URGENT CARE
Coming Soon to an Urgent Care Near You: “The Good, The Bad, and the Ugly” of Patient Presentations!

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DISCLOSURES:

• I have not received any monetary or other reimbursements from any of the resources that I recommend.

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Agenda:

• Introduction – Overview
• Prognostication tools used in Emergency Medicine (EM) to guide further work up
• Case studies for Urgent Care (UC)
• Break – 10 minutes
• Case studies for Urgent Care
• Break out group case studies
• Wind up review
INTRODUCTION: DEFINITIONS

PRIMARY CARE {INSTITUTE OF MEDICINE – (IOM)}

the IOM defines primary care as: “the provision of integrated, accessible health care services by clinicians who are accountable for addressing the large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”

URGENT CARE (MERRIAM WEBSTER)

Medical care provided for illnesses or injuries which require prompt attention but are typically not of such seriousness as to require the services of an emergency room"
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP)-
Definition of Emergency Medicine

Emergency medicine is the medical specialty dedicated to the diagnosis and treatment of unforeseen illness or injury. It encompasses a unique body of knowledge as set forth in the “Model of the Clinical Practice of Emergency Medicine.” The practice of emergency medicine includes the initial evaluation, diagnosis, treatment, coordination of care among multiple providers, and disposition of any patient requiring expeditious medical, surgical, or psychiatric care.

Emergency medicine is not defined by location, but may be practiced in a variety of settings including hospital-based and freestanding emergency departments (EDs), urgent care clinics, observation medicine units, emergency medical response vehicles, at disaster sites, or via telemedicine.
TOOLS OF THE TRADE:

- WELL’S CRITERIA - PULMONARY EMBOLISM (PE)
- PERC RULE FOR PULMONARY EMBOLISM
- HEART SCORE - ACUTE CORONARY SYNDROME
- STROKE - FAST
TOOLS: WELL’S CRITERIA FOR PE

• The Wells' Criteria risk stratifies patients for pulmonary embolism (PE), and has been validated in both inpatient and emergency department settings. Its score is often used in conjunction with d-dimer testing to evaluate for PE.
  - Only useful for low risk patients

• There must first be a clinical suspicion for PE in the patient (this should not be applied to all patients with chest pain or shortness of breath, for example).

• Wells' can be used with either 3 tiers (low, moderate, high) or 2 tiers (unlikely, likely). ACEP’s 2011 clinical policy on PE recommends the two tier model
  - Wells’ is often criticized for having a “subjective” criterion in it (“PE #1 diagnosis or equally likely”)

• Wells’ is not meant to diagnose PE but to guide workup by predicting pre-test probability of PE and appropriate testing to rule out the diagnosis

https://www.mdcalc.com/wells-criteria-pulmonary-embolism#next-steps
TOOLS: WELL’S CRITERIA FOR PE

- Clinical signs and symptoms of DVT  
  No = 0  Yes = + 3
- PE is #1 diagnosis OR equally likely  
  No = 0  Yes = + 3
- Heart rate > 100  
  No = 0  Yes = + 1.5
- Immobilization at least 3 days  
  OR equally likely  
  No = 0  Yes = + 1.5
- Previous, objectively diagnosed PE or DVT  
  No = 0  Yes = + 1.5
- Hemoptysis  
  No = 0  Yes = + 1
TOOLS: WELL’S CRITERIA FOR PE

Two Tier Model

1. Patient risk is determined to be “PE Unlikely” (0-4 points, 12.1% incidence of PE): consider high sensitivity d-dimer testing.
   - If the dimer is negative consider stopping workup.
   - If the dimer is positive consider CTA.

2. Patient risk is determined to be “PE Likely” (>4 points, 37.1% incidence of PE): consider CTA testing.
TOOLS: WELL’S CRITERIA FOR PE

Three Tier Model

1. Patient is determined to be **low risk (<2 points: 1.3% incidence PE)**: consider d-dimer testing to rule out Pulmonary embolism. Alternatively consider a rule-out criteria such as PERC.
   - If the dimer is negative consider stopping workup.
   - If the dimer is positive consider CTA.

2. Patient is determined to be **moderate risk (score 2-6 points, 16.2% incidence of PE)**: consider high sensitivity d-dimer testing or CTA.
   - If the dimer is negative consider stopping workup.
   - If the dimer is positive consider CTA.

3. Patient is determined to be **high risk (score >6 points: 37.5% incidence of PE)**: consider CTA. D-dimer testing is not recommended.
### TOOLS: PERC SCORE FOR PE

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<tr>
<td>Age ≥ 50</td>
<td>0</td>
<td>+1</td>
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<tr>
<td>HR ≥ 100</td>
<td>0</td>
<td>+1</td>
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<tr>
<td>SaO&lt;sub&gt;2&lt;/sub&gt; on room air &lt; 95%</td>
<td>0</td>
<td>+1</td>
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<tr>
<td>Unilateral leg swelling</td>
<td>0</td>
<td>+1</td>
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<tr>
<td>Surgery or trauma ≤ 4 weeks ago requiring treatment with general anesthesia</td>
<td>0</td>
<td>+1</td>
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<tr>
<td>Prior PE or DVT</td>
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- If no criteria are positive and clinician’s pre-test probability is <15%, PERC Rule criteria are satisfied
- No need for further workup, as <2% chance of PE

TOOLS: PERC SCORE FOR PE

- The Pulmonary Embolism Rule-out Criteria is utilized by providers to avoid further testing for Pulmonary Embolism in patients deemed low risk.

