Past Medical History:
-Hypertension
-Diabetes type II
-Hyperlipidemia
-Asthma
-Denis any history childhood illnesses
-Immunizations: Up to date on all immunizations

Past Surgical History:
-Cholecystectomy 2006

Medications:
-Amlodipine 5 mg
-Empagliflozin 10 mg
-Metoprolol Succinate 50 mg
-Rosuvastatin 10 mg

Allergies:
-N.K.D.A
-Denies food allergies
-Admits to seasonal allergies

Family History:
-Mother: Admits HTN and DM II - Deceased
-Father: HTN. Denies DM II - Deceased
-No known cancer in either parent

Immunizations
-Up to date with all childhood immunizations
-Up to date COVID-19 Pfizer vaccines with boosters.
-Not up to date with Influenza vaccine.

Social History:
Status - Pt currently lives with family at home.

Occupation - Pt is retired.

Habits - Spends most days at home. Admits to drinking 1-2 cups of tea every day.

Smoking - Denies any smoking use of cigarettes or vape products.

Illicit drugs - Denis any use of drugs.

Alcohol - Denies any alcohol use.

Diet - Consists of various carbohydrates and meats like rice, potatoes, oatmeal, chicken and fish

Exercise - Denies any exercise use.

Sleep - Admits to getting 7 hours of sleep a night.

Travel - Denis any recent travel in the past 30 days.

Sexual - Not sexually active

Review of systems:
General - Denis weight loss, night sweats, weakness.

Skin, Hair and Nails - Denies skin, hair, nail changes, discolorations, pruritus, or new moles.

Head - Denies vertigo, head trauma or headaches.

Eyes - Denies photophobia, discharge, dryness. Last eye exam- unknown

Ears - **Admits ear clogging sensation.** Denies any ear pain, use of hearing aids, deafness or tinnitus.

Nose/sinus - **Admits to nasal congestion and facial sinus pressure.** Denies pain or epistaxis.

Mouth/throat - **Admits to sore throat and post nasal drip**. Denies any mouth ulcers, bleeding gums, lesions or use of dentures. Last dental exam - unknown

Neck - Denies any known masses or swelling.

Breast - Denies any breast masses, nipple discharge or breast pain.

Pulmonary system - Denies cough, shortness of breath, wheezing or hemoptysis.

Cardiovascular system - Denies chest pain, palpitations, syncope or lower leg edema.

Gastrointestinal System - Denies abdominal pain, nausea, dysphagia, diarrhea, or rectal bleeding.

Genitourinary system - Denies dysuria, urinary frequency, urinary urgency, flank pain or oliguria.

Menstrual/obstetrical – Denies any vaginal bleeding, pain or discharge.

Nervous - Denies seizures, sensory disturbances or ataxia.

Musculoskeletal system - Denies swelling or arthritis.

Peripheral vascular system - Denies any known skin changes or ulcers.

Hematologic system - Denies any hx of anemia, abnormal bleeding, easy bruising.

Endocrine system - Denies heat intolerance, goiter or excessive sweating.

Psychiatric - Denies depression, anxiety or suicidal ideations.

Physical
General: 81 y/o F sitting upright on clinic exam chair on room air , A&Ox3 (person, place, time), responding to questions, appears stated age and in mild discomfort.

Vital Signs
BP: Seated: R: 140/82 mm/Hg
RR: 16 breaths/min, unlabored, regular rhythm
Pulse: 92 beats/minute, regular
Temp: 98.4 F, Oral thermometer
SPO2: 96% in room air
Height: 5’2”
Weight: 170 lbs
BMI: 31.1

Skin: Skin was pink, warm & moist with good turgor. Non-icteric in nature.

Hair: Grayish black hair color, normal texture, distribution, and quantity noted.

Nails: Capillary refill on nails was under 2 seconds. No clubbing, erythema, swelling, lesions were noted.

Head: Normocephalic, atraumatic and nontender on palpation.

Eyes: PERRLA, EOMs intact with no strabismus, exophthalmos, or ptosis. Sclera was white, cornea clear, conjunctiva pink and clear. 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, or neovascularization OU

Ears: **Right ear:** Moderate fluid levels build up noted on the right tympanic membrane. No discharge, TM bulging, ear canal irritation or perforations noted. **Left ear:** Mild tympanic membrane fluid level build up otherwise intact, cone of light in normal position AU. Auditory acuity intact to whispered voice AU. Finger rub test demonstrated intact auditory acuity. Weber midline, Rhinne showed AC>BC B/L.

Nose: **Nasal turbinates appear enlarged and swollen. Clear rhinorrhea noted B/L.** Symmetrical nares. No deviated septum, masses, lesions or trauma. No foreign bodies or nasal septal hematoma noted B/L.

Sinuses: **Tender to palpation and percussion over bilateral maxillary sinuses.** No frontal sinus tenderness.

Lips: Pink, moist, no cyanosis, cheilitis or lesions. Non-tender to palpation

Oral mucosa: Pink and dry. No masses or lesions or leukoplakia. Non-tender to palpation

Palate: Pink and well hydrated. Palate intact with no lesions, masses or scars. Continuity intact.

Teeth: Overall good detention, no signs of loose teeth.

Gingivae: Pink and moist. No hyperplasia, masses, lesions, erythema or discharge.

