FAMILY PRACTICE

SAMPLE CASE REPORT – OFFICE PRACTICE

CORONARY ARTERY DISEASE

A 69-year-old white male presented for a general check up on November 3, 1993. He complained of chronic arthritic pain of the right shoulder but generally felt well despite a 40 year history of cigarette smoking and a history of high cholesterol readings by his prior physician. He was on no medications and had a negative family history of heart disease. He had a past history of adenoma removed from his colon during a colonoscopy 10 months prior and was due for follow up.

PHYSICAL EXAMINATION: BP 130/60, P 72, RR 20, T 97.4, W 202lbs. HEENT: PERRL, EOM, no carotid bruits. HEART: RSR without murmur or extra sounds. LUNGS: clear to susculatation. ABDOMEN: benign. EXTREMITIES: no edema, pulses are equal bilaterally.

LABORATORY: CBC: WBC 10,000/MM3, Hgb 16.6, Hct 48.5%, Differential normal. SMAC: normal except total cholesterol 249, H.L. 57, LDL 165, Ratio 4.37, Triglycerides 133. PSA: 1.1. Sed Rate: 7

He was referred for colonoscopy on 10-25-93 which showed he was clear of any lesions. He was informed of his high cholesterol reading and given a low fat diet with instructions to stop smoking. On 11-17-93, he returned to the office complaining of pain in the right upper quadrant, pain in the anterior thigh, and some difficulty breathing. BP 34/82, P 72, T 96.6, W 204. He was found on physical exam to have an exacerbation of his underlying chronic obstructive pulmonary disease and was instructed on the use of both the beta2-agonist-Ventolin inhaler and the steroid, Azmacort inhaler. On follow-up, 11-30-93, he was doing fairly well with clear lungs and normal vital signs. BP 130/80, P 60, T 97.9. He

stated that he occasionally had vague chest pain on and off. Because of his hypercholesterolemia and smoking history, he was referred for treadmill stress test since his COPD was stable.

His stress test was positive for coronary artery disease. On 1-17-94, he underwent cardiac catheterization. On 1-21-94, he underwent a triple bypass. He had an internal mammary artery implant to the left anterior descending and a very good post operative result.

On the office visit of 2-8-94, his blood pressure was 115/75, heart RSR within normal limits, Lungs clear, and all his wounds including the median sternotomy and leg wounds were clear and healed. He was advised to maintain a daily aspirin regime for the rest of his life, to increase his walking to one mile per day. He reported that he was almost off cigarettes and was using a nicotine patch prn.

During the following year, he was seen approximately every three months. On 11-2-94, he was given both a flu and pneumococcal vaccine. He continued to be free of anginal pain. Blood pressure 132/80, pulse 64, RR 12, temperature 97.1 and weight 204. Heart exam S1 and S2 normal no rub, no murmur and no S3. He has a follow up with his cardiologist on 1-10-95 for cardiolite stress test. His last visit being one year post-op CABG.

SUMMATION: Of the known risk factors for coronary artery disease, the patient had a long history of cigarette smoking, high cholesterol and was male. He was successful in stopping smoking but earlier intervention and emphasis on preventative care is the key to treatment especially in younger patients who are not yet symptomatic on presentation. Weigh reduction to ideal body weight, low fat diet, moderate exercise for one hour three times per week, and stopping the use of tobacco are realizable goals.

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SIGNATURE OF APPLICANT

FAMILY PRACTICE

SAMPLE CASE REPORT – OFFICE PRACTICE

MENSTRUAL DISORDER

A 28-year-old white morbidly obsess G1P1A0 woman with a history of recurrent episodes of amenorrhea. She was seen 8-6-93 when she was 26-years-old for a physical and Pap smear. She stated she had a son age 4. She had tried birth control pills but had been unable to tolerate them. No menses since April 93 (approximately 4 months). She stated her 45-year-old husband had already had a vasectomy.

PHYSICAL EXAM: BP 130/90, P 68, R 18, Weight 268. HEENT – no thyromegaly or nodules PERRI-disc flat HEART-RSR with murmur. LUNGS – clear, ABDOMEN – no organomegaly or bruit, PELVIC – vulva and vaginal exam were normal, no discharge, cervix pink, normal os, fundus normal shape and size, no tilt, RECTAL – negative.

LABORATORY: Pap test including cervical scrape and endocervical swab were normal, estrogen effect present, endocervical cells identified CBC-WBC 6,4000, Hgb 14.2, Hct – 41.3, normal differential and platelet count. SMAC-complete panel were within normal limits including glucose and liver profile except for total cholesterol 227, H.L. – 58, LDL – 151, Ratio 3.91. Prolactin level-normal.

She was given treatment options and subsequently given Provera 10mg medroxyprogesterone for 10 days and advised to expect withdrawal bleeding after the course of therapy. She was seen at the office three visits later in the year for unrelated incidental illnesses – bronchitis, gastroenteritis, and left otitis media until 1-28-94 when she stated that she again had missed two cycles. At that time, I tried one packet on birth control pills, Triphasil 28 with recommendation to recheck if menstrual cycles did not regulate on their own.