- The PERC Rule is a “rule-out” tool - all variables must receive a “no” to be negative.

- The test is *unidirectional*: while PERC negative typically allows the provider to avoid further testing, failing the rule *doesn't force* the clinician to order tests.

- As a rule-out criteria, PERC is not meant for risk-stratification.

- The physicians utilizing this rule must have a gestalt that the patient’s risk of PE is low (generally <15%).

- In the setting of a low-risk patient who is not PERC negative, the provider should consider a d-dimer for further evaluation.

https://www.mdcalc.com/perc-rule-pulmonary-embolism
TOOLS: HEART SCORE

**History:**  Highly suspicious (2 pts)  Moderately suspicious (1 pt)  Slightly suspicious (0 pts)

*High risk features:* Middle/left sided; Heavy pain; Diaphoresis; Radiation; n/v; Exertional; Relief of sx with nitro

*Low risk features:* Well localized; Sharp pain; Non-exertional; No diaphoresis; No n/v

2 pts = mostly high risk features  1 pt = mix of high and low  0 pts = mostly low risk features

**ECG:**  New ischemic changes (2pts)  Non-specific changes (1)  Normal (0 pts)

*Non-specific changes:* Repolarization abnormalities; Non-specific t wave and ST segment changes; Bundle branch blocks; Pacer rhythms; LVH; Early repol; Digoxin effect
TOOLS: HEART SCORE

**Age:**  
- ≥ 65 (2 pts)  
- 45-64 (1 pt)  
- < 45 (0 pts)

**Risk Factors:**  
- 3 or more RF OR known CAD, prior stroke, peripheral arterial disease,  
  - = (2 pts)  
- 1 – 2 RF = (1 pt)  
- 0 RF = (0 pts)

(Risk Factors): Obesity (BMI ≥ 30); Current of recent (≤ 90 days smoker; Currently treated diabetes; Family hx CAD (1st deg relative < 55 yo); Diagnosed and/or treated hypertension; Hypercholesterolemia

**Troponin:**  
- > 0.12ng/mL (2 pts);  
- 0.05 – 0.12 ng/mL (1 pt);  
- ≤ 0.04 ng/mL (0 pts)

Score: 0-3 pts Discharge; 4-6 pts OBS and stress; > 6 Admit to Cardiology

AMERICAN HEART STROKE: F.A.S.T.

F - Face drooping. (Is one side of the person’s face drooping or numb? When they smile, is the smile uneven?)

A – Arm weakness. (Is the person experiencing weakness or numbness in one arm? Have the person raise both arms. Does one of the arms drift downward?)

S – Speech difficulty. (Is the person’s speech slurred or hard to understand? Ask to repeat a simple sentence. Can they repeat it back?)

T – Time to call 9-1-1. (If any of these symptoms are present, dial 9-1-1 immediately. Check the time so you can report when the symptoms began)
URGENT CARE CASE STUDIES
#1. CC: Ankle Pain
20 Y/O F

HPI: 20 y/o F presents to ED with right ankle pain s/p mechanical fall, today. Pt fell down a few stairs injuring her ankle. No head strike, neck pain, knee pain or other injury. Pt is able to bear some weight on the ankle. No prior injury to the right ankle. No medication taken for pain.

PMH: History reviewed. No pertinent past medical hx

PSH: History reviewed. No pertinent past medical hx

Social Hx. Non smoker, social ETOH, neg drugs

Current medications: BCP
NKA

VS: T: 35.7 HR 76 RR 18 BP 127/79 SpO2 100
P/E: Swelling and tenderness over the lateral malleolus; stable to varus and vagus stress; stable anterior drawer test. Non-tender over any metatarsal. Distal sensation/circulation intact. Non tender over proximal fibula

Differential: Fracture, Sprain, Strain

Workup: X-Ray R ankle 3 views

Diagnosis: Distal lateral malleolus non/minimally displaced fracture without widening of the mortise

Treatment: Lower extremity splint– crutches – ice and elevate – crutches – orthopedic follow up 3-4 days –NWB until seen by ortho
#2. CC: Shortness of breath

6 Y/O F

6 yr old with mild persistent asthma (1 hospitalizations, no PICU, no intubations) presenting with cough and wheezing. Is on daily Qvar and prn albuterol. Since 2 days ago, has had cough and wheezing. Have been doing albuterol Q4H. However, today has been needing Q2H albuterol at home- last one at home given at 12:30 pm. Had mild retractions last night but none today. No fevers. Denies congestion, runny nose, sore throat, ear pain, abdominal pain, vomiting, diarrhea. Otherwise eating and drinking well. Urinating normally. Brother with similar symptoms at home. Followed by pedi pulmonology

- Pertinent PMH: Asthma, mild persistent, constipation recurrent UTI, wheezing, Urinary tract infection
- No pertinent surgical history
- Family Hx: Asthma – brother

Current Medications:
- albuterol (PROAIR HFA) 90 mcg inhaler
- albuterol 2.5 mg/3l (0.083%) nebulizer solution
- beclomethasone (QVAR) 40 mcg inhaler
- Montelukast (SINGULAIR) 5 mg chewable tablet
Review of Systems
Constitutional: Negative for activity change, appetite change and fever.
HENT: Negative for congestion and rhinorrhea.
Respiratory: Positive for cough, shortness of breath and wheezing.
Gastrointestinal: Negative for abdominal pain, diarrhea and vomiting.
Skin: Negative for rash.

