**Case Report**

**Clinical Skills V, MUA**

**Date: 05/18/19, 9:00am**

**Name: Michelle Menard**

**Professor: Dr. Drake**

**Internal Medicine Report: Follow up of Diabetic patient with past history of alcohol abuse**

**05/18/19**

**Patient Report:**

A 53 year old retired African American male presented to the clinic for a follow up/check-up with Dr. Ravi. Patient is well nourished, alert and conscious. The patient is 5’7” and obese. BP 120/80, RR 17 bpm. Blood sugar 367.

**History of present illness:**

Upon discussion with the patient, he states that he has been feeling better since his last visit. It is important to note that patient stated he has white bread for breakfast 10 mins prior to his visit. His hypertension is well controlled, the tremors in his hand are improving and the tinea corporis and tinea bullous are starting to get better. He has been a Type 1 Diabetic for around 25 to 30 years. He has been an alcoholic since his early twenties with minor periods of sobriety. He has been sober now for around 1 year. He states that his diabetes is well controlled. He listed Lasix and Aldactone as the medications he is currently takin. Patient discussed previous GI bleed where he was airlifted to St. Marteen to do epistaxis episode and melenic stool.

**Physical Exam:**

On examination, the patient did not appear to be in any pain or respiratory distress.

On examination of his head and neck, there did not appear to be in gross abnormalities. A scar is noted on the back of his neck, patient had a lipoma removed a couple of years ago.

There was no enlargement of the thyroid or cataracts. There was no oral candidiasis.

On examination of his chest area, there was symmetry with respiration and signs of gynecomastia. There is minor tinea corporis spread diffusely over his upper extremities, minor tinea bullous underneath facial hair.

On examination of abdomen, scaphoid in shape and uniform in distension. There was a lowered umbilicus, striae, mild skin irritation, mild hepatomegaly and splenomegaly. Normal bowel sounds present.

On examination of his upper extremities, the tremor in his hands was markedly improved. There was no clubbing, peripheral cyanosis.

On examination of his lower extremities, there was pitting edema and the previous fungal infection of toe nails has resolved.

On examination of his neurological function, patient was alert and previous confusion appears to have resolved.

**Assessment:**

The patient is maintaining his sobriety and doing his best to keep his sugar level within normal limits. His sugar level was higher than normal, at 367. The patient did have breakfast about an hour prior to checking his level. However, he did take his insulin as he normally does with it. Therefore a dose of Humalog was necessary. His hand tremor, a result of his chronic alcoholism, is improving. As per his usual checkup, a shot of B complex was given intramuscularly. It still appears he needs an adjustment on his diuretic in order to help better control the swelling in his feet.

**Plan:**

Encourage him to maintain his sobriety and discuss with him any resources that are available to him in case he begins to struggle with remaining sober.

Discuss with him the importance of monitoring his blood sugar and to avoid foods such as white bread, which may be the cause of his high sugar level.

Discuss with him that sticking to his medication regimen of Furosemide and Spironolactone is critical in order to minimize his edema.

Continue to monitor this patient and set follow up appointment to assess any improvement on his foot edema.