Gagandeep Munday SOAP #1

S:
HP is a 62 y/o F with PMH of HTN, CAD, and hypothyroidism p/w 3 days of dysuria, urinary urgency and frequency.

Denies fever, chills, body aches, n/v, lower back pain, abdominal pain, hematuria, vaginal discharge/irritation, concern for STDs, CP or SOB.

PMH: HTN, CAD, and hypothyroidism
PSH: Denies any
Allergies: NKDA
Medications: Losartan, Simvastatin, Levothyroxine
FHx: Non-contributory
SHx: Non-smoker, Denies EtOH use, Denies illicit drug use

O:
T 37.2C orally | BP 124/84 mmHg | P 90 BPM, regular | RR 16 breaths/min, unlabored | SpO2 98% RA
H 69 in| W 189lb. | BMI 23.3

Gen: Neatly groomed, looks her stated age 62 of years. AxO x3. Appears to be in no acute distress.
Skin: Warm, dry, anicteric
Head: Normocephalic atraumatic
Eyes: PERRL, EOMI
Ear, **nose, mouth, throat**: Mucous membranes moist, no erythema, airway patent, no stridor
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion is symmetrical. No wheezing, rhonchi, rales, dullness.
Abdomen: ***Suprapubic tenderness***, otherwise soft, non-tender to palpation throughout, no guarding, no rebound tenderness, no CVA tenderness
GU: Patient declined.

A:
62 yo female with dysuria, urinary urgency and frequency. Suprapubic tenderness on exam, no CVT. Likely UTI.
Differential Diagnosis:

- UTI
- Pyelonephritis
- Urethritis

P:
Labs: UA, indicating +WBCs, Leuk Esterase, and positive nitrates
Imaging/Tests:None
UTI: Nitrofurantoin 100mg BID x 5d

Initial DDx Based on CC:

- UTI
- Pyelonephritis
- Urethritis
- Chronic cystitis
- Infected nephrolithiasis
- Vaginitis/cervicitis
- PID

Adjusted DDx After H&P:

- UTI
- Pyelonephritis
- Urethritis

SOAP # 2

S:
RC is 29 y/o F with no significant pmhx p/w LT shoulder pain with ROM x1 day. Patient states that pain worsened when she woke up this morning. States that pain radiates from neck to fingertips of her LT hand. Endorses minimal relief w/ 600 mg of ibuprofen.

Denies any recent trauma, past injury to shoulder or neck, headache, dizziness, weakness, LOC, CP, SOB, unintended weight loss, ptosis, cough, fever, chills, body aches, recent illnesses or sick contacts

PMH: Denies any
PSH: Denies any
Allergies: NKDA
Medications: Denies any intake of prescription medications
FHx: Non-contributory
SHx: Non- Smoker, Denies past or present EtOH or illicit drug use

O:
T 36.8C | BP 124/71mmHg | P 68 BPM, regular | RR 16 breaths/min, unlabored | SpO2 97% RA
H 65in | W 123 lb. | BMI 20.5

Gen: Slender, neatly groomed, looks her stated age of 29 years. AxO x3. Appears in no acute distress.
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion is symmetrical. No wheezing, rhonchi, rales, dullness.
Neck: supple, no LAD, no midline c-spine tenderness, ***flexion and extension limited by pain, +spurlings***
Musculoskeletal: ***LT sided paravertebral T-spine spasm, active abduction of LT shoulder limited by pain, passive range of motion limited by pain***, normal tone, strength 5/5 in UE and LE, sensation intact, cap refill <2, 2+ radial pulses bilaterally
Neuro: Cranial nerves II-XII intact, reflexes symmetric, sensation normal, cerebellar testing WNL, EOMI, PERRL

A:
29 yo female with LT shoulder pain radiating to LT hand appearing with positive spurlings and ROM of neck and shoulder limited by pain on exam. Likely cervical radiculopathy.

