

Lisette Romo PA-S2

Chief Complaint: "My left heel has been hurting more"

HPI:

A 76-year-old female with a past medical history significant for atrial fibrillation on Eliquis, hyperlipidemia, and rheumatoid arthritis presents for evaluation of a worsening left heel ulcer. The patient initially developed bilateral heel ulcers approximately four months ago, and at that time, had x-rays of both heels that demonstrated arthritic changes. Since then, the left heel ulcer has progressively worsened. Due to concern for a possible osseous involvement, a repeat radiograph of the left heel was obtained yesterday, (06/01/2026). Today, the patient reports intermittent dull and aching left heel pain rated at 6/10. She states that elevating the left heel on a pillow at night provides mild symptomatic relief. At baseline, she ambulates with a walker; however, due to worsening left heel pain, she uses a wheelchair for mobility. Denies fever, chills, purulent drainage, bleeding, lower extremity swelling, paresthesias, and radiation of pain.

Past Medical History:

Chronic Atrial Fibrillation

Hyperlipidemia

Rheumatoid Arthritis

Surgical History:

Right knee replacement (date unknown)

Medications:

Atorvastatin Calcium Oral Tablet 80mg, 1 tablet by mouth at bedtime for hyperlipidemia

Apixaban oral tablet 5mg, 1 tablet by mouth two times a day for Afib

Metoprolol Succinate ER tablet 1 tablet by mouth one time a day for Afib

Aspercreme Lidocaine Patch 4% topically in the morning

Polyethylene Glycol 3350 Oral Packet 17 grams by mouth one time a day for constipation

Icy Hot Pain Relief topically every shift for RA joint pain

Gabapentin Capsule 300mg 1 capsule by mouth three times a day

Dakin's (1/2 strength) External Solution 0.25%

Patient is compliant with her medications per RN

Allergies:

Lactulose - reaction unknown

Family History:

Unknown family history

Social History:

M.F is a 76-year-old female residing in the LTC unit. She is a friendly resident who enjoys participating in daily activities such as karaoke.

Habits: No past alcohol, tobacco smoking, or illicit drug use.

Diet: Patient eats a diet mainly consisting of carbohydrates and enjoys eating in large portions

Exercise: Patient does not exercise

ROS:

General: Denies fever, chills, and night sweats

Skin: Reports an open skin wound on the left heel

HEENT: Denies headaches, changes in vision, or sore throat

Neck: Denies any neck pain/ stiffness

Cardiovascular: Denies chest pain, palpitations

Pulmonary: Denies SOB, wheezing, coughing, hemoptysis

Gastrointestinal: Denies nausea, vomiting, diarrhea

Neurologic: Denies numbness or tingling sensations, dizziness

Musculoskeletal: Reports left heel pain

Peripheral Vascular: Denies lower extremity swelling, leg cramping, or color changes to the extremities.

Endocrine: Denies excessive thirst, frequent urination, or unintentional weight loss

Hematologic: Denies any easy bruising or prolonged bleeding

Vital Signs:

H: 55 in W: 268.7lbs BMI: 62.4

BP: 138/96 mmHg

HR: 70bpm

RR: 18 breaths/ min

T: 97.6F

O2Sat: 95% on room air

Physical Examination:

General: Patient appears her stated age of 76 years old, AOx3 (to person, place, time), patient found seated comfortably in no acute distress in a wheelchair watching TV in the common area section. Exam performed while seated in WC.

Skin: Wound appreciated on the left posterior heel measuring approximately 1.5cm with red granulation tissue, and mild maceration, no purulence, surrounding erythema, or slough. Surrounding skin is warm, dry and intact.

Cardiac: Irregularly irregular rhythm. No murmurs, gallops, or rubs.

Lungs: Able to speak in full sentences without accessory muscle use. Clear to auscultation bilaterally, no rhonchi/rales, wheezing, or crackles.