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<td>118</td>
<td>(!) 26</td>
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<td>100 %</td>
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Physical Exam
Constitutional: She appears well-developed and well-nourished. She is active. No distress.
HENT:
Right Ear: Tympanic membrane normal.
Left Ear: Tympanic membrane normal.
Nose: Nose normal.
Mouth/Throat: Mucous membranes are moist. Dentition is normal. Oropharynx is clear. Pharynx is normal.
Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal. Right eye exhibits no discharge. Left eye exhibits no discharge.
P/E Continued
Cardiovascular: Normal rate, regular rhythm, S1 normal and S2 normal. No murmur heard.
Pulmonary/Chest: Effort normal. No stridor. No respiratory distress. Expiration is prolonged. She has wheezes. She has no rhonchi. She has no rales. She exhibits no retraction.
Abdominal: Soft. She exhibits no distension. There is no tenderness.
Lymphadenopathy: She has no cervical adenopathy.
Neurological: She is alert.
Skin: Skin is warm and dry. Capillary refill takes less than 2 seconds. No rash noted

Assessment: 6 yr old with mild persistent asthma (1 hospitalizations, no PICU, no intubations) presenting with cough and wheezing, with wheezing on exam but no increased WOB and normal pulse ox. Consistent with acute asthma exacerbation. Less likely pneumonia as no fevers and no focal lung findings except for diffuse wheeze.

Plan:
- prednisolone x 5 days------ (prednisolone 15 mg/5 ml 40 mg – 40 mg (1.55 mg/kg),oral
- stacked duonebs x 3------ipratropium-albuterol 0.5-2.5 mg/3ml (0.155 mg/kg) oral
- then plan to space with albuterol nebs
- reassess
#3. C/C: Nausea, vomiting, diarrhea, abd pain

**HPI: N/V** 21 y/o M presents to ED with n/v, since this morning. Pt states the episodes of emesis occurred every 20 minutes this morning – slowed down to vomiting every 2 hours. Last vomiting was 3 hours ago. He tried taking alka seltzer and TUMS but was unable to tolerate PO due to vomiting. Pt also reports abd pain and 3 episodes of diarrhea, today. No fever or rash. No sick contact.

PMH: no pertinent
PSH: no pertinent
PFH: no pertinent

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<td>18</td>
<td>137/92</td>
<td>99 %</td>
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**Review of Systems**

Constitutional: Negative for chills and fever.
HENT: Negative for congestion and sore throat.
Eyes: Negative for visual disturbance.
Respiratory: Negative for cough and shortness of breath.
Cardiovascular: Negative for chest pain, palpitations and leg swelling.
Gastrointestinal: Positive for **abdominal pain, diarrhea, nausea** and **vomiting**. Negative for blood in stool.
ROS Continued
Endocrine: Negative for polydipsia and polyuria.
Genitourinary: Negative for difficulty urinating, dysuria, frequency and hematuria.
Musculoskeletal: Negative for back pain, joint swelling and neck pain.
Skin: Negative for rash.
Neurological: Negative for dizziness, weakness, light-headedness, numbness and headaches.
Hematological: Negative for adenopathy. Does not bruise/bleed easily.
Psychiatric/Behavioral: Negative for confusion and suicidal ideas.

Physical Exam
Constitutional: He is oriented to person, place, and time. No distress.
HENT: Head: Normocephalic and atraumatic.
Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.
Eyes: Conjunctivae are normal. No scleral icterus.
Neck: No JVD present.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub. No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress.

Abdominal: Soft. Bowel sounds are normal. He exhibits no distension.

Mild epigastric tenderness.

Musculoskeletal: He exhibits no edema or tenderness.

Lymphadenopathy: He has no cervical adenopathy.

Neurological: He is alert and oriented to person, place, and time. Coordination normal.

Skin: Skin is warm and dry. No rash noted. He is not diaphoretic. No erythema.

Psychiatric: He has a normal mood and affect. His behavior is normal. Judgment and thought content normal

Pertinent lab findings: WBC 17.1; CO2 23; Anion Gap (neg); Glucose 152; LFTs all neg

Differential: gastroenteritis, appendicitis, obstruction.

Assessment and plan: Exam benign and has no lower abdominal tenderness. Plan for fluids and zofran. Re-eval and PO trial if improving.

Medications

ondansetron (ZOFRAN) injection 4 mg
sodium chloride 0.9% (NS) bolus 1,000 mL
ondansetron (ZOFRAN ODT) disintegrating tablet 4 mg
#4 CC: Fever and generalized myalgias

51 Y/O M

HPI: 51 y.o. male w/ a hx of heart disease though pt does not know details and is not in our system, on amiodipine, lisinopril and carvedilol who presents to ED with fever and generalized myalgias since last night. Patient reports that he came in today because he never gets sick and was concerned about his symptoms. He denies any chest pain currently, though states he had cramping chest pain earlier this week for multiple days. Endorses some shortness of breath but no cough. Denies nausea, vomiting, abdominal pain, stool or urinary changes.