Differential Diagnosis:
- Torticollis
- Cervical disc herniation
- Rotator cuff tear
- Adhesive capsulitis
- Biceps tendinitis
- Subacromial bursitis
- Cervical radiculopathy

P:
Labs: None
Imaging/Tests: Shoulder x-ray
Cervical radiculopathy:
- Naprosyn 500mg BID 14 days, Flexeril 5mg QHS PRN, follow up with PMD for ortho referral

Initial DDx Based on CC:	Adjusted DDx After H&P:
● Torticollis ● Cervical spondylosis	● Torticollis ● Cervical disc herniation

● Cervical stenosis ● Cancer ● Cervical spine fracture and/or dislocation ● Epidural abscess ● Vertebral osteomyelitis ● Epidural hematoma ● Cervical disk herniation ● Blunt neck trauma ● Anterior horn disease ● C1 and C2 fractures ● Cervical radiculopathy ● Shoulder Dislocation ● Clavicle fracture ● Humerus fracture ● Scapula fracture ● Acromioclavicular joint injury ● Glenohumeral instability ● Rotator cuff tear ● Biceps tendon rupture ● Triceps tendon rupture ● Septic joint ● Rotator cuff tear ● Impingement syndrome ● Calcific tendinitis ● Adhesive capsulitis ● Biceps tendinitis ● Subacromial bursitis ● Cervical radiculopathy ● Brachial plexus injury ● Rucksack paralysis ● Axillary artery thrombosis ● Thoracic outlet syndrome ● Subclavian steal syndrome ● Pancoast tumor ● Myocardial infarction ● Pneumonia ● Pulmonary embolism	● Epidural abscess ● Rotator cuff tear ● Adhesive capsulitis ● Biceps tendinitis ● Subacromial bursitis ● Cervical radiculopathy

SOAP #3

S:
JC is a 25 y/o M endorsing no PMHx presenting with 8/10 pain in distal RT 4th finger 2/2 crush injury from door 8 hours ago. Pt states that he was at home and his daughter accidentally slammed the door on his finger while it was in between the hinges. States that his finger feels very tense.

Denies fever, chills, body aches, n/v, paresthesias, focal weakness, gross weakness, discharge, skin changes, previous injuries to affected area, CP or SOB.

PMH: Denies any
PSH: Denies any
Allergies: NKDA
Medications: Denies any intake of prescription medications
FHx: Non-contributory
SHx: Non Smoker, Denies past or present EtOH use or illicit drug use

O:
T 36.8C | BP 110/75mmHg | P 94 BPM, regular | RR 16 breaths/min, unlabored | SpO2 93% RA
H 70in | W 121 lb. | BMI 17.4

Gen: Slender, neatly groomed, looks stated age of 25 years. AxO x3. Appears.
Skin: Warm, dry, no rash, ***mild erythema to distal LT 4th finger with blood underneath nail***
Head: Normocephalic atraumatic
Eyes: PERRL, EOMI
Ear, **nose, mouth, throat**: Mucous membranes moist, no erythema, airway patent, no stridor
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion is symmetrical. No wheezing, rhonchi, rales, dullness.
Abdomen: Soft, non-tender to palpation throughout, no guarding, no rebound tenderness, no CVA tenderness
MSK: ***TTP and bruising to lateral border of LT 4th fingernail***, no flatulence, no induration, radial pulse 2+ to BILAT UE, FROM intact, negative kanavel sign, intact strength and sensation bilateral UE and LE

A:
JC is a 25 y/o M with pain in distal RT 4th finger 2/2 crush injury from door. PE reveals mild erythema, ecchymosis, and blood underneath the fingernail with tenderness to the affected area. Likely uncomplicated subungual hematoma.

Differential Diagnosis:
- Subungual hematoma
- Distal interphalangeal dislocation
- Distal phalanx fracture

P:
Labs: Type and screen, aPTT, BMP, CBC w/ diff, PT/INR, COVID, TSH, Troponin
Imaging/Tests: Imaging/Tests: LT Hand XR 3 views r/o fracture or FB
Subungual hematoma w/ no acute fx:
- Trephination
- D/C home, advise pt to soak affected finger in warm water BID-TID x7d, and to return if there are any signs of infection.

