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A [redacted] ce Health System

Consultation

Name: [redacted] L
MRN: [redacted]
Account #: [redacted]
DOB - [redacted]

Admit Date: [redacted]
Discharge Date: [redacted]
Location: [redacted]

Report #: [redacted]

Dictating Physician: [redacted] MD

DATE OF CONSULTATION: [redacted]

REASON FOR CONSULTATION:
We have been asked by the Internal Medicine staff to see this patient for evaluation of left hip pain, status post fall.

HISTORY OF PRESENT ILLNESS:
The patient is an 86-year-old woman, who lives independently who was in her closet yesterday, hanging up some clothes, when she turned around and caught her foot on some pocket books that were lying on the ground, causing her to fall onto her left side. She was able to get up on her own and walk back to her bed. After few minutes, she is able to walk around again, but had some pain in the left proximal thigh. She also noted pain over her face and left side of her head, on which she actually focused most of her attention. The fall occurred yesterday. When she got up this morning, she is able to walk and bear weight on the left leg, but had increasing pain over the course of the day. Her granddaughter urged her to come to the hospital. She presented to Mercy Emergency Room where x-rays demonstrated valgus impacted left femoral neck fracture. Aside from pain in the left side of her forehead and left proximal thigh, she denies pain elsewhere. No numbness or tingling down the leg or foot. Denies premorbid pain on this left side. Typically walks with a cane both in and outside of the house.

PAST MEDICAL HISTORY:
Hypertension, hypothyroidism, diverticulosis, pulmonary fibrosis, history of mild CVA [redacted] years ago, which resulted in mild speech deficits, also history of left breast cancer, status post lumpectomy and radiation.

PAST SURGICAL HISTORY:

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Hysterectomy, right rotator cuff repair, left breast lumpectomy as above, multiple small procedures for skin cancer resections.

MEDICATIONS:
1. Aspirin.
2. Omeprazole.
3. Verapamil.

ALLERGIES:
1. NIFEDIPINE.
2. SIMVASTATIN.

SOCIAL HISTORY:
The patient lives alone. She walks with a cane as an assistive device. She uses it both inside and outside of the house. She has a daughter that lives within half-an-hour and her granddaughter that lives just up the street from her and sees her on a regular basis. She lives in a single family dwelling over 2 floors, so notes that she lives primarily all in one floor, the ground floor. She still drives herself, though tries to limit herself to stop in the immediate vicinity. She has assistance with errands outside of the house, but is still fairly independent in the community. She denies tobacco or alcohol use.

FAMILY HISTORY:
Noncontributory.

REVIEW OF SYSTEMS:
Positive for left-sided facial pain. Otherwise, negative x12 except as noted above in the HPI.

PHYSICAL EXAMINATION:
VITAL SIGNS: T-max 36.8, T-current 35.9, pulse 80s-100s, blood pressure 150-170s/90s, respiratory rate 12-16, 94-100% on room air.
GENERAL: Very sweet 86-year-old woman, in no acute distress.
NEUROLOGIC: Awake, alert, oriented x3. Answers questions appropriately. Head, large contusion over the left frontal forehead. No active bleeding. No facial asymmetry with the exception of this large contusion.
NECK: Supple.
HEART: Regular rate by palpation peripherally.
CHEST: No increased work of breathing and no audible wheeze.
ABDOMEN: Soft, nontender, nondistended.
MUSCULOSKELETAL: Left lower extremity: No obvious gross deformity at the hip. No significant leg shortening or external rotation noted. Mildly tender to palpation

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over the lateral hip. No pain with palpation down over the distal femur, knee, tib-fib, ankle, foot or toes. Skin is intact throughout with no evidence of swelling, ecchymosis, or laceration. She tolerates passive range of motion through the knee, ankle, foot and toes with no discomfort. She fires ankle dorsiflexors, EHL and ankle plantar flexors. Sensation intact to light touch, deep peroneal, superficial peroneal, and tibial distributions. She has very faint peripheral pulses at DP and PT, though toes are warm and well perfused with brisk cap refill.

Bilateral upper extremities: Painless active range of motions of the shoulders, elbows, wrists, and fingers. Skin is intact. No gross deformity, ecchymosis, or swelling appreciated. Grossly neurovascularly intact.

Right lower extremity: Skin intact with no gross deformity. No significant swelling or ecchymosis noted. Painless passive range of motion of the hip, knee, ankle, foot, and toes. Grossly neurovascularly intact distally.

IMAGING: AP pelvis, AP and lateral views of the left hip and AP and lateral views of the left femur from the Emergency Room were reviewed. These demonstrated a Garden I valgus impacted left femoral neck fracture. There is no deformity noted on the lateral view. Some sclerosis within the superior roof of the acetabulum, but otherwise no significant degenerative changes noted. No other fractures through the pelvis. No contralateral injury.

Brain CT from the Emergency Room demonstrates no acute intracranial hemorrhage or mass effect, moderate nonspecific deep white matter changes compatible with chronic microvascular ischemia, left frontal scalp contusion per the radiologist.

LABORATORY DATA:
Hemoglobin 15, white blood cell count 10.9, platelets 218, potassium 4.5, random glucose 100, creatinine 0.95, INR 1.21. UA demonstrates protein, moderate occult blood, positive for nitrites and leukocyte esterase, 10 white blood cells, but 44 epithelial cells, heavy bacteria, 5 hyaline casts. Urine culture is currently pending. Type and screen is currently pending.

ASSESSMENT:
Fairly independent 86-year-old woman, status post mechanical fall at home yesterday, able to weightbear through the left leg up until this morning. X-rays demonstrated a valgus impacted femoral neck fracture. This is fairly stable injury. We will plan to treat this with percutaneous pinning. Fact that she is able to weightbear reiterates the stable nature of the injury.

PLAN:

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For surgical intervention tomorrow pending Medicine and Cardiology clearance. The alternative options for treatment i.e., conservative treatment were discussed, though given how independent the patient has been at baseline, she is in favor of proceeding with whatever will give her the fastest return to all activities and that would be surgical intervention. The risks of surgery were discussed including, but not limited to bleeding, infection, injury to nerves, blood vessels, muscles, tendons, malunion, nonunion, hardware complications and need for further surgery. Following this discussion, the patient signed the informed consent in the Emergency Room in the presence of her granddaughter.

Of note, her daughter [redacted], is her healthcare proxy, and I have not yet met her. She will be coming in tomorrow. With regard to the dirty-appearing UA, we will plan to treat this of positive pending urine culture results. We will keep the patient n.p.o. past midnight. Hold pharmacologic anticoagulation past midnight. Mechanical anticoagulation overnight is fine.

[redacted] MD

[redacted]

cc:

[redacted], MD

Dictating Provider: [redacted] MD
[redacted]

<Electronically signed by [redacted] MD>

D: [redacted]
T:
S: [redacted]