Soap Note 3 – Gout

Name:

Grade Course:

Tutor's Name:

Date of Submission:

Patient Information

Informant: Patient is the primary historian who is reliable

Initial and Age: B. F.; Age: 73 years old; Gender: Male; Race: Latino

SUBJECTIVE:

Chief Complaint (CC): A male patient presented in the facility “I have frequent urination, tired and regular mild headache” in the past two days.

History of Present Illness (HPI): B. F. is a 73 years old retired truck driver came to the hospital saying that he was suspecting to be having type II diabetes and he was experiencing symptoms such as frequency in urination, increased thirst and feeling hungry and tiring easily without doing a strenuous activity. These symptoms started about four weeks ago but he has been thinking that its normal to have such symptoms possibly from his dieting but this is not the case.

Location: Bladder and head

Onset: 4 weeks ago

Character: Frequency in urination, mild headache and feeling hungry

Associated Symptoms: Tiredness, fatigue, and increased thirstiness

Timing: Started four weeks ago but the symptoms became severe in the last two weeks.

Relieving Factors: Resting in the bed.

Severity: 4/10 on the face scale

Current Medication: Captopril 25 mg Oral tablet, one table (25 mg) by mouth twice a day; Metformin HCL 500 mg Oral Tablet, one table (500 mg) by mouth twice per day taken with

meals; Ropinirole 2 mg PO daily at bedtime for RLS; and Simvastatin 20 mg Oral Tablet, one table (20 mg) by mouth daily.

Allergic: Allergic to Morphine, Dilaudid, and Bactrim DS, the patient developed a diffuse rash after exposure to these medications 30 years ago

Immunization: Patient confirmed to be receiving Flu vaccine annually. He receives Pheumovax vaccine in 2017. He admitted to have received all the childhood immunization, but he does not remember on specific dates. Therefore, all the immunizations are up-to-date.

Past Medical History (PMH): Patient confirmed hospitalization in 2014 and 2018 for secondary hypertension, type 2 diabetes mellitus, hyperlipidemia and obesity. He also once suffered from chickenpox. Patient also has short history of hypertension.

Past Surgical History (PSH): None

Dental Examination: Patient stated to be visiting the dentist once a year. The most recent visit to the dentist was last year November and the dentist confirmed that there was no problem that needed urgent attention.

Last Eye Examination: Patient uses glasses due to high sensitivity to light. He said that the problem of eyes started when he used to drive long distance and the light from the incoming car was affecting his sight especially the drivers who failed to deem.

Testicular/Rectal Examination: None

Family History: The patient presented himself accompanied by his elder son; her mother died at the age of 75 from type II diabetes; his father died at the age of 63 due to cardiovascular disease. His wife died 15 years ago from pneumonia and seizures. He had one brother who dies as a

result of uncontrolled hypertension and diabetes. He has four children three male and one female; all are in good health with no diagnosed chronic illness.

Personal and Social History: Patient stated to have retired from professional boxing and currently working full-time as boxing coach. M. S. is widowed and lives with his son. Patient confirmed to not using alcohol or cigarette. He does not follow any special diet despite the problem of hypertension. During his professional boxing time, patient confirmed to have travel to many countries across the world. He lives is four-bedroom house and has helper who works for four hours a day. Currently, the patient receives social security and Medicare as well as often supported by the children. Despite his arthritic symptoms, the patient is active and alert.

Review of Systems:

General: Patient denies losing or gaining weight, fever, or chills

HEENT: Patient denies dizziness, lightheadedness, vision change, double vision, tinnitus, hearing loss, nasal congestion or drainage, sore throat, or drainage from his eyes. Patient admitted to occasionally experience headache. He wears glasses.

Neck: Patient denies presences of meningitis, lumps, goiter pain, or swollen glands.

Eyes: Patient denies drainage from eyes. Denies experiencing any pain or itching to bilateral eyes. Patient uses glasses.

Cardiovascular: Patient confirmed slight history of pain in the chest. He also denies any unusual SOB with age appropriate activities.

Respiratory: Patient denies unusual cough, congestion or hemoptysis. He denies sputum or breath shortness.

Gastrointestinal: Patient denies abdominal pain, nausea, or vomiting. He denies appetite loss prior to last evening. Patient denies constipation, diarrhea, flatulence, or known heartburn.

Genitourinary: Patient denies any known discharge or penile pain. He denies frequency of urination. Patient denies sensational burning when urinating.

Musculoskeletal: Patient denies recent fall or injury. He denies lacking in age appropriate activities. Patient confirmed slight swelling on the ankle and pain in joint.

Integumentary: Patient denies skin irritation, bruising, dryness, rashes, or moles.

