Family Medicine – HPI #2

Chief Complaint: “swelling and pimple on my leg” x 2 days

HPI

Ms. P. H. is a 57y/o F with PMHx HLD who presents today complaining of a painful “pimple-like” lesion on her lower left leg for 2 days now. She states that the lesion is located on the distal left shin near the ankle with small pinpoint open ulceration without active bleeding, drainage, or pus. She first noticed the lesion when she woke up in the morning with a bothersome “hot” pain that has been constant. The pain is described as sharp with palpation and achy at rest and when walking, rated as a 5/10. She states that she noticed that there is redness of the area of concern, increased warmth, and swelling that has been worsening over the past 2 days. She denies any itchiness, known trauma, cuts, scratches, insect bites, or application of new products to the area. She states that she has applied Vicks and warm compresses to help with the pain, but the pain and swelling persist. She denies taking any over-the-counter pain medications such as Tylenol or Ibuprofen. She also denies having a similar episode like this in the past. She states that she can ambulate, but the pain limits her daily activities and says that she stays at home for the majority of the day.

She denies fever, chills, chest pain, shortness of breath, abdominal pain, nausea, vomiting, diarrhea, headache, blurry vision, history of blood clots, recent travel, prolonged immobilization, recent hospitalizations, or recent antibiotic use.

PMHx

- Hyperlipidemia → controlled with Rousuvastatin 20mg
- Iron Deficiency Anemia → controlled with Ferrous Sulfate 325mg (65 Fe)
- Immunizations: Up to Date, including influenza, COVID-19, Shingrix, and Pneumococcal (PCV 20)

PSHx

- No known past surgeries or hospitalizations.

Medications

- Rosuvastatin 20mg, QD for HLD
- Ferrous Sulfate 325mg (65 Fe), QD for Fe-Deficiency Anemia
- Daily Supplements/Vitamins: None
- Patient states she is compliant with her Rosuvastatin and Iron Supplements

Allergies

- No known drug, food, or environmental allergies.

FHx:

- Paternal/Maternal Grandparents → unknown medical history.
- Mother → alive and well, Hx of DM 2, HTN, HLD
- Father → alive and well, Hx of HLD, HTN
- 2 Sons → alive and well, no known medical history

SHx

- Ms. P. H. is a home health aide who lives with her husband.
- Habits → denies tobacco smoking, alcohol consumption, and illicit drug use.
- Travel → no recent travel

- Diet → states she eats a balanced diet with mainly salads and greens, rice with curry and meats, and does not like sugary foods
- Exercise → main physical activity is when she works as a home health aide, taking care of people.
- Sexual → states she is sexually active with her husband and uses barrier protection.

<u>Preventive Screenings</u>
Pap Smear: last done in 2023 with HPV co-testing (negative). Next due in 2028.
Mammogram: last done in Feb 2025. Next due Feb 2026, a referral was given to the patient to make an appointment.
Colorectal Cancer Screening: Colonoscopy done in 2022. Next Due 2032.

<u>ROS</u>
General – Denies fever, chills, unexplained weight loss, and night sweats.

Skin – Admits to a new lesion on the left lower leg with redness, warmth, and pain. Denies any new lesions elsewhere, pus drainage, or itchiness.

HEENT – Denies vision changes, blurry vision, hearing loss, epistaxis, or sore throat.

Neck – Denies any neck pain or stiffness.

Chest/Cardiovascular – Denies any chest pain or palpitations.

Pulmonary – Denies shortness of breath, cough, wheezing, hemoptysis, or history of blood clots.

Gastrointestinal – Denies abdominal pain, nausea/vomiting/diarrhea, or constipation.

Nervous – Denies numbness or tingling of the upper and lower extremities, headaches, or dizziness

Musculoskeletal – Admits to pain with walking due to left lower leg discomfort. Denies joint pain, calf pain, or decreased ROM.

Peripheral Vascular – Admits to swelling of the left lower leg. Denies swelling of right lower leg.

<u>Vital Signs</u>
BP: Seated 117/75 mmHg

P: 88 bpm

RR: 16 breaths/min, unlabored breathing with no accessory muscle use

T (temporal): 97.2 °F

O2 Sat: 98% on room air

Height: 60.5 in | **Weight:** 113 lbs | **BMI:** 21.7

<u>Physical Exam</u>

General: AxO3. Well-appearing female in mild discomfort sitting upright on chair, does not appear in any acute distress, and appears well-nourished. Appears stated age of 57 years old.

