**H&P 1 for TLC**

**Overall thinking is good. Write up needs to reflect your thinking a little more clearly. Especially the HPI needs to start with the beginning of the story – the rash and his first visit – and then progress on to what you see and what he says on the day of the visit. A number of areas need more specifics (see below). Assessment needs to include your impression of how he’s doing with each complaint.**

**Identifying Data:**

Full Name: C.L.

Date of Birth: xx/xx/1954

Age: 64 y/o

Sex: Male

Date & Time: 03/18/2019, 9:50 am

Location: VA, Jamaica, NY

Religion: N/A

Source of Information: Self

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** “red patches of skin lesions with pain and itching over left lower leg” x 2 years, "worsening" x 2 months.

**History of Present Illness:**

Mr. L, a 64 y/o male c/o red patches of skin lesions with pain and itching over left lower leg for 2 years, worsening for 2 months. The pain is consistent and sharp. The affected skin is dry. One month ago, he went to VA center and was diagnosed as psoriasis. After Clobex topical treatment, the pain and itching were relieved and the lesions became smaller. Denies fever, chill, cold or hot skin, claudication, trauma, allergy or STDs.

**This HPI would make more logical sense if you talked about the visit 1 month ago at the beginning e.g. “Mr. L, a 64 y/o male was seen in the clinic one month ago with a complaint of red, itching, painful patches of skin over lower left leg x 2 years, but worse over the previous 2 months. He was diagnosed as having psoriasis and started on Clobex topical lotion. Today he reports that he has improved…….” And then go into what his status is at the time you see him.**

**While you are describing his initial visit a month ago, you can also include what the lesions looked like at the time – which you will update later in the HPI with how they look like when seen by you.**

**Past Medical History:** None

**Past Surgery History:** None

**Past Hospitalization History:** None

**Immunizations** – Up to date. **This man is a veteran so we can assume he has had the basic immunizations, but which ones should you inquire about in the present?**

**Medications:** topic Clobex cream.

**Allergies:** Denies any drug, environmental or food allergies. **In this case, you would want to pursue this a little more since his chief complaint is itching lesions which may have an allergic component**

**Family History:** Mother died of MI in her seventies.

**Social History:** Single, living with brother. Denies drinking alcohol/caffeine, or illicit drug use. Smoking with 40 pack-years and quitting for 6 months. Denies recent travelling. Regular diet. Routine running **Would like to know how much running (indicator of his general state of conditioning)**. Denies sleeping problem. Sexually inactive.

**Review of Systems:**

General –Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever, chill or night sweats.

Skin, hair, nails – See Hpi.  **Since this man has a Dx of psoriasis, you would want to document whether he has lesions elsewhere (or has ever had them elsewhere) and also whether he has nail changes consistent with psoriasis.** Denies excessive sweating, moles or changes in hair distribution.

Head – Denies headaches, vertigo or head trauma.

Eyes – Denies pain, redness, swelling, visual disturbances, or photophobia. No glasses. Last eye exam 2018, normal.

Ears – Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or use dentures. Last dental exam 2016, normal. **How recently should he have had an exam?**

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion.

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Denies chest pain, palpitation, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system –Denies change in appetite, intolerance to specific foods, dysphagia, abdominal pain, nausea, vomiting, constipation, diarrhea, or jaundice. No colonoscopy.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysura, incontinence, awakening at night to urinate or flank pain. **In a man this age, also need to ask about hesitancy, dribbling.**

Nervous – Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

Musculoskeletal system – Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

Endocrine system – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric – Denies depression/sadness, anxiety, OCD or ever seeing a mental health professional.

**Physical Exam:**

General: Well developed, well nourished male, in no acute distress. Alert and cooperative. Looks just like his age.  **The usual phrase is “appears stated age”**

Vital signs: BP: R L

Seated 124/82 124/84

Supine 120/80 126/82

R: 16 breaths/min, unlabored

P: 84 beats/min, regular

T: 36.7 degrees C (oral)

O2 Sat: 98% Room air

Height 72 inches Weight 190 lbs. BMI: 25.8

Skin: warm, good turgor. Nonicteric, no tattoos. 5 dry, raised, red skin lesions covered with silvery scales on left lower leg, maximal 2x3 cm, minimal 0.5x0.5 cm, without swelling, discharge or tenderness. **Need a little more information as to where they are – e.g. dorsal, dorsolateral, etc. If they are improved, are they still covered with silvery scales?**

Hair: average quantity and distribution.

Nails: no clubbing, capillary refill <2 seconds throughout.

Head: normocephalic, atraumatic, non tender to palpation throughout

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity (uncorrected - 20/20 OS, 20/20 OD, 20/20 OU). Visual fields full OU. PERRLA. EOMs full with no nystagmus. Fundoscopy - Red reflex intact OU. Cup:Disk < 0.5 OU/no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.

Ears: Symmetrical and normal size. No evidence of lesions/masses / trauma on external ears. No discharge / foreign bodies in external auditory canals AU. TM's pearly white / intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC>BC AU.

Nose: Symmetrical / no obvious masses / lesions / deformities / trauma / discharge. Nares patent bilaterally / Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions / deformities / injection / perforation. No evidence of foreign bodies.

Lips: Pink, moist; no evidence of cyanosis or lesions. Non-tender to palpation.

Mucosa: Pink; well hydrated. No masses; lesions noted. Non-tender to palpation. No evidence of leukoplakia.

