ED Evaluation Note:
Visit Information: Patient seen on 2/16/2024.

Chief Complaint (As documented by Nursing):
Hemorrhoids
Mode of Arrival: Ambulatory
Triage Intervention(s): None

History of Present Illness
52-year-old female presents emergency room complaining of rectal pain. States has been going on and off for about a month. She assumed it was hemorrhoids. She states she had areas of tenderness in the perirectal area. She occasionally felt some "bumps." She states she would apply the Preparation H and the pain would go away. Within a couple days later she noticed pain in another area. On examination today she looks like she has any perirectal or buttocks abscess. She does have some white purulent discharge and drainage. She is did not initially mention that but on further questioning she states that she has noticed some clear to white discharge. With a bad smell.

Histories

Allergies
No Known Medication Allergies

Home Medications (from 'Document Medication by Hx')
cetirizine (ZyrTEC 10 mg oral tablet) 10 mg ONCE A DAY PRN By Mouth
FLUoxetine (PROzac) 10 mg ONCE A DAY By Mouth
glucosamine (glucosamine hydrochloride 1500 mg oral tablet) 1,500 mg ONCE A DAY By Mouth
insulin glargine-lixisenatide (Soliqua 100/33) 60 Unit(s) BEFORE LUNCH subQ [Order Comment: 2pm is her time
to take this med]
metFORMIN (metFORMIN 1000 mg oral tablet) 1,000 mg 2 TIMES A DAY By Mouth Miscellaneous Medication ONCE A DAY multivitamin 1 tab(s) ONCE A DAY By Mouth
omega-3 polyunsaturated fatty acids (Fish Oil 500 mg oral capsule) 1,000 mg 2 TIMES A DAY By Mouth

Social History:
Smoking (As documented by Nursing):
Currently in past 12 months have you smoked or used tobacco products: No
Alcohol Use (As documented by Nursing):
Do you use Alcohol?: Never Type of Alcohol:
How Frequently do you use Alcohol?:
Describe Alcohol Usage:
Date Last Used:

Substance Use (As documented by Nursing):
Substance Use: Never Type of Substance:
IV Drug Use: Frequency of Use:
Experience Withdrawals: Additional Details:
Date of last use:
Withdrawal Symptoms:

Review of Systems
Gynecologic
Pregnancy Information: No documentation per Nursing.

Physical Examination
GEN: Well developed, well nourished. No acute distress
HEENT: Normocephalic/atraumatic. Mucous membranes are moist. Extraocular movements intact.
Sclera anicteric.
Neck: Supple. No tenderness.
CARDIAC: S1S2+. No murmurs, rubs, or gallops.
PUL: Clear to auscultation bilaterally. No wheezes, rales, rhonchi or stridor.
ABD: Soft. Non tender. Non distended. Bowel sounds positive. No guarding or rebound. Non peritoneal exam.
Rectal exam: Patient's perirectal buttocks area seems edematous and swollen. Very painful when I tried to separate her buttocks. There was a evidence of infection with a opening with white purulent discharge or drainage coming from it.
EXT: Well perfused distally. No clubbing, cyanosis or edema. Pulses are 2+ and bilaterally equal.
NEURO: Awake, alert and oriented. Moving all 4 extremities. Speech intact. CN 2-12 grossly intake. No focal neuro deficits. Medications Given in the ED:
2/17 Meds
0:23 a Piperacillin-tazobactam 4.5 gm IV
2/16 Meds
11:40 p Insulin regular 10 Unit(s) IV
11:38 p Lactated Ringers 1,000 mL IV
10:21 p Acetaminophen 1,000 mg IV