Skin: No signs of diaphoresis, cyanosis, or pallor. Warm and dry to palpation. Comparably warmer on the left lower anterior and lateral shin near the ankle versus the right lower extremity.

HEENT: PERRLA bilaterally, sclera is white, conjunctiva is pink, mucous membranes are pink and moist without lesions or exudates seen

Cardiac: Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4 gallops.

Lungs: Able to speak in full sentences without accessory muscle use. Lung sounds are vesicular bilaterally without rales or wheezing.

MSK: Full active ROM of the knee and ankles bilaterally, but with pain with dorsiflexion and plantarflexion of the left ankle. No calf tenderness or palpable cords bilaterally.

Peripheral Vascular: capillary refill <2 seconds in upper & lower extremity nailbeds. Left lower extremity of the lower shin/ankle area is noticeably erythematous that is not well-demarcated of approximately 5 x 8 cm, warmer to the touch, and edematous (non-pitting) compared to the right lower extremity. There is a central ulceration without active bleeding, drainage, fluctuance, or purulence to palpation. The erythematous area is tender to palpation without signs of crepitus. Dorsalis pedis/posterior tibial pulses are 2+/2+ on the right and 2+/3+ on the left.

<u>Labs/Imaging</u>
None done at this visit.

<u>Assessment</u>

Ms. P. H. is a 57y/o female with PMHx of HLD who presents with 2 days of progressive unilateral left lower leg erythema that is poorly demarcated and spreading, warmth, tenderness, and swelling with a central ulceration without purulence, crepitus, fluctuance, or systemic symptoms. She is afebrile and hemodynamically stable with intact lower peripheral pulses. Given these findings, uncomplicated cellulitis is most consistent at this time.

Primary Diagnosis: Cellulitis

- <u>Rationale:</u> Most likely due to the acute onset of unilateral erythema, warmth, tenderness, swelling with central ulceration, which is most likely the cause of the infection. There is no purulence, fluctuance, crepitus, fever, or other systemic symptoms.

<u>D/Dx</u>

1. DVT
    a. <u>Rationale:</u> DVT can become acutely life-threatening and presents similarly with unilateral lower extremity swelling and pain. However, the absence of calf tenderness, palpable cords, normal distal pulses, and risk factors (e.g., recent immobilization/travel, recent surgery, prior history of clots) makes this less likely.
2. Erysipelas
    a. <u>Rationale:</u> Can be considered, but less likely than cellulitis due to poorly demarcated borders of the erythema and absence of fever and other systemic symptoms.
3. Soft Skin Tissue Abscess

   a. Rationale: Can be considered due to localized pain and skin lesion, but less likely with the absence of fluctuance, purulence, and systemic symptoms.
4. Contact Dermatitis
   a. Rationale: Can present with localized erythema and swelling, but is least likely given that there is mainly pain without itchiness, no known exposures to potential allergens or new products, and the progressive spreading of erythema.

Problem Lists & Plan

Cellulitis [Primary Plan]

- Start patient on Cephalexin 500mg taken 3 times a day (1 capsule every 8 hours) for 7 days.
- Start patient on mupirocin ointment 2% to apply to the affected area externally 3 times a day for 7 days.
- Marked the current region of erythema with a pen
- Patient Education: Informed the patient about suspected cellulitis and the treatment regimen. Advised the patient to finish the course of treatment as prescribed, even if symptoms improve, keep the affected area clean and dry, and avoid scratching or applying other non-prescription products (e.g., Vicks). Advised patient to monitor for any worsening and spreading of redness, swelling, increased pain, drainage of blood/pus, or development of fever. Advised patient to seek urgent care or go to the emergency room if systemic symptoms like fever/chills develop or if the lesion and affected area quickly worsen despite treatment. Follow up in 1 week or sooner if symptoms worsen.

HLD

- Continue Rosuvastatin 20mg. Patient is due for blood work. Advised patient to return for blood work once suspected cellulitis is resolved.

Iron Deficiency Anemia

- Continue Ferrous Sulfate 325mg QD. Recheck CBC and iron panel when patient returns for blood work.

Preventative Health

- Mammogram is due this February. Referral was given to the patient to make an appointment sometime in February or after.

Other Patient Education

- Discussed the importance of medication adherence for HLD and Fe-deficiency anemia. Discussed lifestyle measures for overall health, such as a balanced diet, avoiding processed foods, and maintaining regular physical activity as tolerated.