Initial DDx Based on CC:	Adjusted DDx After H&P:
● Distal interphalangeal dislocation ● Distal phalanx fracture	● Subungual hematoma ● Distal interphalangeal dislocation

• Skin infection • Nail Bed laceration • Nail avulsion • Subungual hematoma	• Distal phalanx fracture

SOAP #4

S:
JP is a 34 y/o F with pmh of DM2 and HTN p/w LT sided facial drooping, numbness, and weakness for the past 4 hours. Patient states that sxs started this morning after waking up, endorses difficulty drinking fluids and states that they spill out of her mouth.

Denies any recent trauma, head injury, LOC, headache, dizziness, nausea, vomiting, hearing/vision changes, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory, CP, SOB

PMH: DM2 and HTN
PSH: Denies any
Allergies: NKDA
Medications: Metformin and Atenolol
FHx: Non-contributory
SHx: Non-Smoker, Social EtOH use, Denies illicit drug use

O:
T 37.2C | BP 112/71mmHg | P 68 BPM, regular | RR 16 breaths/min, unlabored | SpO2 98% RA
H 62in | W 146 lb. | BMI 26.7

Gen: Overweight, neatly groomed, looks her stated age of 34 years. AxO x3. Appears in no acute distress.
Skin: warm, dry, ***no rashes***
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion is symmetrical. No wheezing, rhonchi, rales, dullness.
Musculoskeletal: Strength 5/5 in UE and LE. Full active/passive ROM of all extremities without rigidity or spasticity. No deformity or edema throughout. Warm to touch. Negative straight leg raise B/L. Sensations intact throughout. Pulses 2+ throughout.
Neurological: ***LT sided facial drooping, inability to wrinkle the LT forehead, inability to voluntarily contract LT facial muscles, drooping at the LT corner of mouth, incomplete closure of LT eye, inability to hold air in and puff out.*** Otherwise cranial nerves intact, reflexes symmetric, sensation normal, cerebellar testing WNL, EOMI, PERRL, no nystagmus

A:
34 yo female with LT sided facial drooping, numbness, and weakness appearing with LT sided facial drooping with sparing of forehead, drooping at the LT corner of mouth, incomplete closure of LT eye, and inability to hold air and puff out cheeks on exam. Likely Bell's Palsy.

Differential Diagnosis:
- Bell's Palsy
- CNS tumor

P:
Labs: None
Imaging/Tests: None
Bell's palsy:
- Prednisone 60mg qd x 1 wk
- Valacyclovir 1000mg TID x1 week
- Artificial tears as needed for dryness, wear protective glasses or goggles for safety, tape LT eye close at night
- Follow up with optho

Initial DDx Based on CC:	Adjusted DDx After H&P:

● Bell's Palsy ● CVA ● Trigeminal neuralgia ● Tick paralysis ● Lyme Disease ● Ramsay Hunt syndrome ● CNS tumor ● Acoustic neuroma or other cerebellopontine angle lesions ● Meningioma ● Facial nerve schwannoma ● Cerebral Aneurysm	● Bell's Palsy ● CNS tumor

Gagandeep Munday SOAP #5

S:
EM is a 60 y/o F with PMH of smoking and asthma p/w 3 days of cough, subjective fever and nasal congestion. Denies chills, body aches, sore throat, ear pain, sinus congestion, abdominal pain/n/v/d/c, hemoptysis, unintentional weight loss, CP or SOB.