Medical Decision Making
52-year-old female presented to the emergency room complaining of perirectal pain. Had evidence of infection on physical exam. CT scan confirms she has cellulitis/phlegmon in her gluteal cleft and perirectal area. I did speak with Dr. W of general surgery who stated that there is nothing surgical to do and if there is no fluid collection. Recommend IV antibiotics and he will see the patient in consultation. She is also a diabetic and takes metformin but does not check her sugars. Her initial blood sugar was between 6 and 700. But she is not acidotic and no anion gap. On the

venous blood gas pH was 7.395. CO2 of 38.9. Glucose was measured at 619 and lactic acid was normal. Patient was given 10 units of IV insulin and have ordered IV fluids. She has 2 L of lactated Ringer's ordered. Unfortunately the patient had her arm bent and the fluids did not infuse. She was instructed to keep her arm straight so can continue infusing at a steady rate. But repeat blood sugar is down to 500. Beta hydroxybutyrate slightly elevated and she has 20 ketones in her urine. But based on the remainder of her lab work does not appear to be an actual DKA.
Patient states that she has not taken her metformin in about a week because "it does not work anyways." She is on no other medications for diabetes. Although she is interested in starting Ozempic for her diabetes and weight loss. I spoke with Dr. of the hospital service who kindly accepted the patient to a monitored bed.

Impression and Plan
Diagnosis: Perirectal cellulitis/phlegmon
Hyperglycemia
Noncompliance with diabetes medications.
Plan: Admit.

Professional Services
Credentials Title and Author
Credentials: MD.
Title: Attending.

Endocrine
Consultation

HISTORY OF PRESENT ILLNESS: A 52-year-old female known to me, but not has been in the office for the last 2 years. The patient has history of type 2 diabetes with diabetic neuropathy. The patient is on Soliqua 60 units daily with metformin 1000 mg twice a day. However, she ran out of Soliqua about a year ago or so and just did not call in for refill or did not show up at office visits and continued on metformin monotherapy. The patient is now admitted with rectal pain and bleeding. We have been asked to see this patient for diabetes control. Her blood sugars are all over 500 mg percent with no evidence of acidosis.
PAST MEDICAL HISTORY: Diabetes mellitus type 2, diabetic neuropathy, DJD, OSA.

PAST SURGICAL HISTORY: Includes foot surgery, D and C, C-section, bilateral breast reduction, cataract extraction with implant, vitrectomy.

FAMILY HISTORY: Negative for diabetes mellitus.

SOCIAL HISTORY: Denies smoking, alcohol or illicit drugs.

MEDICATIONS: As reviewed in electronic record.

ALLERGIES: AS REVIEWED IN ELECTRONIC RECORD.

REVIEW OF SYSTEMS: A 10-system review, denies obvious chest pain, shortness of breath, cough. Denies abdominal pain, diarrhea, vomiting. Admits to rectal pain and bleeding. Denies polyuria, polydipsia, visual disturbances. Denies dysuria or frequency.
Denies hemoptysis or hematemesis. Admits to joint pains.

PHYSICAL EXAMINATION:
GENERAL: Reveals a 52-year-old female, clinically anemic, no jaundice, no pedal edema.
CARDIOVASCULAR SYSTEM: Pulse of 90, blood pressure 120/70. Heart sounds 1 and 2 are heard. No murmurs, gallops, or friction rubs.
RESPIRATORY SYSTEM: Chest symmetrical. Trachea central. Breath sounds are equal. No adventitious sounds are heard.
ALIMENTARY SYSTEM: Abdomen is soft, no hepatosplenomegaly, no ascites, no masses, no rebound or guarding. Bowel sounds are heard.
CENTRAL NERVOUS SYSTEM: The patient is awake, alert. Pupils equal, reactive. Neck soft. No focal neurological deficit. Cranial nerves I-XII are intact.
NECK: No goiter, no bruit.
EXTREMITIES: Shows no pedal edema. Pedal pulses are palpated.
<LCI>
LABORATORY DATA: Hemoglobin is 8.5 with a white count of 15,400. Sodium is artificially low at 130 with a sugar of 554 mg percent with a bicarbonate of 23. Serum creatinine has ranged from 1.42-1.21. Blood sugars have been all excess of 500 mg. Her liver function tests are normal. Calcium is normal.

