Rachel Freundlich

SOAP #1

S:
Pt is a 54 y/o male with PMH of DM, HTN, CAD and L hallux OM s/p amputation (1/16/24) initially admitted on 1/31/24 for acute on chronic anemia 2/2 heavy bleeding from L foot improved after multiple transfusions. Pt now presents with complaints of bilateral fullness in ears with decreased hearing, mild pain and some dizziness. Pt states symptoms are slightly worse in left ear. Denies headaches, loss of sensation, tinnitus, vertigo, fever, chills and nausea.

O:
Vitals: BP - 117/82, Temp - 98.1F, HR - 72, Resp 16, SpO2 - 98%
Labs: WBC - 8.48, Hgb - 8.3, Hct - 25.2, Plt - 397, Sodium - 135, Potassium - 4.1, Chloride - 103, CO2 - 24.0, Creatinine - 0.7, BUN - 16.0

Normal: Sodium: 136 to 144 mmol/L. Potassium: 3.7 to 5.1 mmol/L. Calcium: In adults, 8.5 to 10.2 mg/dL. Chloride: 97 to 105 mmol/L.
PE:
General Appearance: A&Ox3, appears in no acute distress, sitting up in bed
Skin: Good turgor, no masses or lesions noted. Slight bruising around lower left foot
HENT: Normocephalic, atraumatic, EOM intact, PERRLA
Ears: bilateral cerumen noted, black in color, could not visualize TM due to impaction. No edema or erythema noted
Lungs: Unlabored breathing, symmetrical rise of chest
Extremities: Well perfused, pulses palpable

A:
54 y/o M admitted for acute on chronic anemia 2/2 heavy bleeding from L foot amputation now with complaints of fullness bilaterally in his ears. Bilateral cerumen impaction noted that is black in color.
P:
Follow up with ENT clinic on Monday afternoon during clinic hours for earwax disimpaction.

SOAP 2:

S:
Pt is a 52 y/o male who presented to the ED with complaints of 1 week of abdominal pain. Pt presented to the ED last week with the same complaint and was discharged with Zofran and Pepcid. He reports that this did not help alleviate the pain. Pain initially began in the epigastrium and RUQ. Pt describes pain as 6/10 and describes it as feeling like a sense of “pressure” in his abdomen. He denies radiation to the back. Pt reports the pain is aggravated by moving and is alleviated when lying down. He admits association

with food, nausea, and 1 episode of vomit last week. He has not had any episodes since. Pt denies fevers, hx of GERD, gastritis, constipation and urinary symptoms.

O:
Vitals: BP - 127/83, Temp - 98.6F, HR - 88, Resp 18, SpO2 - 100%
Labs: WBC - 9.28, Hgb - 15.7, Hct - 45.2, Plt - 322, Sodium - 127, Potassium - 4.2, Chloride - 90, CO2 - 28.0, Creatinine - 0.8, BUN - 10.0, Total Bilirubin - 2.6, Direct Bilirubin - 1.8, Alk Phos - 438, ALT - 568, AST - 274, Lipase - 44

- Direct (also called conjugated) bilirubin: less than 0.3 mg/dL (less than 5.1 µmol/L)
- Total bilirubin: 0.1 to 1.2 mg/dL (1.71 to 20.5 µmol/L)

Medications:
Aluminum-Magnesium Hydroxide - 200mg/5mL suspension, 10mL by mouth every 6 houses PRN up to 10 days
Famotidine - 40mg tablet, 1 tablet my mouth nightly for 14 days
Pantoprazole - 40mg tablet, 1 tablet by mouth daily

PE:
General Appearance: A&Ox3, appears in no acute distress, lying down in bed
HEENT: Normocephalic, atraumatic, EOM intact, PERRLA
Lungs: Unlabored breathing, symmetrical rise of chest
Abdomen: non-distended, soft with tenderness to light and deep palpation in the epigastrium and RUQ, no rebound or guarding. Positive Murphy's sign.

Imaging
US: 2/20/24 - Findings consistent with cholecystitis; dilated common bile duct; choledocholithiasis cannot be excluded.

A:
52 y/o M presenting with abdominal pain to the ED for 1 week with associated nausea with concerns for cholecystitis and possible choledocholithiasis on US. Pain is most prominent in the epigastirum and RUQ with positive Murphy's sign. Concern for cholecystitis and possible choledocholithiasis on US.