Tongue: Pink and well papillated. No masses, lesions or deviation noted.

Oropharynx: **Post nasal drip noted.** No exudate, lesions, foreign bodies of any kind noted. Uvula is midline.

Neck: **Mild anterior cervical lymphadenopathy present.** Trachea midline. No masses, lesions or scars present.

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

Chest -Anterior/posterior chest appears symmetrical in nature. Respirations unlabored with no signs of paradoxical respirations or use of accessory muscles noted. Lats to AP diameter 2:1. Non-tender to palpation throughout.

Lungs – Regular rate, rhythm, depth. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. Negative bronchophony, egophony, or whispered pectoriloquy.

Heart: S1 and S2 are present. No murmurs or S3/S4 sounds heard. Carotid pulses are brisk 2+ bilaterally without bruits. JVP is 3 cm above the sternal angle with the head of the bed at 30 ° .The PMI is tapping, 1 cm lateral to the midclavicular line in the 5th intercostal space.

Abdomen: Abdomen symmetric and round throughout with no pulsations noted. Bowel sounds hypoactive in all four quadrants with no renal/iliac or femoral bruits. No hepato-splenomegaly to palpation, no CVA tenderness appreciated. Light and deep palpation over all four quadrants with negative TTP, guarding or rebound tenderness. Percussion in all four quadrants are tympani in nature. Negative tenderness to palpation at McBurney's point. Neg Rovsing sign, no guarding, no rebound tenderness. Negative Murphy's sign.

Musculoskeletal: Muscles are symmetrical in size with no involuntary movements. Full ROM and joints are without pain, tenderness or swelling.

Breast: Not preformed

Female genitalia: Not preformed

Anus, rectum: Not performed.

Neurologic: Mental status: Pt is alert and oriented to person, place and time. Recent and remote memory is intact, attention, abstract thinking, and new learning ability are intact. Cranial nerves II-XII intact. Good muscle bulk and tone with strength 5/5, no fasciculations. Cerebellar: Rapid alternating movements, finger to nose intact. Gait includes normal stride, on toes, on heels, and tandem walking intact. Negative Romberg and Pronator Drift. Sensory- Pinprick, light touch, graphesthesia, stereognosis, position and vibration intact bilaterally.

Reflexes:

	Bicep	Tricep	Brachioradialis	Patellar	Ankle/Achilles	Babinski
Right	2+	2+	2+	2+	2+	Absent
Left	2+	2+	2+	2+	2+	Absent

Initial labs/imaging:
-None were performed
-Declined Rapid covid and flu testing in clinic

Differential Diagnosis:

1. **Acute Bacterial Sinusitis:** The patient's symptoms of nasal congestion, sore throat, postnasal drip, facial pressure, and greenish-yellow nasal discharge are classic signs of sinusitis. The duration and worsening of symptoms over seven days suggest a bacterial etiology rather than viral sinusitis. Examination findings of tender sinuses and tympanic membrane fluid build-up further support this diagnosis.
2. **Allergic Rhinitis:** The patient's symptoms with a history of seasonal allergies could potentially suggest allergic rhinitis. However, the presence of greenish-yellow nasal discharge and facial pressure around the maxillary sinus makes this diagnosis less likely.
3. **Viral Upper Respiratory Infection:** A viral URI could present with similar symptoms but again the presence of greenish-yellow nasal discharge may suggest a bacterial component.

Assessment: 81 y/o F with a PMH of HTN and DMII presenting to urgent care due to symptoms of ear congestion, nasal congestion, sore throat and post nasal drip for the past 8 days. Physical exam showed evidence of maxillary sinus tenderness, post nasal drip and air fluid levels in both ears. Along with the physical exam and worsening of symptoms for 8 days suggest a bacterial etiology of sinusitis.

Plan:

#Bacterial Sinusitis

- Start Augmentin Tablet, 875-125 MG, 1 tablet, Orally, every 12 hrs, 10 day

-Continue Flonase (Fluticasone) Nasal Spray for ongoing symptom relief from nasal congestion and inflammation.

-Acetaminophen (Tylenol) 500 mg: Take 1-2 tablets every 8 hours as needed for pain or fever.

-Consider humidification: Use a humidifier in your bedroom to maintain moisture in the air, which can help alleviate nasal congestion and throat irritation.

-Avoid Environmental Triggers by minimizing exposure to known allergens or irritants that may exacerbate sinus symptoms, such as dust, pet dander, smoke, or strong odors.

#HTN, DMII and HLD

-Continue all medications as prescribed

Patient education:

Hello Mrs. G.S, based on everything you told us and your physical exam, it seems you have a bacterial sinus infection. As you know, sinusitis is an infection of the sinuses, the air-filled spaces in the bones of your face. Usually within a week's time, it's viral but based on your presentation, I suspect it's bacterial in origin. To treat your acute bacterial sinusitis, I have prescribed you a broad spectrum antibiotic known as Augmentin, to help as it is the first line for treatment. Additionally, you may continue to use Flonase nasal spray to reduce inflammation and acetaminophen for pain relief. It's important to take these medications as directed and to drink plenty of fluids to help thin mucus and promote drainage. If your symptoms worsen, don't hesitate to come back or head to the nearest ER.