Neurological: Patient denies recent headache. He denies gait abnormalities.

Psychiatric: Patient denies history of depression, stress or anxiety. He confirmed engaging appropriately for age in all activities and conversation.

Endocrine: Patient denies experiencing polyphagia or polydipsia. Weight appropriate for age. He denies sweating, cold intolerance, or heat.

Hematologic/Lymphatic: Patient denies history of increased bruising, anemia, or easy bleeding. He denies inguinal lymphadenopathy, or history of splenectomy

Allergic/Immunologic: Patient denies history of exposure to seasonal or bodily fluids allergies.

OBJECTIVE DATA

Vital Signs: Blood Pressure: 125/67; Temperature: 37.3 ^{0}C; Respiration Rate: 12; Heart Rate: 88; Height: 5.8 ft; Weight: 178 lbs.; Oxygen Concentration: 99 %

General: Patient is well developed, slightly obese, elderly Spanish male sitting on the chair, breath heavy.

HEENT: Eyes are extraocular with full motion, gross visual fields fully to confrontation, conjunctiva clear, intact extra ocular movement. Sclerae non-icteric, pupil equal round and reactive to light and accommodation. Patient experience poor bilaterally hearing. Tympanic membrane landmark well visualized. Negative for papules on helix, nodules, lesion or scars. Negative for obstruction, or discharge. Septum without deviated. The mouth has complete set of upper and lower dentures. Pharynx is not injected. Negative for exudates. Uvula move up in midline. Normal gag reflex.

Cardiovascular: Negative for pounding or thrills. PM positioned in the 5th intercostals space, normal S1 and S2 heart rhythm, audible heart at mitral, aortic, tricuspid and pulmonic regions, JVD 4 cm at 30.

Respiratory: Negative for cough, sputum, or breath shortness.

Gastrointestinal: Negative for abdominal pain, nausea, diarrhea, vomiting or abdominal blood. Bowel sound heard in all four quadrants. Negative for tenderness or distention observed upon palpation. Patient negative for rebound tenderness. Negative for murphy's sign roysing's sign or tenderness at McBurney's point. Negative for palpable mass or hernia. Abdominal series completed and showed normal bowel gas pattern and negative for acute illness in chest or abdomen.

Genitourinary: Negative for burning sensations when passing urine. Negative for bacteria or Leukocyte esterase.

Neurological: Negative for headache. Alert and appropriate for age. Negative for sign of focal motor or sensory deficit.

Musculoskeletal: Negative for tenderness, deformities or warmth upon palpation of medial and lateral joint lines. Negative for tender body nodule noted at 1st MPT bilaterally with hallux valgus. Moderate lower extremity edema to knees bilaterally.

Psychiatric: Patient's reactions are appropriate for age.

Hematologic/Lymphatic/Immunologic: Negative for outward sign of bleeding. Vital sign does not indicate severe anemia. Fatigue appropriate for midnight evaluation.

Allergies: None

Assessment

Assessment showed that the patient experiences migratory joint pain in knew and ankle. The pain is exacerbated by edema, and has continue to worsen in the past 1 ½ years. Physical examination reveals non tender, soft, non-erythematous bilateral 3 cm nodules and bony deformities of right 1st MCP and bilateral hallux vagus.

Differential Diagnosis

- *Tophaceous gout*: This differential diagnosis is the most appropriate since the patient is complaining of migratory joint pain pattern (McCance, *et al*., 2019). Assessment also showed the presence of bony deformities of MCP and MTP joints, diuretic use, and olecranon nodules.
- *Osteoarthritis*: This differential diagnosis is warranted by progressive joint pain and less probable when olecranon nodules and migratory joint pain pattern (Underwood, 2006).

- *Rheumatoid arthritis*: The probability of the patient suffering from this condition is decrease with presence the monoarticular and the migratory pattern in joint pain (Rothschild, 2020).

Plan

Patient to continue taking Isosorbide dinitrate 10mg TID (CHF), Torsemide 100 mg QD (CHF), OTC Ibuprofen for joint pain.

Education: Patient to be educated to reduce the intake of high cholesterol diet and red meat. Patient should also be informed to continue with physical exercise.

References

McCance, K. L., Huether, S. E., Brashers, V. L., Rote, N. S. & McCance, K. I. (2019). *Pathophysiology: The Biologic Basic for Disease in Adult and Children* . St. Louis, MO: Elsevier.

Rothschild, M. B. (2020, February 03). *Gout and Pseudogout Clinical Presentation*. Retrieved from Medscape: https://emedicine.medscape.com/article/329958-clinical

Underwood, M. (2006). Diagnosis and Management of Gout. *BMJ*, 3(332): 1315-1319.