ASSESSMENT: A 52-year-old female known to me; however, has not shown up in the office for at least 2 years, was on Soliqua and metformin, stopped taking Soliqua almost a year ago because she ran out of prescription, now admitted with perirectal abscess.
<LCI>
RECOMMENDATIONS:
1. Discontinue Soliqua, to start Lantus 35 units twice a day, to start Humalog 10 units with meals plus moderate dose correction.
2. The patient will be treated with intensive insulin therapy to reverse glucose toxicity, then as an outpatient would recommend adding a GLP receptor agonist.
The patient has agreed to be seen in the office after discharge.
We will follow the patient with you. This has been discussed with the nursing staff. The patient is n.p.o. for possible surgery, will give Lantus 35 units today and we will hold prandial insulin, but will need correction factor since her blood sugars are significantly elevated.
Thank you for the consultation.

GI Surgery Consult (PDI):
Patient seen on 2/17/2024 .

History of Present Illness
Very pleasant 52 yo female with anal pain and bpr that was initially thought to be due to hemmorhoids, but the started to drain foul smelling fluid and the pain was getting worse She cane to the ER where she was found to have significant induration and was admitted for IV abx.
I am consulted to eval from a surgical perspective

Histories
Past Medical History
DM
.
Past Surgical History

D&C
c-section breast
reduction.
Family History
No reported family history.

Home/Inpatient Medications

Allergies

Allergies
No Known Medication Allergies

Review of Systems Constitutional:
Negative.
Eye: Negative.
Respiratory: Negative.
Cardiovascular: Negative.
Gastrointestinal: Negative, Perianal pain and swelling with drainage bloody foul smelling.

Objective Vital
Signs:
Vital Signs Most Recent (Vitals in past 36 hrs; Dosing Wt and BMI this visit)
TempC 36.9 (36.5-36.9) SBP 108 (108-159) DBP 58 (58-84) Pulse 100 (91-107) RR 18 (18-20)
SaO2 97 (93-98) Dosing Wt 104 kg BMI 36.4
.
I & O (Summary)
_____
I&O (02/16) 7a-3p 3p-11p 11p-7a Total (02/17)
7a-3p 3p-11p 11p-7a
Intake: 100 2100 2200
Output:
Balance: 100 2100 2200
_____

Alert
NAD
Heart reg
Lungs clear
Abd soft nt nd
Buttock /perianal region very indurated small open area with min drainage. no fluctuance/drainable fluid identified

Impression and Recommendations

Diagnosis: cellulitis possible perirectal abscess.

ID Consult (PDI):
Patient seen on 2/17/2024 .

Reason for Consult: Perirectal phlegmon, uncontrolled diabetes.

History of Present Illness
52 yof with past medical history of DM, DJ, OA, and obesity who presented to UPMC East emergency room on 2/17/2024 for rectal pain and discomfort x 1 week. She reports having painful sitting for work over the past week, noticed white purulent malodorous drainage over the past few days, normal bowel bowel movement but have been painful, no fevers or chills, abdominal pain, nausea, vomiting, dysuria. When she presented to the emergency room WBC was 14.9, hemoglobin 9, platelets 246, sodium 128, potassium 4.8, creatinine 1.42, AST 25, ALT 26, T. bili 0.5, lactate 1.2 and glucose greater than 500 she was afebrile Tmax 36.9 °C, normotensive, not tachycardic and saturating well on room air, UA with clear-colored urine, leukocyte esterase negative, nitrite negative, urine WBC 10 and urine culture pending, blood cultures from 2/16 are also pending. She did CT on 2/16/2024 which showed's extensive perirectal stranding with questionable soft tissue around the anal verge which may represent a perianal phlegmon no evidence of loculated fluid collection/abscess but study was limited because of lack of IV contrast. Patient was started on Zosyn and ID consulted for assistance. Patient reports she has not been adherent with her diabetic management recently, reports choosing not to do it, not having any issues with insurance, etc... She denies headache, chest pain, abdominal pain, dysuria, bleeding or fever. Reports passing semiformed stool this morning which was more painful.

