CC : F/U post ER visit 05/28/2026

HPI: Mr. J is a 75-year-old African American male with PMHx of HTN, CHF, DM2, PVD, CAD, HLD, HTN, BPH, PTSD and left BKA who was seen today for follow-up after evaluation in the Manhattan VA Emergency Department for fever and chills. Resident initially developed a low-grade fever which progressed to 101.2°F with associated chills despite supportive measures at the facility, prompting transfer to the ED for further evaluation. Prior to transfer, laboratory workup including CBC, BMP, and urinalysis was obtained. In the ED, resident was diagnosed with an acute urinary tract infection and discharged back to the facility on cefpodoxime 100 mg PO BID for 7 days. Since returning to the facility, resident reports improvement in symptoms and has been compliant with antibiotic therapy. Today, resident denies fever, chills, headache, dizziness, chest pain, palpitations, shortness of breath, cough, abdominal pain, nausea, vomiting, dysuria, urinary frequency, urinary urgency, or flank pain. He is tolerating oral intake without difficulty and reports no new concerns at this time.

Medications

- Acetaminophen 1000 mg PO TID for pain
- Aluminum/magnesium hydroxide/simethicone 30 mL PO q6h PRN GI upset
- Ascorbic acid 500 mg PO every other day
- Aspirin 81 mg PO daily
- Atorvastatin 80 mg PO daily
- Bisacodyl 5 mg PO QHS
- Creon 2 capsules PO TID AC
- Gabapentin 300 mg PO QHS
- Glucagon 1 mg IM q15 min PRN hypoglycemia
- Insulin aspart 4 units SC TID AC
- Insulin glargine 10 units SC QHS
- Metoprolol succinate 25 mg PO daily; hold for HR <60 and SBP <95
- Polyethylene glycol 3350 1 packet PO QHS
- Sacubitril/valsartan 1 tablet PO q12h; hold for SBP <100
- Senna 17.2 mg PO QHS
- Sertraline 150 mg PO daily
- Spironolactone 25 mg PO daily
- Tamsulosin 0.4 mg PO daily
- Tramadol 50 mg PO q8h for pain
- Trazodone 100 mg PO QHS
- Hydralazine 75 mg PO q8h

- Cefpodoxime 100 mg PO BID x7 days after ER visit for UTI

PMHx

- ST-elevation myocardial infarction, status post cardiac catheterization in 2024
- Coronary artery disease
- Congestive heart failure
- Hypertension
- Hyperlipidemia
- Type 2 diabetes mellitus, insulin-requiring
- Peripheral vascular disease
- Chronic right third digit non-healing wound/eschar
- Chronic pancreatitis
- Exocrine pancreatic insufficiency
- Constipation
- Anemia
- Pulmonary nodules
- Benign prostatic hyperplasia
- Chronic pain
- Neuropathic pain
- Post-traumatic stress disorder
- Major depressive disorder
- History of cellulitis
- History of tinea pedis

PSHx

- Cardiac catheterization in 2024 - 2 stent placement, no complication
- Left below-knee amputation in 10/2025
- Right first and second toe amputations
- Left fifth digit and partial ray amputations in 08/2025
- Left lower extremity diagnostic angiogram on 10/17/2025
- Right lower extremity diagnostic angiogram on 04/28/2026
- Penile implant in 2006, no complication

Allergies

Shellfish

Zolpidem (Ambien)

FHx

Unknown

SHx

Habits → History of cocaine, alcohol, and tobacco use.

Diet → Facility diet as ordered with diabetic diet considerations

Exercise → Participates in PT/therapy as tolerated. Uses left lower extremity prosthesis during therapy.

Baseline functional status → Long-term care resident. Primarily wheelchair-dependent at baseline, s/p left BKA

ROS

General: Denies fever, chills, fatigue, weakness, or night sweats.

Skin: Admits chronic right 3rd toe wound. Denies worsening pain, drainage, malodor, increased redness, or new skin breakdown.

HEENT: Denies headache, dizziness, lightheadedness, blurred vision, or recent vision changes.

Cardiovascular: Denies chest pain, palpitations, or syncope.

Pulmonary: Denies shortness of breath, cough, wheezing, or sputum production.

Gastrointestinal: Admits Constipation. Denies abdominal pain, nausea, vomiting, or diarrhea.

Genitourinary: Denies dysuria, urinary frequency, urgency, hematuria, suprapubic pain, or flank pain.

Neurological: Denies weakness, numbness, tingling, dizziness, or changes in mental status.

Musculoskeletal: Admits chronic right 3rd toe pain. Denies recent falls, myalgias, or arthralgias.

Psychiatric: Denies worsening depression, anxiety, hallucinations, or acute mood changes.