PMH: No pertinent PMH, PSH, PFH

Social Hx: Former smoker (10 years tobacco free) ETOH: social Drug use: never

ROS:


HENT: Negative for rhinorrhea.

Respiratory: Positive for shortness of breath. Negative for cough.

Cardiovascular: Positive for chest pain (earlier in the week, now resolved).

Gastrointestinal: Negative for abdominal pain, nausea and vomiting.

Genitourinary: Negative for dysuria.

ROS continues
Skin: Negative for rash.
Neurological: Positive for headaches.
Psychiatric/Behavioral: Negative.

VS: BP: 155/105    HR: 85    RR:  18    T: 37.1 °C (98.8 °F)

Physical Exam
Constitutional: No distress.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Right eye exhibits no discharge. Left eye exhibits no discharge.
Neck: Normal range of motion.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. He exhibits no distension. There is no tenderness.
Musculoskeletal: Normal range of motion.
Neurological: He is alert.
Skin: Skin is warm and dry
**Differential:** Viral illness; ACS; UTI; Pneumonia

**Pertinent labs:** Troponin 0.01; WBC 8.1; UA neg for UTI

**ECG:** NSR, HR 82, no ischemic changes

**Assessment:** Neg troponin (sxs began over 12 hours ago), abd benign, taking PO without N/V/D, VS WNL, UA neg for UTI

**Treatment:** Tylenol 950 mg Q 6 hrs, oral fluids, rest

**Plan:** Education regarding symptomatic treatment for a viral illness and indications for FU with PCP or ED presentation
#5: CC: Rash – 6 Y/O M

6-year-old male presents with rash. Mom and grandmother reports they noticed a rash starting yesterday. Noticed erythematous hives approximately half a centimeter in size spread over his body. Initially on his arms, then resolved, then his legs, then resolved, then his face, then resolved. They called his pediatrician yesterday, awaiting a call back. They noticed recurrent symptoms today so they decided to come to Urgent Care for evaluation. They did give 1 dose of Benadryl this morning which tended to improve the hives until it wore off. Mom has a history of multiple sensitivities. The patient has been tested for allergies and is apparently only allergic to willow trees. They deny any new medications, medication changes, detergents, exposures, foods, or other inciting events. Chronic cough, unchanged.

The patient has been otherwise healthy, no fevers, no runny nose, no sore throat, no belly pain, no vomiting, no diarrhea. Is acting like himself.
History provided by: Parent, patient and relative

Rash
Quality: itchiness and redness
Quality: not blistering, not bruising, not burning, not painful, not scaling, not swelling and not weeping
Onset quality: Sudden
Progression: Waxing and waning
Chronicity: New
Context: not animal contact, not chemical exposure and not exposure to similar rash
Relieved by: Antihistamines
Worsened by: Nothing
Associated symptoms: no abdominal pain, no diarrhea, no fever, no headaches, no myalgias, no nausea, no shortness of breath, no sore throat and not vomiting
Behavior: Normal
Intake amount: Eating and drinking normally
Urine output: Normal
PMH: Pertinent only for asthma
PSH: Pertinent none
PFH: Pertinent only for asthma - mother

**Review of Systems**
Constitutional: Negative for fever, rhinorrhea and sore throat.
Eyes: Negative for discharge.
Respiratory: Positive for cough. Negative for shortness of breath.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Negative for abdominal pain, diarrhea, nausea and vomiting.
Genitourinary: Negative for decreased urine volume.
Musculoskeletal: Negative for myalgias.
Skin: Positive for color change and rash.
Neurological: Negative for syncope and headaches.

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<td>104</td>
<td>16</td>
<td>100/64</td>
<td>98 %</td>
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Physical Exam
Constitutional: The patient appears well-developed and well-nourished.
HENT:
Head: Normocephalic.
Eyes: Conjunctivae are normal.
Neck: Neck supple.
Cardiovascular: Regular rhythm, S1 normal and S2 normal. Murmur heard.
**Known murmur  Per mom**
Pulmonary/Chest: Effort normal and breath sounds normal. There is normal air entry.
Abdominal: Soft. Bowel sounds are normal.
Musculoskeletal: The patient exhibits no tenderness or deformity.
Neurological: The patient is alert.
Skin: Skin is warm. No rash noted. Rash is not papular, not pustular, not vesicular and not scaling.
**Pertinent skin findings include --> (no) petechiae, (no) purpura, (no) vesicles, (no) bullae**
Psychiatric: The patient's behavior is normal.
**Differential diagnosis:** Cellulitis, abscess, bug bites, autoimmune disorder, inflammatory condition, atopic dermatitis, viral exanthem

**Medical Decision Making:** Rash likely viral exanthem versus allergic reaction, low clinical suspicion for bacterial infection, no signs of systemic toxicity