Histories
The past medical, family, and social histories were reviewed from the H&P on the following date by the following author

Home/Inpatient Medications

Anti-infective Medications
Start Stop Scheduled Medications
02/17 02/24 piperacillin-tazobactam (Zosyn) 4.5gm IV Q8H
Given One-Time Medications(Given in the past 3 days) 02/17
00:23 piperacillin-tazobactam (Zosyn) 4.5gm IV ONCE
.

Allergies

Allergies
No Known Medication Allergies

Review of Systems
All other systems are negative

Objective Vital
Signs:
Vital Signs Most Recent (Vitals in past 36 hrs; Dosing Wt and BMI this visit)
TempC 36.9 (36.5-36.9) SBP 108 (108-159) DBP 58 (58-84) Pulse 100 (91-107) RR 18 (18-20)
SaO2 97 (93-98) Dosing Wt 104 kg BMI 36.4
.
Constitutional: Alert and oriented, No acute distress.
Eyes: Normal conjunctiva.
ENMT: Oral mucosa is moist.
Neck: Supple.
Respiratory: Normal auscultation, Lungs are clear to auscultation, Respirations are non-labored, Breath sounds are equal.
Cardiovascular: Normal rate, Regular rhythm, No rub, No gallop.
Gastrointestinal: Soft, Non-tender, Normal bowel sounds, Non-distended, perianal tense induration with 2 small slit areas, able to express thin milky drainage from inferior wound. + periwound erythema and increased warmth. Skin: No rash.

Results Review
Microbiology: (Resulted in the past 36 hrs. Ordered by last time updated.)
Last Update: 2/17/24 6:58 AM BLOOD CULTURE
Collected: 2/16/24 10:00 PM Accession Num: F19816638 Status: Preliminary
Specimen Desc: Peripheral Blood Special Request: L HAND
Culture: No Growth 1 Day

Last Update: 2/17/24 6:58 AM BLOOD CULTURE
Collected: 2/16/24 10:00 PM Accession Num: F19816637 Status: Preliminary
Specimen Desc: Peripheral Blood Special Request: R WRIST
Culture: No Growth 1 Day

Last Update: 2/17/24 12:08 AM URINE CULTURE
Collected: 2/16/24 11:46 PM Accession Num: F19817752 Status: Preliminary
Specimen Desc: Urine Special Request: None Reflexed from F19817664

2/16/24 CT abdomen and pelvis without contrast IMPRESSION:

Extensive peri-rectal stranding with questionable soft tissue around the anal verge which may suggest a perianal phlegmon. There is no evidence of a low attenuation area to suggest loculated fluid collection/abscess although evaluation of this region is limited because of the lack of IV contrast. Additionally there is subcutaneous stranding associated with the gluteal region suggesting inflammation.

Impression and Recommendations
52 yof with poorly controlled DM who presetned with 1 week of rectal pain with purulent malodorous drainage, CT with extensive perirectal stranding with questionable perineal phlegmon

without loculated fluid collection, she had leukocytosis, afebrile and hemodynamically stable. ID consulted to evaluate

Perianal phlegmon
– Seen on CT 2/16, noncontrasted study
– GI and surgery consulted
Leukocytosis
– Secondary to above
– 2/16 blood cultures negative to date
– 2/16 urine culture pending
– No hypoxia
DM–not adherent to treatment
AKI
Impression/plan
Patient with perianal phlegmon in setting of non adherence to diabetic management, CT performed without contrast secondary to AKI, surgery and GI are following. Follow-up blood and urine culture, continue Zosyn. There was drainage from wound and personally collected a culture. Thank you for this consultation, we will continue to follow. Case d/w bedside RN.

