Mid-Site Visit: HandP

Name: [redacted]
Address: 123 45th St, Queens, NY 11419
DOB: [redacted]
Location: [redacted] Pediatric Medical Office
Religion: unknown
Source of information: Self and Mom
Reliability: Reliable
Source of Referral: Mom

CC: “I have been coughing, I'm congested, and my throat is sore” x3 days

HPI: [redacted] is a [redacted]yo F bib mom c/o cough, nasal congestion, and sore throat x3 days. R.G. c/o an intermittent dry cough that is not worsened w/ exertion. States episodes typically last a couple of seconds up to 30 seconds. She denies hemoptysis, SOB, difficulty breathing, wheezing, or chest pain. R.G thinks the throat is sore because of her cough, stating it's only sore after a bout of coughing. R.G. reports fever last night and is currently afebrile. R.G. denies pain w/ swallowing, anorexia, and rates the throat pain 4/10. R.G denies recent sick contacts or travel outside the country. Has not taken any medication

R.G. had one bout of non-bloody vomit last night after dinner. She finished dinner, had a coughing bout, and brought up her food. She denies any preceding nausea. She denies recent diarrhea, abdominal pain, or eating new foods.

PMHx:
High BMI
Recurrent ear infections

Immunizations:
Completed childhood series
- MMR, Varicella, HepB, HepA, Polio, DTap

Tdap booster (2025)
Influenza (2026)
Covid Series (date unknown)

PSH:
Tube placement in the R ear (2005)

Medications: None

Allergies: NKDA

FHX:
Mom - 41 htn and DM2
Dad - unknown
No siblings

Social Hx:
Living Situation: lives with her mom
Social life: has friends at school
Psych: denies feeling sad or anxious. Denies wanting to hurt herself or others
Diet: She likes steak, rice, and going out to dinner.
Sexual hx: denies sexual activity
Smoking: denies
ETOH: denies
Drugs: denies
Recent travel: denies
Sleep: likes to go to sleep early

ROS:
Constitutional: see HPI
Skin, Hair, Nails: denies rashes, masses, ulcers, or swelling
Head: denies HA
Eyes: denies changes in vision or ocular pain
Nose/Sinus: reports congestion
Mouth/Throat: see hpi
Neck: denies neck stiffness or lumps
Breast: denies fhx of breast CA, tenderness, or discharge
Pulm: see hpi
CV: denies chest pain, palpitations, or syncope
GI: see hpi
GU: denies difficulty urinating
Neuro: denies confusion, dizziness, or paresthesias
Heme: denies new rashes or easy bruising
Endo: denies heat or cold intolerance
Psych: pt denies anxiety, depression, suicidal ideation, or memory loss

Physical exam:
General: Pt is 14 yo F in NAD w/ black pants and a pink sweatshirt, sitting on the exam table, accompanied by her mom. Pt is dressed appropriately for the weather and appears pleasant.

Vital Signs:
BP: Right seated: 110/76 Left seated: 112/76
RR: 15
P: 85
T: 97.8
O2 sat: 99%

Height: 61in Weight: 145lbs BMI 27.5 BMI% 95.3

Hair: long brown hair. No signs of alopecia or lice.

Skin and Nails: skin appears smooth w/out rashes or lesions. Nails appear normal-shaped and non-brittle.

Neck: Neck is supple w/ full ROM. No masses or lymphadenopathy noted. Trachea midline

Eyes: No conjunctival injection or pallor present. PERRLA b/l. no pain w/ EOM

Ears: There is a white plaque present on the lower border of the Right TM. Both TMs are intact w/out perforation. A pearly gray cone of light is present and the umbo is visible. External structures are non-tender w/out masses. The EAC is non-tender w/out erythema or edema.

Nose: mucous noted. mucosa is pink and moist w/out signs of bleeding or purulence.

Mouth and Pharynx: There is a .8cm, white, cystic structure on the R tonsil. Touching the structure w/ a tongue depressor did not elicit pain. Mucosa is moist and pink w/out rash. The uvula is midline and rises symmetrically. There is a cobblestone appearance of the posterior pharynx w/ mild erythema. There are no tonsilar exudates.

Tongue: normal papillae present. No atrophic glossitis or angular chelitis present. No strawberry tongue

Upper Extremity: radial pulses 2+ b/l. NV status intact b/l. Cap refil <2 seconds

Heart: RRR, S1 and S2 present. No S3 or S4. No rubs, murmurs, or arrhythmias

Lung: No adventitious breath sounds b/l. Chest expands symmetrically w/ no accessory muscle use

Abdominal exam: Abdomen is non-tender to light and deep palpation in all 4 quadrants. No peritoneal signs present.

Lower Extremity: DP and PT pulses 2+ b/l. NV status intact b/l

Assessment: [redacted] is a [redacted] yo F c/o cough and sore throat x3 days. Presentation is consistent w/ a viral URI. The pt had 2 abnormal PE findings: a cystic structure on the R tonsil and a white plaque on the R t m anic membrane. There was no tenderness to palpation of the cystic structure. The pts mom reports [redacted] had tubes put in her ear when she was a child. [redacted] mom also reports tha [redacted] is hard of hearing, [redacted] agrees.

Problem List:

1) Cough
2) Sore throat
3) x1 bout of vomit
4) White plaque on TM
5) Difficulty hearing
6) Tonsilar mass
7) Obesity

DDx:

1) Viral URI
    a) Cough, nasal congestion, and sore throat are consistent w/ viral URI. Pt is afebriel, has no abnormal lung findings, no tonsilar exudates, clear tympanic membranes, and no cervical lymphadenopathy. At this time, it should be treated as a virus.
2) Cough-induced vomit
    a) The abdominal exam is unremarkable, the pt denies nausea, and one isolated incidence of vomit directly after a coughing fit aligns w/ cough-induced vomit. The pt denies all other GI complaints
3) Tonsilar Cyst
    a) The mass had a bright white, perfectly spherical appearance directly on the right tonsil. There was no tenderness upon palpation. Tonsilar cyst is the most likely benign finding. There is no tenderness to palpation of the neck or parotid swelling, which points away from parotid pathology.
4) Tympanosclerosis
    a) Given the child's history of ear surgery and tube placement, tympanosclerosis aligns well with the PE finding. The plaque on the membrane had a distinct “frosted” or “snowflake” distribution classic to tympanosclerosis
5) Cholesteatoma
    a) This is important to r/u for this child but less likely. The pt has a hx of ear surgery and is reporting hearing loss. This is a must not miss.
6) Excess calorie-induced obesity
    a) Early intervention needed to prevent long term complications

Plan:

1) Treat the URI conservatively
    a) APAP 10-15mg/kg q4-6 hours
    b) Ibuprofen 10mg/kg q6-8 hours
    c) Throat lozenges
        i) Return precautions
            (1) If the pain in the throat progresses over 1 week, return for re-evaluation
2) Monitor vomiting
    a) If nausea, vomiting away from mealtimes, or other GI symptoms develop, return for re-evaluation
    b) Encourage fluids
3) Referral to ENT
    a) Ear findings
        i) Difficulty hearing, TM plaque, hx of tube placement
    b) Oral cyst
        i) Non-tender to palpation,
4) Obesity
    a) Referral to a nutritionist
    b) Encourage physical activity, avoid sedentary lifestyle, limit screen time, limit processed foods
    c) Perform a lipid panel at the next visit