**Dispo Plan:** Viral exanthem symptoms: non-descript maculopapular eruption may result from infection with some common viruses. Discussed any new or concerning symptoms – need for return should the child develop a sore throat, decreased fluid intake, lethargy or fever. Additional verbal discharge instructions were given and discussed with the patient and family: Bendedryl if symptoms improve, hydration. Advised PCP f/u in 1-2 days.
#6: CC: Sore throat  HPI:
19 y/o female presents to ED for sore throat starting 4 days ago. She also c/o a fever last night, postnasal drip, productive cough (yellow-brown sputum), neck pain, earache, and swelling on the L side of the throat. She states being diagnosed with strep throat about 1.5 months ago which was treated with penicillin. She states she became sick again last week, was negative for strep and mono at a previous urgent care visit, but given keflex and felt better. 4 days ago she noted the sore throat again, which prompted her to return to the ED where she was triaged to the Urgent Care area. She states she has been taking tylenol and motrin for her Sx, which help somewhat. She also notes tonsillitis in April of last year. She denies nausea, vomiting, diarrhea, or sick contacts.

PMH: None pertinent  
PSH: None pertinent  
PFH: Thyroid disease – Mother
Social Hx: Never a smoker  
ETOH: None  
Drug Use: None
Home Meds: None  
Allergies: NKA

Review of Systems
HENT: Positive for ear pain, postnasal drip and sore throat. Negative for nosebleeds and rhinorrhea.
Eyes: Negative for photophobia and visual disturbance.
C/C: Sore throat

Review of Systems Continued:

**Cardiovascular:** Negative for chest pain, palpitations and leg swelling.

**Gastrointestinal:** Negative for abdominal pain, constipation, diarrhea, nausea and vomiting.

**Genitourinary:** Negative for dysuria, frequency, hematuria and urgency.

**Musculoskeletal:** Positive for neck pain. Negative for back pain and myalgias.

**Skin:** Negative for rash and wound.

**Neurological:** Negative for dizziness, syncope, weakness and headaches.

**Psychiatric/Behavioral:** Negative for confusion, dysphoric mood, sleep disturbance and suicidal id

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**Physical Exam**

**Constitutional:** She is oriented to person, place, and time. She appears well-developed and well-nourished.

**HENT:**

**Head:** Normocephalic and atraumatic.

**Right Ear:** Tympanic membrane, external ear and ear canal normal.

**Left Ear:** Tympanic membrane, external ear and ear canal normal.

**Mouth/Throat:** Uvula swelling present.
L-sided lymphadenopathy.
L tonsil very erythematous 2+ enlargement (halfway between the tonsillar pillars and the uvula). No exudates.

Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress.
Neurological: She is alert and oriented to person, place, and time.
Skin: Skin is warm and dry.
Psychiatric: She has a normal mood and affect.

Differential (MDD): Strep pharyngitis, tonsillitis, peri-tonsillar abscess

Work up: Rapid Strep, CT Soft tissue neck with contrast
Rapid Strep: Neg
CT:
• Bilateral tonsillitis with small hypodense collection in the L palatine tonsil, likely phlegmon versus developing abscess
• Bilateral adenoids hypertrophy and prominent upper cervical lymph nodes are thought to be reactive
• Mild mass effect on the oropharyngeal airway can be better assessed by clinical correlation
**Treatment:** NS 1000 ml bolus, Unasyn 3 grams IV Q 6 hrs

**Consult:** Otolaryngology – Recommendations: IV hydration, antibiotic, single dose of steroids (Decadron 8 mg IV) – Admit to the CDU (ED Observation) for continued hydration and antibiotics. Will evaluate the patient after reviewing the CT to determine if urgent drainage of this abscess is needed.

**Disposition** – Placed into the CDU

**CDU Coarse** – Evaluated by ENT, no abscess drainage indicated, placement lasted 28 hours for additional IV antibiotics and hydration. Discharged after taking adequate PO fluids, Prescribed Augmentin 875/125 mg PO q 12 hrs X 7 days
#7 C/C Finger laceration – Hand injury

**HPI:** 22 y.o. R handed female presents to the ED c/o R hand pain and L 4th finger lac sustained 3 hours ago. States she was attempting to open a window and she tried to wedge her fingers underneath the window to lift it when it fell on her L 4th digit. After she got her hand out she punched the wall with her R hand because she was angry. Pain in the L hand is localized the 4th finger with some pain in her palm. R hand pain is localized to the 4th and 5th digit. Reports paresthesia in the 4th and 5th digit on the R. Denies abd pain, shoulder pain, or elbow pain. Tetanus status unknown.

**PMH:** None pertinent  
**PSH:** None pertinent  
**PFH:** None pertinent  
**Social Hx:** Non smoker, ETOH: social  
**Drugs:** Occasional marijuana  
**Home meds:** BCPs  
**Allergies:** NKA

**REVIEW OF SYSTEMS:**
Gastrointestinal: Negative for abdominal pain.  
Musculoskeletal: Negative for back pain.  
**Positive for R 4th and 5th finger pain and L 4th finger pain. No elbow or shoulder pain**  
Neurological:  
**Paresthesia in the R 4th and 5th digit**
Physical Exam
Constitutional: She appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Pupils are equal, round, and reactive to light. Conjunctivae and EOM are normal. No scleral icterus.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds. Exam reveals no gallop and no friction rub.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales. She exhibits no tenderness.
Abdominal: Soft. She exhibits no distension. There is no tenderness. There is no rebound and no guarding.
Nursing note and vitals reviewed.