Diagnosis: Perianal abscess : ICD10-CM K61.0, Working, Diagnosis.
Professional Services
Credentials Title and Author
Credentials: PA-C.
Title: PA.
Addendum on February 17, 2024 10:37 PM EST:
Pt seen and evaluated. I have reviewed the chart, vital signs, laboratory work, imaging studies and microbiology data. I agree with findings, assessment and plan documented Continue zosyn pending cx results.
On iv hydromorphone for pain control.

Hospitalist History and Physical:

Chief Complaint
Rectal pain and bleeding

History of Present Illness
This is a 52-year-old female who presented to the ED for the above complaint. She states that last night she developed rectal discomfort and felt that she probably had hemorrhoids so she started using Preparation H with some relief. However her discomfort continue to worsen, she had some intermittent bleeding which she thought was from hemorrhoids as well. Her work involves sitting and over the past week she says that it has been extremely uncomfortable, she has not been able to sit for any period of time without significant discomfort, also cannot lay on her back and has to lay on her side due to discomfort. She noticed some white purulent malodorous discharge as well over the past couple of days from the area. Her bowel movements have been normal but she says that they are painful. No fevers or chills reported. No abdominal pain, nausea, vomiting reported. No chest pain, shortness of breath, palpitations reported. Patient says she follows with endocrinologist but has not for several years and has been off her medications for a year now. In the ED, she was hemodynamically stable, afebrile, saturating well on room air. Labs demonstrated

acute kidney injury, hyperglycemia, normal pH, normal anion gap, microcytic anemia, normal lactate, leukocytosis of 15 K, urinalysis equivocal for infection. CT abdomen pelvis demonstrated perianal phlegmon. 2 sets of blood cultures were drawn in the ED. She received Tylenol, Zosyn, regular insulin in the ED. Surgical consult was placed. She was admitted for further management.

Histories
Past Medical History
DJD
DM OA
neuropathy

Past Surgical History foot
surgery
D&C
c-section
B/L breast reduction
cataract extraction OD with iol implant
vitrectomy Family
history:
None reported
Social history: No tobacco use reported
Allergies

Allergies
No Known Medication Allergies

Home/Transfer/Inpatient Medications

Home Medications (from 'Document Medication by Hx')
cetirizine (ZyrTEC 10 mg oral tablet) 10 mg ONCE A DAY PRN By Mouth
FLUoxetine (PROzac) 10 mg ONCE A DAY By Mouth
glucosamine (glucosamine hydrochloride 1500 mg oral tablet) 1,500 mg ONCE A DAY By Mouth
insulin glargine-lixisenatide (Soliqua 100/33) 60 Unit(s) BEFORE LUNCH subQ [Order Comment: 2pm is her time
to take this med]
metFORMIN (metFORMIN 1000 mg oral tablet) 1,000 mg 2 TIMES A DAY By Mouth Miscellaneous Medication ONCE A DAY multivitamin 1 tab(s) ONCE A DAY By Mouth
omega-3 polyunsaturated fatty acids (Fish Oil 500 mg oral capsule) 1,000 mg 2 TIMES A DAY By Mouth

Inpatient Medications
Scheduled Medications
One-Time Medications (Time shown is time ordered to be given.)
[2/16 22:21] acetaminophen 1,000mg IV ONCE
[2/16 23:40] insulin regular (HumuLIN R U-100 (insulin regular)) 10Unit(s) IV ONCE
[2/16 23:38] Lactated Ringers (Lactated Ringers (bolus)) 1,000mL IV ONCE
[2/17 00:23] piperacillin-tazobactam (Zosyn) 4.5gm IV ONCE
Future Medications
(Ordered for 2/17 01:00) Lactated Ringers (Lactated Ringers (bolus, no pump)) 1,000mL IV (bolus, no
pump) ONCE

