Date of visit: 2/09/2026

Chief complaint: Here for test results.

HPI: Pt is a 35 YOM with PMHx of HTN, HLD, type II DM, and obesity, currently on antibiotics for left first hallux infection, who presents to the clinic to discuss recent blood results. While here, pt complains of left wrist pain for 6 months which he attributes to heavy lifting for his job as a meat butcher. Pain was gradual in onset without acute trauma and is progressively worsening, affecting his ability to work because he is left-hand dominant. He describes the pain as constant, aching, rated 8/10, and localized to the posterior and lateral portions of the wrist without radiation. Pain is exacerbated by wrist rotation, heavy lifting, and cold weather. He was using a wrist brace which helped temporarily, and he has not tried any medications to relieve the pain. Denies fever, chills, joint swelling, erythema, numbness, tingling, weakness, or morning stiffness.

Pt reports taking Lantus 30 units daily and Humalog 50 units after meals twice daily. He rarely checks his home glucose readings because he is "too busy with work." He was previously prescribed a Dexcom for continuous glucose monitoring but he never used it. Denies polyuria, polydipsia, or blurred vision.

Past Medical History
- Hypertension x current
- Hyperlipidemia x current
- Type II diabetes x current
- Osteomyelitis of left first hallux, currently on antibiotics under podiatry management.

Immunizations:
- Pzifer COVID-19 vaccine administered 03/2021; booster 04/2022
- Not UTD with Flu vaccine; last administered 2024

Past Surgical History
- Debridement of left 1st hallux (I&D of abscess)

Medications
- Lisinopril 10 mg oral; take 1 tablet by mouth daily for high blood pressure
- Insulin glargine (Lantus) 30 units SQ nightly
- Insulin lispro (Humalog) 50 units SQ before meals twice daily
- Dexcom G6 receiver, sensor, and transmitter
- Flonase Allergy Relief 50 mcg; inhale 2 nasal, 1 time daily in each nostril for inflammation of the sinuses and nose as needed
- Olopatadine HCl 0.1% solution; instill 1 ophthalmic 1 time every 12 hours as needed
- Magnesium 400 mg; take 1 tablet by mouth daily at bedtime
- Melatonin 5 mg oral; take 1 tablet by mouth daily at bedtime as needed for trouble sleeping
- Fish oil capsules for HLD

Allergies
No known medication allergy
No known food allergy
Allergy to pollen

Family History
- Mother 52 years of age, alive & well, no medical problems
- Maternal grandmother, aunt, and cousin all with hx of breast cancer

- Father deceased at age 60; hx of HTN and DM
- Paternal grandparents both with hx of type II DM

Social History
Habits: endorses social alcohol use, 1-2 drinks occasionally on the weekends only; current smoker of 13 years, including 1 cigar per day. Denies illicit drug use.
Diet: patient endorses only 1 meal per day due to busy work schedule. He does not eat breakfast, goes to work, and eats when he gets home at night (says his meals vary, but includes red meats, rice, pasta).
Exercise: does weight-lifting once a week.
Travel: no recent travel.
Sleep habits: doesn't sleep much; 4-5 hours per night.
Marital status/living situation: lives in Manhattan with girlfriend.

Screenings:
PHQ 2 & PHQ9 Depression screening negative in office today
Audit C screening negative in office today
Dast 10 screening negative in office today
Social needs screening negative in office today
Ophthalmology: last visit was May 2025; has appointment for next month (March 2026)
Dental: last visit was 2025 (unable to recall month); plans to make appointment in 2026

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
Skin: denies rash, itching, excessive sweating or dry skin
HEENT: denies headache, visual changes, double vision or blurriness, tinnitus, discharge from ears, nose bleed or discharge, congestion, sore throat, mouth ulcers or bleeding gums
Neck: denies localized swelling, lumps, stiffness or decreased ROM
Pulmonary: denies cough, SOB, orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: denies chest pain, palpitations, or swelling of legs or feet
Gastrointestinal: denies nausea, vomiting, diarrhea, constipation, abdominal pain, decreased appetite, or pain with swallowing
Genitourinary: denies urinary frequency or urgency, nocturia, dysuria, hematuria, incontinence, flank pain or vaginal discharge
Neurological: denies numbness, weakness, tingling, or seizures
Musculoskeletal: reports left wrist pain; denies swelling, redness, deformity, or trauma
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Psychiatric: denies depression, anxiety, mood changes, new difficulty sleeping, difficulty concentrating or suicidal ideations