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<td>131/83</td>
<td>98 %</td>
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Physical Exam Continued:
Musculoskeletal: Normal range of motion. She exhibits no edema or deformity.
RUE: Normal ROM at her shoulder and elbow. Normal supination pronation of the R forearm. No bony ttp to wrist. Swelling and tenderness over the 4th and 5th metacarpal. LUE: L hand with lac at the distal tip of the 4th digit with disrupted nail bed. No C, T, L-spine tenderness
Neurological: She is alert. Pt has sensation intact - Reports that it is diminished in the R 4th and 5th digit compared to other digits.
Skin: Skin is warm and dry. No erythema.
Psychiatric: She has a normal mood and affect. Her behavior is normal.

Differential Diagnosis:
• L fourth finger tip fx, Contusion, Nailbed partial avulsion, Nailbed laceration
• R 4th and 5th metacarpal fx, contusion, soft tissue injury

Workup:
X-Ray L hand 3 views; X-Ray R hand 3 views
**X-Ray results**
Left hand: Minimally displaced fractures through the tuft of the fourth distal phalanx with overlying soft tissue injury
Right hand: Mildly displaced intra-articular fx at the base of the fifth metacarpal

**Assessment and plan:**
Pain control – Percocet 5/325 PO x 1
19 y.o. female RHD who presents with a left ring finger nailbed injury and right fifth metacarpal base fracture after a window fell on her left ring finger and she subsequently punched a wall with her right hand. On exam, the left ring finger had a 1 cm oblique laceration across the nail bed with no exposed bone, sensation was intact distal and she was warm well-perfused. Her right hand had no scissoring and intact cascade.
Her left ring finger and was washed out, the nail was removed and the nailbed was splinted open with the nail and held in place by a stay suture, this was then covered with a dry sterile dressing. Her right hand was placed into an ulnar gutter splint by the orthopedic resident. She was given 5 days of Keflex. She will follow-up in the Ortho Hand Clinic. She will be non-weightbearing on the right upper extremity and weightbearing as tolerated on her left upper extremity.
#8 – C/C: Heel pain

20 y.o. female presents with L Achilles pain and L foot numbness that began when she woke up this morning. Pt reports being unable to move the foot when she awoke, and increased pain with any movement of the foot. She took ibuprofen (200mg x1) without relief of her symptoms. Pt was seen by her PCP earlier today and referred to the ED – and triaged to Urgent Care, for further evaluation. She is on birth control. She denies playing sports, wearing any new shoes, any pain in the calf or more proximal, taking any other long-term medications, trauma, or any other medical problems. Pt denies rash, fever, or chills.

**PMH:** None pertinent  
**PSH:** None pertinent  
**PFH:** Sickle cell anemia – Sister  
**Social Hx:** Negative for ETOH, tobacco and drugs  
**Home Meds:** BCP  
**Allergies:** NKA

Review of Systems
Constitutional: Negative for chills and fever.
Respiratory: Negative for shortness of breath.
Cardiovascular: Negative for chest pain and leg swelling.
Gastrointestinal: Negative for nausea and vomiting.
Genitourinary: Negative for dysuria and hematuria.
Review of symptoms continued..

Musculoskeletal: Negative for back pain.  
    Positive for L achilles pain.
Skin: Negative for rash and wound.
Allergic/Immunologic: Negative for immunocompromised state.
Neurological: Positive for numbness (L foot). Negative for weakness and headaches.
Hematological: Does not bruise/bleed easily.
Psychiatric/Behavioral: Negative for dysphoric mood and suicidal ideas.

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<th>Heart Rate</th>
<th>Resp</th>
<th>BP</th>
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<td>65</td>
<td>17</td>
<td>107/64</td>
<td>99 %</td>
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Physical Exam
Constitutional: The patient appears well-developed and well-nourished. No distress.
HENT: Head: Normocephalic and atraumatic.
Cardiovascular: No murmur heard.
Pulmonary/Chest: Effort normal. No respiratory distress.
Musculoskeletal: The patient exhibits no edema.
LLE: No pain to palpation of hip, thigh, knee, proximal shin or calf. Tenderness to palpation along the L Achilles. Pain with flexion, extension of the ankle localized to Achilles. No bony tenderness of the ankle. No swelling or erythema. No palpable defects along the Achilles tendon. No swelling over calf.
Neurological: The patient is alert. Answers questions appropriately moving all extremities equally.
Skin: Skin is warm and dry.
Psychiatric: The patient has a normal mood and affect. The patient’s behavior is normal.

Differential Diagnosis: Achilles tendonitis, Achilles tendon partial rupture. Achilles tendon rupture, Heel fx, Distal tibia fx

Work up: X-Ray Ankle L 3 views
Final Result- L ankle – 3 views

FINDINGS and IMPRESSION:

Tiny irregular punctate ossific bodies are seen adjacent to the posterior malleolus of the distal tibia on the lateral views of the ankle and foot. These are of uncertain significance. In the setting of trauma, they could represent tiny fracture fragments. The remainder of the bones and joint spaces of the ankle and foot are intact. The ankle mortise is congruent. The joint spaces of the foot are maintained. The soft tissues are unremarkable.