Abdomen: Positive normoactive bowel sounds in all four quadrants, soft, non-tender, non-distended, large pannus at baseline

Musculoskeletal: Moves B/L upper and lower extremities spontaneously

Peripheral Vascular: Capillary refill <2 seconds in B/L upper and lower extremities. No B/L lower extremity pitting edema noted. Difficult to palpate dorsalis pedis and posterior tibial pulses bilaterally, likely secondary to increased body habitus.

Labs/Imaging:

Left heel x-ray (6/1): Marked osteopenia and arthritic changes noted. Questionable osteolysis of the posterior calcaneus noted. Increased loss of bone was noted when compared to the previous study on 02/27/26. (Radiologist recommended an MRI for further evaluation based on the report.)

Assessment:

A 76-year-old female with a significant past medical history of atrial fibrillation, rheumatoid arthritis, hyperlipidemia, presents with a chronic left heel ulcer of approximately four months and reported worsening left heel pain now. Physical examination was notable for a 1.5cm left posterior heel wound with granulation tissue and maceration. A repeat X-ray was performed, demonstrating osteopenia and questionable posterior calcaneal osteolysis in comparison to prior imaging from 02/26. Given clinical presentation and imaging findings, concerned for a possible osteomyelitis.

Differential Diagnosis:

1. Osteomyelitis
 - a. Rationale: She presents with a chronic left heel ulcer and worsening heel pain. Repeat X-ray demonstrates osteolysis and increased bone loss compared to prior imaging, concerning for an underlying bone infection.
2. Pressure Ulcer:
 - a. Rationale: The patient is wheelchair-dependent and obese (class III based on BMI), placing her at higher risk for pressure injury development. Pressure ulcers commonly

develop over the bony prominences, such as the heels, hips, and sacrum areas, particularly in patients with prolonged pressure and decreased activity.

3. Rheumatoid Arthritis (related bony erosion)
 - a. Rationale: The patient has a history of RA, and this condition can also cause bony erosion changes on imaging and chronic osteopenia; however, the patient has an overlying chronic heel ulcer, which lowers this on the DDX.
4. Peripheral Arterial Disease:
 - a. Rationale: Although the pt's B/L LE pulses were difficult to palpate, a concern for PAD should be considered, affecting wound healing. However, the pt did not complain of intermittent claudication; the ulcer was also on the heel and not on the lateral malleolus, as a typical arterial ulcer would be located. Her clinical presentation is less concerning for PAD.

Problem list/ Plan:

#Left Heel Pressure Ulcer / R/O Osteomyelitis

- Start Levofloxacin 500 mg PO daily x 7 days
- Scheduled podiatry in-house consult today
- Continue Dakin's solution wound care as ordered
- Reinforce use of bilateral heel-offloading boots and pillow elevation while in bed to maintain skin integrity
- Reviewed 6/1 x-ray of the left heel demonstrating marked osteopenia, arthritic changes, and questionable posterior calcaneal osteolysis
- Consider MRI if concern for osteomyelitis persists
- Obtain bloodwork for signs of infection (CBC w/ differential, ESR/CRP)
- Start Juven supplementation to support wound healing
- Encourage repositioning as tolerated to reduce pressure and promote wound healing
- Monitor for drainage, erythema, worsening pain, fever, or signs of systemic infection

Chronic conditions:

#Rheumatoid Arthritis

- Continue diclofenac gel PRN for pain flare-ups.
- RA might contribute to calcaneal erosive changes/ osteopenia seen on imaging → obtain MRI
- Conduct a medication review to assess current DMARD therapy
- Monitor for worsening joint pain, swelling, stiffness, or functional decline

#Atrial Fibrillation

- Continue Apixaban for stroke prophylaxis
- Continue Metoprolol for rate control

#Hyperlipidemia

- Continue Atorvastatin 80 mg PO daily

- Schedule an in-house appointment with a registered dietitian to encourage healthy eating habits.

#Constipation

- Continue polyethylene glycol 3350, 17 g PO daily.
- Continue senna 17.2 mg PO at bedtime.
- Encourage PO hydration

#Patient Education

- Reinforced the importance of heel offloading and pressure reduction
- Instructed patient to report worsening pain, drainage, redness, swelling, or fever

Code Status: Full code