PMH: Asthma
PSH: Denies any
Allergies: NKDA
Medications: Albuterol
FHx: Non-contributory
SHx:Smoker 20 pack years, Denies EtOH use, Denies illicit drug use

O:
T 100.9F orally | BP 144/84 mmHg | P 101 BPM, regular | RR 20 breaths/min, unlabored | SpO2 96% RA
H 60 in| W 139lb. | BMI 27.1

Gen: Neatly groomed, looks her stated age 60 of years. AxO x3. Appears to be in no acute distress.
Skin: Warm, dry, anicteric
Head: Normocephalic atraumatic
Eyes: PERRL, EOMI
Ear, **nose, mouth, throat**: ***Cobble-stoning***, mucous membranes moist, no erythema, airway patent, no stridor, TMs pearly grey, ear canals nonerythematous, ***boggy turbinates with clear nasal discharge***
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: ***Rhonchi bilaterally***. Chest expansion is symmetrical. No wheezing, rales, dullness.
Abdomen: Soft, non-tender to palpation throughout, no guarding, no rebound tenderness, no CVA tenderness

A:
60 y/o female w/o 2- pack year h/o smoking p/w cough, fever, and nasal congestion. Likely pneumonia or viral URI
Differential Diagnosis:

- Viral URI
- Pneumonia
- Bronchitis
- COVID
- Flu

P:
Labs: none
Imaging/Tests: COVID swab was negative, CXR hyperinflation of lungs no acute infiltrates
Viral URI: Supportive care with tylenol for fever, flonase for congestion, and mucinex extended release for congestion

Initial DDx Based on CC:

- URI
- Bronchitis
- Pneumonia
- Influenza
- Asthma
- Foreign body
- GERD
- Lung cancer

Adjusted DDx After H&P:

- Viral URI
- Pneumonia
- Bronchitis
- COVID
- Flu

SOAP # 6

S:
PM is a 20 year old M with no significant PMH % bilateral lower leg swelling that he first noticed upon waking up this morning. Pt states that he was sitting and playing video games for over 10 hours yesterday, and then laid down to sleep for 6-7 hours. Endorses no aggravating or relieving factors.
Denies any CP, SOB, abdominal pain, radiating arm/jaw pain, nausea, dizziness, headaches, weakness, recent travel, other extended periods of immobilization, family h/o cardiac conditions, h/o arrhythmias, congenital heart defects, intake of any illicit substances.

PMH: Denies any
PSH: Denies any
Allergies: NKDA
Medications: Denies any intake of prescription medications
FHx: Non-contributory
SHx: Non- Smoker, Denies past or present EtOH or illicit drug use

O:
T 36.8C | BP 111/75mmHg | P 58 BPM, regular | RR 16 breaths/min, unlabored | SpO2 97% RA | H 65in | W 123 lb. | BMI 20.5

Gen: Slender, neatly groomed, looks stated age of 20 years. AxO x3. Appears in no acute distress.
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, or friction rubs.
Pulm: Clear to auscultation and percussion bilaterally. Chest expansion is symmetrical. No wheezing, rhonchi, rales, dullness.
Abdomen: Soft, non-tender to palpation throughout, no guarding, no rebound tenderness
Neuro: Cranial nerves II-XII intact, reflexes symmetric, sensation normal, cerebellar testing WNL, EOMI, PERRL
MSK: ***Non-pitting edema to B/L lower leg***, without ulcerations, warmth, or signs of infection. Negative homans. FROM. Strength 5/5 in UE and LE.

A:
20 yo male with bilateral lower leg swelling. Normal exam. Need EKG to rule out any acute cardiac pathology. Likely venous insufficiency.

Differential Diagnosis:
- MI
- PE
- HF
- AKI
- Electrolyte imbalance
- Venous insufficiency
- Lymphedema
- Cirrhosis

P:
Labs: None
Imaging/Tests: EKG with peaked T waves throughout and ST-elevations in leads II, III, and aVF, no axis deviation, no BBB, 54 bpm, no QRS widening, normal PR interval
Anterior MI:
- Immediate f/u in ED for further evaluation

Initial DDx Based on CC:	Adjusted DDx After H&P:
● MI	● MI

• PE • HF • AKI • Venous insufficiency • Lymphedema • Cirrhosis	• PE • HF • AKI • Venous insufficiency • Lymphedema • Cirrhosis

SOAP #7

S:
CR is a 17 y/o M w/ PMH of asthma BIB father for cough x3 weeks that worsens at night. Patient feels the need to use his albuterol inhaler. No OTC meds.
Denies fever, chills, body aches, sore throat, nasal/sinus congestion, ear pain, CP, SOB.