MDM: 20F presents to ED with L Achilles pain. Pt denies known trauma, awoke with pain, no hx of similar. No systemic sx, no pain/rashes elsewhere. No rashes to area. Worse with putting weight.

On exam: VS as noted, overall well appearing. Pt tender along L Achilles no pain/tenderness elsewhere, no defect of tendon, no bony tenderness. No rashes/lesions. X-rays obtained, hx most consistent with Achilles tendonitis/tendinopathy. Discussed otc analgesia, can use walking boot PRN, f/u with PCP and sports medicine. Return precautions given.
Sports Medicine Follow up:

**Mechanism of Injury**: Not applicable

**Diagnosis**: Left Achilles tendinitis and Haglund's deformity

**HPI**: 20 y.o. female community ambulator here in the clinic today for evaluation of left heel pain that started 2 days ago. Started abruptly right after she woke up. Atraumatic in nature. Denies any inciting event. No swelling. Pain is sharp. Worse when ambulating. Takes ibuprofen/Tylenol with moderate relief. Overall pain is improving. She had initially seen her PCP who was unsure of the cause of her pain and sent to the emergency department. In the emergency department she received x-rays which were negative. She was referred to our clinic for further workup and management.

**Physical Examination:**
General: NAD
Neuro: A&O x3
Ophtho: Slera anicteric
HEENT: Moist mucous membranes
CV: distal extremities WWP
Pulm: non-labored breathing
Psych: normal mood and affect
Dermatologic: no rashes or lesions
MSK: On examination of the left lower extremity, patient has full motor function in the foot and ankle. She is able to actively dorsiflex and plantarflex her foot. Sensation is intact light touch in all distributions in the foot. She has a palpable DP pulse. Thompson test negative. She has tenderness to palpation over the Achilles insertion on the calcaneus. No discrete areas of swelling or erythema.

Performing the Thompson Test
To perform the Thompson test, the patient should lie face-down on the examination table. The feet extend farther than the end of the bed. The examiner then squeezes the calf muscle. This motion, in a normal patient, should cause the toes to point downward as the Achilles pulls the foot. In a patient with a ruptured Achilles tendon, the foot will not move. That is called a positive Thompson test.
**Imaging:**
Plain x-rays of the ankle and foot were reviewed in clinic today showing a mild Haglund's deformity. Otherwise no other osseous abnormalities. No fractures or dislocation. No gross instability or malalignment.

"**Haglund's deformity** is a bony enlargement on the back of the heel. The soft tissue near the Achilles tendon becomes irritated when the bony enlargement rubs against shoes. This often leads to painful bursitis, which is an inflammation of the bursa"
**Assessment & Plan:**
20 y.o. female with left Achilles tendinitis in the setting of a Haglund’s deformity. Symptomatically she is already improving with NSAID therapy. She should continue this. We will also provide her with some gel lifts to place in her Aircast boot. She can slowly wean off the gel lifts as her symptoms improved.

Weightbearing status: Weightbearing as tolerated with Aircast boot and gel lifts
Physical therapy: None at this time
Work status/restrictions: None at this time
Prescriptions given: None given
Follow-up: On an as-needed basis
Imaging needed on follow-up: None required

https://www.foothealthfacts.org/conditions/haglund’s-deformity
#9 C/C: Abd pain

**HPI:** The pt is a 21 y/o female presenting to the ED for evaluation due to sudden onset of sharp RLQ abdominal pain yesterday afternoon. She found some relief with tylenol but pain returned soon after last night. It has been constant since then. She awoke at 4 am this morning and had 3 episodes of vomiting and states she "felt hot". She denies any diarrhea or constipation associated with this. Her last BM was yesterday morning. Pt denies experiencing similar pain previously. She has a long hx of recurrent kidney stones and states this does not feel similar to those prior episodes. Her LMP began approximately 3.5 weeks ago. Denies any urinary sx's or other acute medical complaints at this time.

**PMH:** History of hematuria 4 years ago; Kidney stones

**Social Hx:** Current every day smoker

**ETOH:** Neg

**Drug use:** Neg

**PFH:** None

**Allergies:** NKA
Review of Systems
Constitutional: Negative for chills and fever.
HENT: Negative for congestion and sore throat.
Eyes: Negative for visual disturbance.
Respiratory: Negative for cough and shortness of breath.
Cardiovascular: Negative for chest pain, palpitations and leg swelling.
Gastrointestinal: Positive for abdominal pain, nausea and vomiting. Negative for blood in stool and diarrhea.
Endocrine: Negative for polydipsia and polyuria.
Genitourinary: Negative for difficulty urinating, dysuria, frequency and hematuria.
Musculoskeletal: Negative for back pain, joint swelling and neck pain.
Skin: Negative for rash.
Neurological: Negative for dizziness, weakness, light-headedness, numbness and headaches.
Hematological: Negative for adenopathy. Does not bruise/bleed easily.
Psychiatric/Behavioral: Negative for confusion and suicidal ideas.
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<td>93</td>
<td>18</td>
<td>118/89</td>
<td>97%</td>
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Physical Exam

Constitutional: The patient is oriented to person, place, and time. No distress.