Palate: Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation.

Teeth: Good dentition / no obvious dental caries noted.

Gingivae: Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.

Tongue: Pink; well papillated; no masses, lesions or deviation noted. Non-tender to palpation.

Oropharynx: Well hydrated; no evidence of injection; exudate; masses; lesions; foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions

**I would consider combining these gray sections – only need to comment on the mucosa once, also the lesions, masses etc. Specifically, would note elevation of palate, condition of teeth and gums, and then more generally the hydration and condition of mucosa and whether there are any lesions, masses, etc.**

Neck: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no palpable adenopathy noted.

Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted.

Chest: Symmetrical, no deformities, no evidence trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation.

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious sounds.

Heart: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

Abdomen: Flat/ symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present. No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Soft. No evidence of organomegaly. No masses noted. No evidence of tenderness, guarding or rebound tenderness. No CVAT noted bilaterally.

Rectal: refused.

Peripheral Vascular: Skin normal in color and warm to touch upper and lower extremities bilaterally. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No cyanosis, clubbing / edema noted bilaterally.

Neurological:

Mental Status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted.

Cranial Nerves

I - Intact no anosmia.

II- VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopic + red light reflex OS/OD, discs yellow with sharp margins. No AV nicking, hemorrhages or papilledema noted.

III-IV-VI- PERRLA, EOM intact without nystagmus.

V- Facial sensation intact, strength good. Corneal reflex intact bilaterally. **While it’s good to practice this, in current day, mostly this is only used to document death.**

VII- Facial movements symmetrical and without weakness.

VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.

IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No Pronator Drift. Gait normal with no ataxia. Tandem walking and hopping show balance intact. Coordination by RAM and point to point intact bilaterally. Romberg negative.

Sensory: Intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally.

Reflexes R L R L

Brachioradialis 2+ 2+ Patellar 2+ 2+

Triceps 2+ 2+ Achilles 2+ 2+

Biceps 2+ 2+ Babinski neg neg

Abdominal 2+/2+ 2+/2+ Clonus negative

Meningeal Signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative.

Musculoskeletal: No soft tissue swelling / erythema this contradicts your earlier findings/ ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Non-tender to palpation / no crepitus noted throughout. FROM (Full Range of Motion) of all upper and lower extremities bilaterally. No evidence of spinal deformities.

**Assessment:** 64 y/o male with red patches of skin lesions with pain and itching over left lower leg for 2 years, worsening for 2 months, along with PE findings, compatible with diagnosis with psoriasis. **Need an assessment of how he is – improved/same/worse and why.**

**Plan:**

- Continue Clobex cream, apply to affected area BID.

- Retinoid cream, apply to affected area qdaily.

- Fish oil 3 g, qdaliy, PO.

- Follow up within 2 weeks.

Differential diagnosis based on the chief complaint: Psoriasis, Allergic Contact Dermatitis, Atopic Dermatitis, Cutaneous Squamous Cell Carcinoma, Lichen Planus, Lichen Simplex Chronicus, Mycosis Fungoides, Nummular Dermatitis, Pityriasis Alba, Pityriasis Rosea, Pustular Eruptions, Syphilis, Tinea, Subacute Lupus Erythematosus.

Differential diagnosis after H&P: Psoriasis, Atopic Dermatitis, Lichen Planus, Lichen Simplex Chronicus, Mycosis Fungoides, Tinea.

Work up: After treatment, the symptoms were relieved. Diagnosis and treatment are proper and timely. **This is more properly included with your Assessment**

Follow up: follow up with dermatologist within 2 weeks.

Patient education: Psoriasis is a long-lasting autoimmune disease characterized by patches of abnormal skin. These skin patches are typically red, dry, itchy, and scaly. Psoriasis varies in severity from small, localized patches to complete body coverage. There are five main types of psoriasis: plaque, guttate, inverse, pustular, and erythrodermic. Plaque psoriasis, also known as psoriasis vulgaris, makes up about 90 percent of cases. It typically presents as red patches with white scales on top. Areas of the body most commonly affected are the back of the forearms, shins, navel area, and scalp. The disease affects two to four percent of the population. The disease may begin at any age, but typically starts in adulthood. Psoriasis is associated with an increased risk of psoriatic arthritis, lymphomas, cardiovascular disease, Crohn's disease and depression. Psoriasis is generally thought to be a genetic disease that is triggered by environmental factors. Symptoms often worsen during winter and with certain medications, such as beta blockers or NSAIDs. Infections and psychological stress can also play a role. Psoriasis is not contagious. The underlying mechanism involves the immune system reacting to skin cells. Diagnosis is typically based on the signs and symptoms. There is no cure for psoriasis; however, various treatments can help control the symptoms. These treatments include steroid creams (no long term use), vitamin D3 cream, ultraviolet light and immune system suppressing medications, such as methotrexate. About 75 percent of cases can be managed with creams alone. Call doctor right away if any of these unlikely but serious side effects occur: stretch marks (striae), skin thinning/discoloration, excessive hair growth, acne, hair bumps (folliculitis), skin peeling or bleeding.

**As discussed at our visit, this is a good discussion of the disease, but is not what you would tell the patient – here you would discuss instructions for treatment of the lesions, any dressings or similar that need to be done and any issues he would need to understand better – like proper use of retinoid cream (and need to avoid sunlight exposure when using it) and similar.**