P:
Admit to medicine for further workup with GI consult
MRCP to rule out choledocholithiasis
NPO/IVF
Surgery will continue to follow and likely schedule cholecystectomy

SOAP 3:

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M.P. is a 68y/o F with PMH of hypothyroidism, fibromyalgia, HTN, and a former smoker with a LUL nodule concerning for lung adenocarcinoma. Pt underwent L thoracotomy with LUL lobectomy this morning. Pt is now admitted to the SICU for close monitoring. Pt remains intubated and sedated with two chest tubes for continuous suctioning. Pt is afebrile and hemodynamically stable with NG tube in place.

O:

Vitals: BP - 128/59, Temp - 98.6F, HR -77, Resp 18, SpO2 - 98%
Labs: WBC - 9.97, Hgb - 14.8, Hct - 44.7, Plt - 349, PLT - 349, INR - 1.1

Medications:

Cefazolin - in dextrose 50mL IVPB, IV infusion, PRN (2g given)
Fentanyl - injection, IV push, PRN (100mcg given)
Lactated Ringers - IV infusion, Continuous PRN
Midazolam - injection, IV push, PRN (2mg given)
Phenylephrine - injection, IV push, PRN (100mcg given)
Propofol - 10mg/mL injection, IV push, PRN (200mg given)
Rocuronium - injection, IV push, PRN (50mg given)

PE:

General Appearance: Pt is intubated and sedated, in no acute distress
Skin: Good turgor, no masses or lesions noted
Head/Face: Normocephalic, atraumatic, no other gross abnormalities
Eyes: no gross abnormalities
Mouth/Throat: mucosa moist, no lesions; pharynx without edema or exudates
Neck: supple, no masses
Lungs: Unlabored breathing, symmetrical rise of chest
Heart: regular rate and rhythm. Normal S1, S2. No murmurs noted
Abdomen: soft, non-distended. No masses or lesions noted
Extremities: warm, pink, capillary refill <2 seconds, no edema noted
Peripheral Pulses: 3+ in upper and lower extremities

A:

68 y/o F with PMH of hypothyroidism, fibromyalgia, HTN, former smoker with LUL lung nodule concerning for lung adenocarcinoma, now s/p L thoracotomy and LUL lobectomy. Pt is intubated and sedated with 2 chest tubes in place, 1L anterior and 1L posterior to remain on suction.

P:

Neuro - post-op pain control
- IV tylenol 1000mg every 6 hours
- Gabapentin 300mg TID
- PRN dilaudid

Cardiovascular - HTN
- Restart home amlodipine 5mg

- Monitor Vital Signs

Pulm
- Wean off fentanyl
- RR 15
- TV 400
- FiO2 40
- L chest tube x2 to suction
- CXR today to confirm placement of chest tubes, no pneumothorax
- Repeat CXR tomorrow before extubating

GI
- Diet: NPO/NG tube placed
- IVF: LR 75

GU
- Foley in place, monitor Is and Os

Heme
- Monitor CBC every AM
- Initiate transfusion if Hgb <7
- SQH 2500U starting tonight - continue every 8 hours

Encourage early ambulation

Resume home-medications
- Amlodipine 5mg daily
- Aripiprazole 10mg daily
- Symbicort 2 puffs 2x per day
- Fluoxetine 20mg daily
- Montelukast 10mg nightly
- Synthroid 100mcg daily

SOAP 4:

S:
60 y/o M with PMH of T2DM (on trulicity and metformin), ex lap with lap antrectomy with gastrojejunostomy for perforated gastric ulcer on 2/10/2020 who presents with complaints of ventral hernia. Pt states that he has had the hernia for more than 2 years. Pt states that it has been getting bigger and started noticing it increasing in size over a year ago. Pt states that it causes him pain and there is burning in the skin around the area. Denies any issues with bowel movements.

O:
Vitals: BP - 127/77, Temp - 98.8F, HR - 84, Resp 18, SpO2 - 95%
Labs pending

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Medications:
Acetaminophen - 500 mg Oral every 4-6 hours PRN

PE:
General Appearance: A&Ox3, appears in no acute distress
HEENT: Normocephalic, atraumatic, EOM intact, PERRLA
Lungs: Unlabored breathing on room air, symmetrical rise of chest
Abdomen: non-distended, soft, nontender. Midline ex lap scar well healed, hernia palpable to the right of the midline lateral to the umbilicus
MSK: moving extremities freely

A:
60 y/o M with PMH of ex lap antrectomy with gastrojejunostomy for perforated gastric ulcer on 2/10/20 presents with complaints of ventral hernia. Pt has palpable hernia defect to the right of the midline lateral to the umbilicus.

P:
Pt educated regarding laparoscopic ventral hernia repair
Received consent in clinic
Book patient for laparoscopic ventral hernia repair
Referrals sent for primary care and cardiology clearance prior to surgery date