HENT: Head: Normocephalic and atraumatic.
Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.
Eyes: Conjunctivae are normal. No scleral icterus.
Neck: No JVD present.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No stridor. No respiratory distress.
Abdominal: Soft. Bowel sounds are normal. The patient exhibits no distension. There is tenderness (moderate) in the right lower quadrant. There is no rebound and no guarding.
Musculoskeletal: The patient exhibits no edema or tenderness.
Lymphadenopathy: The patient has no cervical adenopathy.
Neurological: The patient is alert and oriented to person, place, and time. Coordination normal.
Physical Exam continued
Skin: Skin is warm and dry. No rash noted. The patient is not diaphoretic. No erythema.
Psychiatric: The patient has a normal mood and affect. The patient’s behavior is normal. Judgment and thought content normal.

Differential diagnosis: UTI, pregnancy, gastroenteritis, appendicitis

Work up: CBC, Urine pregnancy test, UA with reflex to cx

Pertinent results:
UA with reflux to cx: completely negative, no Nitrite, no Leukocyte Esterase, I WBS, < 1 RBC, Squamous epithelial cells 1; Bacteria None
CBC: WBC 10.8 (normal)
HCG: 38.6 – positive for pregnancy (An hCG level of less than 5 mIU/mL is considered negative for pregnancy, and anything above 25 mIU/mL is considered positive for pregnancy.)

Assessment and treatment: Reviewed all findings with patient. Discussed need for early follow up in 2 days. Based on history, exam, and quant I have a low suspicion for ectopic at this point. Her pain is umbilical, and she denies any pelvic pain. Encouraged her to return to the ED if pain worsens, persists, or if her symptoms progress in any way.
# 10: Dog bite

**HPI:** 30 y/o male presents to ED for a dog bite on his R leg and both hands occurring today. He states he was on his way to work when a bulldog at a park attacked him. He notes the owners were there and he doesn't know them, but he does have their information. He states his tetanus vaccine status is unknown. He was triaged to the Urgent Care area of the ED. He has bite on his R hand and L hand and R leg. The attack was non provoked.

**PMH:** None pertinent

**PSH:** None pertinent

**PFH:** None Pertinent

**Social Hx:** Never smoked

**ETOH:** Denied

**Drug Use:** Denied

**Review of Systems**

**Constitutional:** Negative for fever.

**Respiratory:** Negative for shortness of breath.

**Cardiovascular:** Negative for chest pain.

**Gastrointestinal:** Negative for abdominal pain.

**Skin:** Positive for wound (Dog bites on R leg, R and L hand).

**Neurological:** Negative for headaches.
Physical Exam
Constitutional: He appears well-developed. No distress.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Conjunctivae and EOM are normal.
Musculoskeletal:
On the R lower leg there are several small superficial lacerations.
No significant bruising or swelling.
Bleeding controlled.
Bilateral hands have multiple abrasions.
Neurological: He is alert. GCS eye subscore is 4. GCS verbal subscore is 5. GCS motor subscore is 6.
Skin: Skin is warm and dry.

Assessment and MDM: Patient presents with a dog bite. The bites are small and should heal on their own. Therefore I feel the risks of infection with suturing outweighs the benefit. Will prescribe Augmentin for prophylaxis. Also given a tetanus shot. Nurse to irrigate the wounds and apply bacitracin and dressings. Since the dog owners are known to the patient and believed to have up-to-date shots and normal behavior, do not believe rabies prophylaxis is indicated at this time.
# 10 - Tooth Pain
HPI: 25 year old healthy male presents to the ED with c/o left lower 2nd molar pain. Pt states that he chipped the tooth while eating chicken 4 days PTA, and chipped it again today. He complains of shooting pain every time something touches the tooth. He was triaged to the Urgent Care area.

He has tried Tylenol and ibuprofen without relief. Pt notes he is staying at Independence Hall (a Veteran’s temporary homeless shelter) waiting for placement into a halfway house after EtOH detox. He reports that he had dental caries on the tooth filled when he was a child. Pt denies fever, vomiting, SOB, and has no other complaints at this time.

PMH: None pertinent  PSH: None pertinent  PFH: None pertinent
Social Hx: Current every day smoker  Denies current ETOH or Drug use

**Review of Systems**
Constitutional: Negative for chills and fever.
HENT: Positive for dental problem.
Respiratory: Negative for shortness of breath.
Gastrointestinal: Negative for nausea and vomiting.
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<td>143/85</td>
<td>100 %</td>
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**Physical Exam**

**Constitutional:** He is oriented to person, place, and time. He appears well-developed and well-nourished.

**HENT:**

**Head:** Normocephalic and atraumatic.

**Mouth/Throat:** No trismus in the jaw.

**Dental carries to tooth 18, no gum swelling or fluctuance.**

**Eyes:** Conjunctivae are normal.

**Neck:** Normal range of motion. Neck supple. No edema present.

**Pulmonary/Chest:** Effort normal. No respiratory distress.

**Neurological:** He is alert and oriented to person, place, and time.

**Skin:** Skin is warm and dry.

**Psychiatric:** He has a normal mood and affect. His behavior is normal.
**Assessment and plan:** 25-year-old male with pain to tooth #18. Chipped tooth multiple times and sensitive now. No evidence of infection or abscess but significant caries. Does not have a dentist will give referral and put on Orajel and penicillin.