

**CC:** “I have had pain in both calves for about 2 weeks”

**HPI:** Mr. V is a 74-year-old Hispanic male with PMHx of hypertension, morbid obesity, vitamin D deficiency, vitamin B12 deficiency, hypertriglyceridemia, chronic venous insufficiency, osteoarthritis, obstructive sleep apnea, vertigo, debility, PTSD, alcohol abuse, and schizoaffective disorder was seen and examined at bedside today for his monthly visit. During today's visit, patient % bilateral calf pain that began approximately 2 weeks ago. He describes the pain as a constant aching sensation involving both calves, rated 6/10 in severity. He denies radiation of pain into the feet, thighs, or back. Resident states that he has not experienced similar symptoms in the past and is unable to identify any specific aggravating or alleviating factors. Resident has a history of DVT/PE and reports compliance with chronic rivaroxaban therapy. He denies recent falls, trauma, prolonged immobilization, or changes in activity level. He also denies associated redness, warmth, increased swelling, numbness, tingling, weakness, chest pain, palpitations, or shortness of breath.

### **Medications**

- Acetaminophen 1000 mg PO q12h
- Cyanocobalamin (Vitamin B12) 1000 mcg PO daily
- Ferrous sulfate 325 mg PO daily
- Fluoxetine 40 mg PO daily
- Gabapentin 600 mg PO q8h
- Hydrochlorothiazide 12.5 mg PO daily
- Lidocaine 5% patch to right hip daily (12 hours on/12 hours off)
- Lidocaine 5% patches to bilateral knees daily (12 hours on/12 hours off)
- Losartan 50 mg PO daily
- Polyvinyl alcohol ophthalmic solution 1 drop OU QID
- Rivaroxaban 20 mg PO daily
- Tirzepatide (Zepbound) 2.5 mg SC weekly
- Trazodone 200 mg PO at bedtime
- Vitamin D2 50,000 units PO weekly
- Risperidone 2 mg PO at bedtime

### **PMHx**

- Hypertension
- Morbid obesity
- Vitamin D deficiency

- Vitamin B12 deficiency
- Hypertriglyceridemia
- Chronic venous insufficiency
- Peripheral vascular disease
- Osteoarthritis
- Obstructive sleep apnea (OSA)
- Vertigo
- Debility
- Edentulous
- Alcohol use disorder
- Post-traumatic stress disorder (PTSD)
- Schizoaffective disorder
- History of DVT/PE
- Dry eye syndrome
- Hyperopia OU, astigmatism OS, presbyopia
- Bilateral hearing loss

**PSHX:** None

**Allergies**

Banana

Strawberries

**FHx:** unknown

**SHx**

Habits → History of alcohol use disorder. Denies current tobacco or illicit drug use.

Exercise → Participates in recreational and community activities as tolerated

Uses wheelchair for mobility

Diet → No added salt diet.

Sleep → History of obstructive sleep apnea; reports CPAP use at night.

**ROS:**

**General:** Denies fever, chills, fatigue, weight loss, night sweats, or recent illness.

**Skin:** Admits chronic xerosis of bilateral lower extremities. Denies new rash, drainage, bleeding, or new skin lesions.

**HEENT:** B/L hearing loss. Denies headache, dizziness, blurred vision, or sore throat.

**Neck:** Denies neck pain, stiffness, masses, or decreased range of motion.

**Cardiovascular:** Denies chest pain, palpitations, or syncope.

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

**Gastrointestinal:** Denies abdominal pain, nausea, vomiting, diarrhea, constipation, melena, or hematochezia.

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

**Musculoskeletal:** Admits bilateral calf tenderness, chronic back pain. Denies recent falls, trauma, or joint swelling

**Neurological:** Denies weakness, numbness, tingling, seizures, dizziness, or focal neurologic deficits.

**Peripheral Vascular:** Admits bilateral calf pain, chronic lower extremity edema and bilateral LE discoloration. Denies cool extremities, or non-healing wounds.