Objective Vital
Signs:
Vital Signs Most Recent (Vitals in past 36 hrs; Dosing Wt and BMI this visit)
TempC 36.5 (36.5-36.5) SBP 131 (131-159) DBP 71 (64-71) Pulse 96 (91-107) RR 20 (20-20) SaO2 98 (94-98) Dosing Wt 108 kg BMI 37.8
-Monitor electrolytes
Diabetes mellitus complicated with hyperglycemia:
-Patient is not taking her diabetic medications or followed up with her endocrinologist in over a year
-BGM~700s on arrival, improved following IV regular insulin in the ED
-VBG normal x 2, anion gap within normal limits-not DKA
-Pseudohyponatremia noted on labs, normal on correction
-Resume home dose of Soliqua 60 units at lunch, metformin 1 g twice daily
-Supplement with moderate dose sliding scale with meals
-Capillary checks AC/at bedtime
-Check A1c with a.m. labs
-Endocrinology, diabetes educator consults
Microcytic anemia:
-Last hemoglobin of 12 in 2018 in Cerner/epic, today at 9. Suspect likely anemia of chronic disease but she has had intermittent rectal bleeding-obtain formal stool Hemoccult, iron studies with a.m. labs, continue to monitor hemoglobin daily and monitor for bleeding while inpatient. Endoscopy and further workup per GI recs-consult placed Depression: -Continue Lexapro FEN:
-Monitor lytes
-N.p.o. except meds, consistent carb diet when appropriate
-Lactated Ringer's at 125 PPX:
-SCDs in setting of anemia
-PT/OT
Discussed with ED physician and agree with plan for admission

Professional Services
Credentials Title and Author
Credentials: MD.
Title: Attending.

GI Hepatology consult (PDI):

Subjective
Reason for consult is due to GI bleed
This is a 52-year-old female with a history of perirectal pain she thought she had some hemorrhoids and had some blood in stools but it was noted that she had foul-smelling stools
Contrast do CT was consistent with perirectal stranding with soft tissue around the anal verge which may suggest a perirectal phlegmon gluteal region also had inflammatory process She is being evaluated by both surgery and ID and has been started on antibiotics

Assessment

blood in stools with possible perirectal phlegmon
At this point in time we will hold off on colonoscopy however at sometime in the near future we will schedule likely as outpatient after a few weeks of antibiotics
Will check an IBD serology 7
Will follow conservatively

Renal Consult (PDI):

Impression and Diagnosis:
Acute renal failure
-Foley catheter is in place and she is making urine so obstruction seems unlikely. Her fractional excretion of sodium is extremely low a urine sodium of less than 5 and a urine creatinine of 266. However, she has been receiving IV fluid and is eating and drinking okay. I have seen this with vancomycin toxicity. She has not received contrast which also can give a low fractional excretion of sodium. She remains on vancomycin and Zosyn. These seem to be the likely causes. An infection related glomerulonephritis seems unlikely. Dialysis today negative for red cells.

Hyperkalemia
Hyponatremia
Perirectal abscess
-On vancomycin and Zosyn. White blood cell count is increasing
Diabetes
Osteoarthritis

Comments/Recommendations:
I will reach out to infectious disease regarding changing antibiotics
She is on IV fluid and has a Foley. We may need to check an ultrasound if her creatinine rises furtherCheck vancomycin level in a.m.
Hold further vancomycin dosing
Low potassium diet
We will follow closely with you

Professional Services
Credentials Title and Author
Credentials: MD.

Title: Attending.

Urology Consult Note (PDI):

Impression and Recommendations
52 y/o female with PMHx of DM type 2, who presented with rectal pain, found to have hyperglycemia and perirectal abscesses s/p I&D by Dr. Willis on 2/18. She reported difficulty urinating and required straight cath for 1700cc, then Foley catheter was inserted on 2/19. Urinary retention is likely multifactorial in the setting of perirectal abscess, pain, impaired mobility, and recent anesthesia. Recommend Foley be maintained with void trial prior to her discharge. If she fails void trial, will consider initiating Flomax 0.4 mg daily. Encourage ambulation and bowel regimen as needed for constipation.