Physical Exam
General: 35 year old obese male, well developed and well groomed. Pt appears stated age. Wearing boot on left foot secondary to first hallux infection.

Vital Signs:
Blood pressure: 156/96 mmHg
Respiratory rate: 16 breaths per minute
Pulse: 91 BPM
Temperature: 98 F
SpO2: 97%
Height: 6 feet 5 inches
Weight: 336 pounds

BMI: 39.84

Skin: warm and moist, good turgor. Nonicteric, no lesions.
Head: normocephalic, atraumatic. No tenderness. No palpable masses. Even hair distribution.
Eyes: normal pink conjunctiva; white sclera. PERRL, EOMI. Anicteric. No discharge or exudates.
Ears: normal hearing. External canal is intact, no discharge. TM intact with no bulging, fluid, or blood collection noted.
Nose: symmetrical, patent nares. No nasal flaring/grunting/discharge.
Mouth/oropharynx: good dentition. Moist mucus membranes. No oropharyngeal exudates or ulcers. No oral or gum erythema, swelling, or bleeding. No FBs.
Neck: symmetric and supple. Trachea midline. Full ROM. No JVD. Non tender. No palpable lymphadenopathy, masses, or goiter. No bruits.
Pulm: symmetrical expansion with respiration. No intercostal retractions, or tenderness. Breath sounds equal bilaterally. No rules, wheezes, or rhonchi auscultated. No fremitus.
CV: regular rate and rhythm. S1 and S2 heard. No murmur, thrills, or clicks.
Abdomen: soft and non distended. No tenderness or guarding. No palpable masses or organomegaly. No inguinal hernia. No palpable lymphadenopathy.
Extremities/MSK: tenderness to palpation and with active/passive rotation of left wrist, crepitus on radial region of left wrist, limited ROM of left wrist secondary to pain; no obvious deformities, clubbing, cyanosis, or edema noted. No visible joint swelling or erythema. Bilateral upper and lower pulses present.
Mental status/neuro exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to person, place, and time. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically. Strength and sensation intact.

Prior lab results from 12/2025:
Hemoglobin A1C: 9.2%
Glucose: 248
Total cholesterol: 232
Triglycerides: 285
LDL: 152
HDL: 32

Assessment: Pt is a 35 YOM with PMHx of HTN, HLD, poorly controlled type II DM, and active osteomyelitis of left first hallux on antibiotics who presented to the clinic for blood work interpretation. Recent labs demonstrate persistent hyperglycemia (elevated A1C and glucose) and uncontrolled hyperlipidemia (elevated LDL and triglycerides and low HDL), placing pt at a significantly elevated cardiovascular risk given HTN, BMI of 39.84 and tobacco use. Pt also meets criteria for metabolic syndrome.

Pt also reports chronic left wrist pain for 6 months, progressively worsening and interfering with his job as a meat butcher, as it is painful to move his wrist, lift heavy objects, or cut meat with a knife. Clinical presentation is most consistent with chronic overuse tendinopathy vs early degenerative changes. Low suspicion for inflammatory processes given absence of swelling or systemic symptoms. Neuropathy is also less likely given lack of neurological deficits such as numbness or tingling.