**Endocrine:** Denies heat intolerance, cold intolerance, polyuria, polydipsia, or recent changes in weight.

**Psychiatric:** History of schizoaffective disorder, PTSD, anxiety, and insomnia. Denies worsening depression, hallucinations, suicidal ideation, or homicidal ideation.

### **Vital Signs**

BP: Seated 127/69 mmHg

P: 69 bpm

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

T (oral): 97.9 °F

O2 Sat: 97% on room air

Height: 67 in | Weight: 373 lbs | BMI: 58.54

### **Physical Exam**

**General:** Well-appearing morbidly obese Hispanic male in no acute distress, lying in bed. Alert and oriented x3. Appears stated age.

**Skin:** Warm and dry. No open lesions, erythema, or drainage noted. Xerosis noted to bilateral lower extremities and feet.

**HEENT:** Anicteric sclerae. Oral mucosa moist. Edentulous.

**Cardiac:** S1 and S2 present. No murmurs, rubs, or gallops.

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

**Abdomen:** Obese, soft, non-tender, non-distended. Bowel sounds present in all four quadrants.

**Neurologic:** Denies numbness or tingling of the upper and lower extremities, headaches, or dizziness

**Musculoskeletal:** Bilateral calf tenderness to palpation. No erythema, warmth, deformity, or acute swelling noted. No joint tenderness.

**Peripheral Vascular:** Mild bilateral non-pitting edema. Extremities warm to touch. Peripheral pulses difficult to palpate bilaterally. Hard crusting noted to bilateral feet with dystrophic toenails. No cyanosis or skin breakdown noted.

### Assessment

Mr. V is a 74 year old Hispanic male with PMHx of morbid obesity, chronic venous insufficiency, peripheral vascular disease, osteoarthritis, hypertension, schizoaffective disorder, PTSD, and history of DVT/PE on chronic rivaroxaban therapy, seen during monthly follow-up with complaint of bilateral calf pain for approximately 2 weeks. Patient describes constant aching bilateral calf pain rated 6/10 without associated trauma, falls, erythema, warmth, or acute swelling. Physical examination notable for bilateral calf tenderness and chronic trace non-pitting edema. Given his history of venous disease and prior thromboembolic events, further evaluation is warranted despite current anticoagulation. Clinical presentation is most consistent with chronic venous insufficiency, however, recurrent DVT must be excluded.

### D/Dx

#### **1. Chronic Venous Insufficiency**

- History of chronic venous stasis and morbid obesity.
- Bilateral calf discomfort with chronic lower extremity edema.
- Common cause of chronic lower extremity aching and heaviness.

#### **2. Deep Vein Thrombosis**

- History of prior DVT/PE.
- Although DVT classically presents with unilateral leg pain and swelling, resident reports new bilateral calf tenderness for approximately 2 weeks.
- Resident is primarily wheelchair-dependent with multiple risk factors including obesity, limited mobility, and prior thromboembolic disease.
- Although currently on rivaroxaban and lacks significant swelling, warmth, or erythema, recurrent thrombosis cannot be completely excluded and should be evaluated with bilateral lower extremity venous Doppler ultrasound.

#### **3. Peripheral Vascular Disease**

- Known PVD with nonpalpable pulses.

- May contribute to lower extremity discomfort due to impaired circulation.

#### **4. Musculoskeletal Pain Secondary to Osteoarthritis and Deconditioning**

- History of osteoarthritis, lumbar disc degeneration, debility, and obesity.
- Chronic altered gait mechanics and limited mobility may contribute to bilateral lower extremity pain.

#### **5. Lumbar Radiculopathy / Referred Pain from Degenerative Spine Disease**

- History of lumbar disc degeneration.
- Lower extremity pain may be referred from spinal pathology.
- Less likely as the patient denies numbness, tingling, weakness, or radiating pain.