She came into the office 8-17-94 for her annual pap. At that visit, she was 29-years-old and had no complaints. No vaginal discharge, itch, or missed cycles. At that visit, I discussed her three pound weight gain as well as her hypercholesterolemia from the year before. We discussed family history, weight reduction techniques, exercise patterns and had a short discussion about anovulatory cycles. I did not hear from her again until 12-14-94 when she was seen in the office and reported that she had not had a mensus since the pap and pelvic in August. At that visit, I obtained FSH (follicle-stimulating hormone), LH (luteinizing hormone), and TSH (thyroid stimulating hormone). All were normal.

SUMMARTION: Amenorrhea is a pattern of abnormal uterine bleeding defined as no uterine bleeding for at least six months. In this patient, secondary amenorrhea is the old terminology used to describe a woman who has had normal cycles in the past. Review of her previous medical and menstrual history suggested anovulatroy periods. She had no evidence of high androgen levels based on normal hair distribution and habitus. However, the obesity was presenting a problem for her lifestyle with lack of exercise as well as hypercholesterol compounding her health problems in the future.

She had no history or evidence of galactorrhea, or CHS complaints to warrant x-ray of her sella turcica. Had she not had two completely normal pelvic exams or had I had any suspicions, a pelvic ultrasound is easily obtained in this practice to rule out polycystic ovaries or premature ovarian failure.

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FAMILY PRACTICE

SAMPLE CASE REPORT – HOSPITAL ADMISSION

ACUTE APPENDICITIS

PATIENT #: 1

DATE OF ADMISSION: 7/30/89

DATE OF DISCHARGE: 8/3/89

ADMITTING DIAGNOSIS: Acute appendicitis

FINAL DIAGNOSIS: Perforated gangrenous appendicitis

REPORT:

Complaint: Abdominal pain

History: This 56-year-old patient presented himself in the emergency room with only one day history of abdominal pain and nausea without any vomiting. He had two bouts of diarrhea the day prior. He was alert and conscious and not in severe distress.

Physical Findings: He had a low grade fever with a temperature of 100.5°F. Abdominal examination showed a diffuse tenderness over the entire abdomen with specific rebound tenderness over the right lower quadrant. Rectal examination reviewed tenderness over the left upper quadrant and a positive hemoccult blood test.

Laboratory Findings: A CBC ordered showed a WBC count of 18,000 with 73% Segs and 19% Bands.

Diagnosis: This patient was diagnosed with acute appendicitis

Treatment: The surgeon was consulted, and the patient was taken to the operating room. A perforated appendix was removed. The peritoneal cavity was cultured, and the incisional wound was left opened. The patient was started on iv Ancef. The peritoneal culture grew moderate amount of E. Coli sensitive to Cephalosporin. The patient's WBC went down to 13,600 on 8/1/89 and 7,400 on 8/3/89. With much improved condition, the patient was discharged home on 8/3/89. The pathology report of the appendix showed the presence of severe acute necrosis with in some area is a full thickness necrosis. A fecalith was present within the appendiceal lumen. The conclusion was a gangrenous appendicitis with perforation and presence of intraluminal fecalith.

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SIGNATURE OF APPLICANT

FAMILY PRACTICE

SAMPLE CASE REPORT – HOSPITAL ADMISSION

C.O.P.D.

PATIENT #: 1

DATE OF ADMISSION: 1/29/94

DATE OF DISCHARGE: 2/4/94

ADMITTING DIAGNOSIS: 1. Acute Respiratory Failure

2. Severe Emphysema with Exacerbation

FINAL DIAGNOSIS: 1. Acute Respiratory Failure

2. C.O.P.D.

REPORT

Complaint: Shortness of breath

History: This 70-year-old male was seen in the emergency room with several day history of increasing dyspnea. He did not have any crushing chest pain, fever, of shaking chills. He coughed up occasional small amount of whitish sputum without any blood. He was a smoker for more than 20 years averaging one to two packs per day. However, he had stopped smoking completely for 13 years. He had been diagnosed with emphysema, and his medications included bronchodilators orally as well as by inhalation.

Physical Findings: Physical examination showed an elderly man who was awake and alert. However, he expressed moderate respiratory distress with increased respiration rate of 28 per minute. Auscultation of chest showed decreased breath sounds bilaterally and some wheezing.

Laboratory Findings: A chest x-ray ordered showed hyperinflated lungs bilaterally and no obvious acute pneumonia. However, the arterial blood gases at room air showed a pH of 7.38, pC02 of 68, and p02 of 34.

Treatment: The patient was diagnosed with acute respiratory distress and severe emphysema with exacerbation. He was started on 1.5 liters per minute of oxygen and monitored through the intensive care unit. A repeat arterial blood gases showed an increase p02 concentration of 56. However, the pC02 had risen to 82 indicative of severe C02 retention. Pulmonologist was consulted, and possible intubation was anticipated. Proventil inhalation therapy was started along with 40mg. of intravenous Solumedrol. With close monitoring, the patient did not require any intubation, and his respiratory status improved. After two days, on 1/31/94, he was still on 1.5 liters per minute of oxygen, but his respiratory status improved. After two days, on 1/31/94, he was still of 1.5 liters per minute of oxygen, but his arterial blood gases were much improved. His p02 was 96, and his pC02 was 67. "Sixty-ish" was the patient's baseline for chronic obstructive pulmonary disease (C.O.P.D.). His intravenous doses of steroid were slowly lowered and eventually-replaced with oral prednisone. He was finally feeling much better and was discharged on 2/4/94. Inhalation bronchodilators were prescribed.

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SIGNATURE OF APPLICANT