PMH: Asthma
PSH: Denies any
Allergies: NKDA
Medications: Albuterol HFA
FHx: Non-contributory
SHx: Non Smoker, Denies past or present EtOH use or illicit drug use

O:
T 36.8C | BP 114/76mmHg | P 80 BPM, regular | RR 16 breaths/min, unlabored | SpO2 98% RA H 70in | W 141 lb. | BMI 20.2

Gen: Neatly groomed, looks stated age 17 of years. AxO x3. Appears to be in no acute distress.
Skin: Warm, dry, anicteric
Head: Normocephalic atraumatic
Eyes: PERRL, EOMI
Ear, **nose, mouth, throat**: ***Cobble-stoning***, mucous membranes moist, no erythema, airway patent, no stridor, TMs pearly grey, ear canals nonerythematous, ***boggy turbinates with clear nasal discharge***
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: ***Rhonchi bilaterally***. Chest expansion is symmetrical. No wheezing, rales, dullness.
Abdomen: Soft, non-tender to palpation throughout, no guarding, no rebound tenderness, no CVA tenderness

A:
17 y/o M BIB father for cough x3 weeks that worsens night, pt feels need to use his albuterol inhaler more often. Likely mild asthma exacerbation.

Differential Diagnosis:
- Asthma exacerbation
- Bronchitis
- Allergic rhinitis
- Viral URI

P:
Labs: None
Imaging/Tests: COVID swab was negative
Asthma exacerbation:
- Nebulized albuterol solution, mucinex DM, follow up with pulm for re-eval and possible maintenance therapy

Initial DDx Based on CC:
- URI
- Bronchitis
- Pneumonia
- Influenza
- Asthma
- Foreign body
- GERD
- Lung cancer

Adjusted DDx After H&P:
- Asthma exacerbation
- Bronchitis
- Allergic rhinitis
- Viral URI

SOAP #8

S:
JC is a 22 y/o M endorsing no PMHx presenting with SOB and atraumatic acute CP that radiates from right to left. Denies recent trauma, fever, chills, body aches, weight loss, palpitations, diaphoresis, orthopnea, edema, any recent procedures, sick contacts, h/o asthma, h/o HIV, h/o incarceration, or h/o smoking

PMH: Denies any
PSH: Denies any
Allergies: NKDA
Medications: Denies any intake of prescription medications
FHx: Non-contributory
SHx: Non Smoker, Denies past or present EtOH use or illicit drug use

O:
T 36.8C | BP 110/75mmHg | P 94 BPM, regular | RR 16 breaths/min, unlabored | SpO2 93% RA H 70in | W 121 lb. | BMI 17.4

Gen: Slender, neatly groomed, looks stated age of years. AxO x3. Appears.
CV: RRR. S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs.
Pulm: ***No breath sounds on RT***. LT lung clear to auscultation and percussion bilaterally. Chest expansion is symmetrical. No wheezing, rhonchi, rales, dullness.
Musculoskeletal: No signs of trauma, no focal tenderness

A:
JC is a 22 yo male with SOB and atraumatic CP appearing with no breath sounds on RT lung on exam. Likely spontaneous pneumothorax.

Differential Diagnosis:
- Tension pneumothorax
- Spontaneous Pneumothorax

P:
Labs: None
Imaging/Tests: CXR indicates RT sided pneumothorax, no tracheal deviation
Spontaneous Pneumothorax:
- Follow up in ED for the following
- Type and screen, aPTT, BMP, CBC w/ diff, PT/INR, COVID, TSH, Troponin.
- CXR, CT-Lung w/o contrast
- Needle decompression and chest tube insertion followed by CXR to confirm placement
- Supplemental O2
- Monitor over 1-5 days

Initial DDx Based on CC:	Adjusted DDx After H&P:
● Tension pneumothorax ● Iatrogenic pneumothorax ● Spontaneous Pneumothorax	● Tension pneumothorax ● Spontaneous Pneumothorax