### **Problem Lists & Plan**

#### **#Bilateral Calf Tenderness**

- Bilateral lower extremity venous Doppler
- Continue to monitor pain and lower extremity changes.
- Notify provider for worsening calf pain, swelling, redness, warmth, SOB, chest pain, or change in condition.

#### **#Morbid Obesity**

- Zepbound/tirzepatide approved; start weekly injection today.
- Continue MOVE program and diet.
- Educated resident on portion control, diet modification, and physical activity as tolerated.
- Consult with registered dietician
- Currently on no added salt diet.
- Encourage out of bed activity and wheelchair mobility as tolerated.
- Monitor weight, appetite, GI side effects, nausea/vomiting, abdominal pain, and tolerance to medication.

#### **#Chronic Pain due to Osteoarthritis**

- History of lumbar disc degeneration and chronic OA pain.
- Continue acetaminophen 1000 mg PO q12h for pain.
- Continue gabapentin 600 mg PO q8h for neuropathic pain.
- Continue lidocaine 5% patch to right hip, 12 hours on/12 hours off.
- Continue lidocaine 5% patches to bilateral knees, 12 hours on/12 hours off.

- Continue fall/safety precautions.
- Encourage frequent position changes and use of pressure redistribution wheelchair cushion/surface.
- Encourage activity as tolerated.
- Continue to monitor pain and response to treatment.

#### #Chronic Venous Stasis / Xerosis / PVD

- Bilateral lower extremities with trace nonpitting edema, hard crusting of feet, and dystrophic nails.
- Continue moisturizing cream/skin care
- Encourage leg elevation while in bed.
- Continue using compression stockings
- Podiatry to continue following.
- Vascular consult as needed.
- Monitor skin integrity and lower extremity changes.

#### #Hypertensive Heart Disease / Diastolic Dysfunction / HLD

- BP goal <130/80.
- HTN controlled on current regimen.
- Continue losartan 50 mg PO daily; hold for SBP <100.
- Continue hydrochlorothiazide 12.5 mg PO daily with losartan; hold for SBP <100.
- Lipitor discontinued per prior plan.
- Continue to monitor BP.

#### #History of DVT/PE / Anticoagulation

- Continue rivaroxaban 20 mg PO daily with full meal.
- Monitor for signs/symptoms of bleeding.
- Continue compression stockings

#### #Schizoaffective Disorder / PTSD / Anxiety / Insomnia / Adjustment Disorder

- Continue fluoxetine 40 mg PO daily.
- Continue trazodone 200 mg PO HS.
- Continue risperidone 2 mg PO QHS.
- Chronic coarse tremors noted at baseline; not affecting ability to hold objects/function at this time.
- Continue to monitor mood, sleep, behavior, EPS/TD, metabolic syndrome, weight, bowel movements, tremor, and medication side effects.

- Continue participation with recreation therapy and community activities.
- Continue supportive care.
- Psychiatry follow-up PRN.
- Follow up EKG q4 months; last 04/04/2026.
- Follow up risperidone level q6 months as indicated.

#Dry Eye Syndrome / Hyperopia OU / Astigmatism OS / Presbyopia

- Continue polyvinyl alcohol 1.4% ophthalmic solution, 1 drop QID.
- Optometry follow-up pending/as indicated.

#Obstructive Sleep Apnea

- Resident reports trouble sleeping at night and uses CPAP at night.
- Encourage CPAP use nightly.
- Pulmonary follow-up as needed.

#Bilateral Hearing Loss

- Resident uses bilateral hearing aids.
- Audiology follow-up PRN.

#Vitamin B12 Deficiency / Vitamin D Deficiency / Iron Supplementation

- Continue cyanocobalamin 1000 mcg PO daily.
- Continue vitamin D2 50,000 units PO weekly.
- Continue ferrous sulfate 325 mg PO daily.
- 12/10/2025 B12: 375.
- 12/10/2025 iron: 43.
- Monitor CBC, B12, vitamin D, and iron studies as indicated.

**Code status : Full Code**