Physical Exam

Vital Signs

BP: Seated 96/61 mmHg

HR: 73 bpm

RR: 18 breaths/min, unlabored breathing with no accessory muscle use

T (oral): 97.9 °F

O2 Sat: 99% on room air

Height: 73 in | Weight: 144.5lbs | BMI: 19.1 kg/m²

General: Thin 75-year-old male in no acute distress, found sitting on bed. Alert and oriented x3. Appears to be stated age.

Skin: Warm and dry. Chronic right 3rd toe wound with stable eschar noted. No active drainage, malodor, surrounding erythema, or ascending cellulitis.

HEENT: Normocephalic, atraumatic. Mucous membranes moist.

Cardiovascular: S1 and S2 present.

Lungs: Respirations unlabored. Lung sounds clear to auscultation bilaterally without wheezes, rales, or rhonchi.

Abdomen: Round, soft, non-tender, non-distended. Bowel sounds present.

Genitourinary: No suprapubic tenderness.

Neurologic: Alert and oriented x3. No acute focal deficits noted.

Extremities: Left below-knee amputation noted. Right foot s/p 1st and 2nd toe amputations. Right 3rd digit with stable eschar and tenderness to palpation. No active drainage, erythema, or acute edema noted.

Labs / Imaging

CBC (05/27/2026)

- WBC: 8.21 K/uL

BMP (05/27/2026)

- Glucose: 295 mg/dL (H)
- Sodium: 134 mmol/L (L)
- Creatinine: 1.1 mg/dL
- eGFR: 70 mL/min/1.73m²

Urinalysis / Urine Culture

- Positive for urinary tract infection per ED evaluation.

Imaging

- Chest X-ray: No acute cardiopulmonary abnormality.

Assessment

Mr. J is a 75 year old male with PMHx of STEMI s/p cardiac catheterization (2024), insulin-dependent type 2 diabetes mellitus, HTN, HLD, CHF, PTSD, PVD, s/p right 1st and 2nd toe amputations, and s/p left BKA, seen today for follow-up after emergency department

evaluation for fever and chills. Resident was diagnosed with an acute urinary tract infection and discharged back to the facility on cefpodoxime 100 mg PO BID for 7 days. Today, resident reports improvement in symptoms and denies any associated symptoms. He is hemodynamically stable, and in no acute distress. Clinical presentation is consistent with improving acute urinary tract infection with resolution of fever following initiation of antibiotic therapy.

D/Dx

1. Acute Urinary Tract Infection (Most Likely)

- Resident presented with fever and chills and was diagnosed with a UTI during a recent ED evaluation.
- Most likely source of fever and chills

2. Diabetic Foot Infection / Chronic Right 3rd Toe Wound

- History of diabetes mellitus, peripheral vascular disease, prior toe amputations, and chronic non-healing right 3rd toe wound.
- Chronic wounds can serve as a source of infection and fever.
- Less likely as wound appears stable without drainage, malodor, or cellulitis.

3. Cellulitis

- History of cellulitis and chronic lower extremity wounds.
- Can present with fever in elderly patients.
- Less likely due to absence of erythema, warmth, swelling, or skin breakdown.

4. Upper Respiratory Infection / Pneumonia

- Common causes of fever in LTC residents.
- Less likely as resident denies cough, sputum production, shortness of breath, and lung exam is unremarkable.

5. Sepsis (Less Likely)

- Must be considered in an elderly resident with diabetes mellitus who initially presented with fever and chills.
- Urinary tract infection can serve as a source of systemic infection and progression to sepsis if untreated.
- Less likely at this time given hemodynamic stability, normal WBC count, absence of persistent fever, improvement in symptoms, and positive response to antibiotic therapy.
- No evidence of acute mental status changes, hypotension, tachypnea, or other signs of ongoing systemic infection.

Plan/Problem List

#Acute Urinary Tract Infection

- Continue Cefpodoxime 100 mg PO BID x 7 days.
- Encourage increased PO fluid intake.
- Monitor for dysuria, urinary frequency, urgency, hematuria, suprapubic pain, or flank pain.
- Monitor for adverse reactions to antibiotic therapy.

#Fever

- Continue Acetaminophen 650 mg PO q6h PRN
- Monitor temperature and vital signs.
- Encourage hydration.
- Notify provider for recurrent fever, worsening symptoms, or change in mental status.

#Right 3rd Toe Non-Healing Wound

- Continue local wound care with Betadine and dressing changes
- Continue follow-up with Podiatry and Vascular Surgery.
- Monitor for worsening pain, drainage, malodor, erythema, or signs of infection.

#Type 2 Diabetes Mellitus

- Continue current insulin regimen.
- Monitor fingerstick blood glucose levels.
- Encourage diabetic diet compliance.

#Patient Education

- Complete the full course of antibiotics.
- Maintain adequate hydration.
- Report fever, chills, dysuria, flank pain, confusion, or worsening wound symptoms.

Code status : Full Code