Differential Diagnoses
1. Tendinopathy due to chronic overuse
    A. Pt's occupation as a meat butcher since he was a teenager involves repetitive wrist rotation and heavy lifting, which places significant mechanical stress on the wrist tendons. His pain developed gradually without acute trauma, and has progressively worsened over 6 months, consistent with a repetitive strain injury. Pain is worsened by wrist rotation and lifting, and was

temporarily improved with wrist brace, further supporting a mechanical etiology. On exam, pt has localized tenderness and pain with active and passive ROM, without swelling erythema or systemic symptoms, making inflammatory or infectious causes less likely. Pt admits to never allowing the area to heal, and continued receptive use without adequate rest likely impairs tendon healing. Additionally, his poorly controlled diabetes may contribute to tendon glycosylation and delayed tissue repair.

2. De Quervain's tenosynovitis
    A. Pt's job requires repetitive cutting, lifting, and wrist rotation leading to overuse which may cause De Quervain's tenosynovitis, an inflammatory condition that affects the tendons of the thumb side of the wrist. Crepitus is noted along this area of pt's wrist (radial side). Further, his pain is worsened with rotation of the wrist and when he has to work (which includes grasping a knife and cutting meat). A brace temporarily relieved the pain, which supports a tendon sheath irritation. Further, this condition is most common in ages 30-50, fitting this patient's age group. A physical exam finding that would have further supported this diagnosis would have been the Finkelstein test.
3. Early osteoarthritis
    A. Osteoarthritis is a non-inflammatory, degenerative joint disease caused by the gradual breakdown of cartilage that may be caused by repetitive stress. Although OA is more common in older populations, it should still be considered in this 35 year old patient with poorly controlled type II diabetes and who's occupation requires receptive mechanical use. Diabetes is a pro-inflammatory state and is associated with cartilage degeneration, advanced glycation end products in joint tissue and increased risk of early degenerative joint diseases, such as OA. His obesity further contributes to accelerated degenerative changes. The gradual progression of pain, limited ROM, crepitus, and increased pain with cold weather all support a diagnosis of OA, but pt's age, relatively short symptom duration, and lack of chronic stiffness makes this diagnosis less likely.
4. Diabetic neuropathy
    A. Given the pt's history of poorly controlled type II diabetes (evident by inadequate medication adherence and elevated glucose/A1C), diabetic neuropathy was considered. However, given the lack of bilateral stocking-glove distribution, neurological symptoms such as numbness, tingling, weakness, and the presence of activity-related mechanical pain with crepitus, this diagnosis is least likely.

Plan/Workup

Labs:

- Will repeat blood work in 3 months, including A1C to assess diabetes control, CMP to assess renal function, and lipid panel to assess cholesterol levels

Imaging:

- XR to rule out osteoarthritis (assess for joint space narrowing)
    - If (-) —> will consider MRI

Medications:

- Continue Lantus 30 units nightly
- Continue Humalog 50 units BEFORE meals
- Initiate Mounjaro 10 mg/0.5 mL SQ auto-injector; administer 10 mg SQ one time weekly for type II diabetes
- Initiate Atorvastatin 40 mg for HLD (and continue fish oil)
- Continue Lisinopril 10 mg; will consider dose adjustment if BP is consistently >140/90
- Continue antibiotics for osteomyelitis
- Diclofenac sodium topical gel 1%; apply 2-4 g to affected area 4x daily

Referrals:

- Physical therapy for chronic left wrist pain
- Orthopedics

Patient education:
Pt was advised to rest the wrist in order to allow healing, and to continue using the wrist brace at night. He was advised to use topical NSAIDs as needed for pain.

Pt was educated on the importance of medication adherence, specifically to take Humalog before meals, not after. He was advised to use the Dexcom to monitor his glucose very closely, especially due to the addition of Mounjaro, a GLP-1/GIP receptor agonist, to assess for hypoglycemia and the need to titrate dose down. He was given a glucose log for him to bring to the next visit. He was also given a BP log and advised to take his BP at least once a day to monitor for high readings.

Pt was educated on lifestyle changes, including eating 3 structured meals per day with foods high in lean protein and fiber. He was encouraged to do 150 minutes of physical activity every week, in order to lose 5-10% of his initial body weight. He was educated on the importance of smoking cessation due to increased risk of cardiovascular disease. Pt was offered nicotine replacement therapy which he declined.