Diagnosis: Perianal abscess : ICD10-CM K61.0, Working, Diagnosis, Acute urinary retention : ICD10-CM R33.8, Working, Diagnosis.

Professional Services
Credentials Title and Author
Credentials: CRNP.
Addendum on February 20, 2024 7:08 PM EST:
I saw and evaluated the patient. Discussed with CRNP/PA and agree with the CRNP/PA's findings and plan as documented. I have personally performed...
Patient was seen and examined
Foley catheter draining well
She denies prior history of urinary retention
Postoperative retention could be multifactorial however
she has poorly controlled diabetes with hemoglobin A1c >14 and she may have a component of diabetic cystopathy
Continue PT and bowel regimen
Voiding trial prior to discharge
-Ogagan

Operative note

PREOPERATIVE DIAGNOSIS: Bilateral buttock abscesses.
POSTOPERATIVE DIAGNOSIS: Bilateral buttock abscesses.
PROCEDURE: Complex incision and drainage bilaterally with expression of large amounts of pus particularly from the left side.
ESTIMATED BLOOD LOSS: 10 mL.
SPECIMENS: Cultures.
COMPLICATIONS: None.
WOUND CLASS: 4.
ANESTHESIA: General.
PROCEDURE SUMMARY: The patient gave consent to the procedure after risks and benefits were explained in detail. She was taken to the operating room where general anesthetic was administered. She was placed in the left lateral decubitus position. She was prepped and draped in a normal sterile fashion. Incisions were made over the fluctuant areas both sides. There was a small amount of pus on the right, having opened up the area that was draining and extending inward. All loculations

were cleared with blunt digital examination of the wound. Attention was turned to the left side, which was opened and a large amount of pus was exuded from that. This was also explored opening all cavities. Once I opened up over them widely, each of the wounds were made hemostatic with electrocautery, then packed with half-inch plain packing gauze fairly snugly, covered with 4 x 4 gauze and ABD pad, and then taped into position. The patient tolerated the procedure, was taken to the operating room to the recovery room. All sponge, needle, and instrument counts were correct at the end of the case x2.

Gen Med Progress Note (PDI):

52-year-old lady with past medical history of obesity and type 2 diabetes mellitus with no medication compliance who presents to the ED at with complaints of rectal pain. She was found to have uncontrolled diabetes mellitus complicated by neuropathy and retinopathy. As part of the workup done in the ED patient was found to have a perianal phlegmon, recent for which she is admitted for further management.

#Perianal phlegmon:
Presented initially with 1 month of discomfort in her buttocks however pain has been exacerbated within the last week
Risk factors: Obesity, sedentarily, uncontrolled diabetes mellitus given no medical compliance
No concern for sepsis given absence of SIRS criteria, no fever, no tachycardia, no lactate
CT A-P: Extensive peri-rectal stranding with questionable soft tissue around
the anal verge which may suggest a perianal phlegmon. There is no
evidence of a low attenuation area to suggest loculated fluid
collection/abscess
ID, surgery and GI consulted
Blood cultures, superficial culture and MRSA swab collected
In the ED patient was started on Zosyn, given AKI no coverage with vancomycin
Plan:
-We will continue with Zosyn 4.5 GM IV every 8 hours [2/17-]
-General surgery consulted: No drainable fluid identified in current CT--> ordered CT of pelvis without contrast for better visualization,
if something identified patient may have procedure for I&D tomorrow, n.p.o. after midnight
-ID consulted, appreciate recommendation
-IBD panel ordered in the ED pending will follow
-Will follow blood cultures, wound culture and MRSA swab
-Pain regimen Tylenol as needed for mild pain, Norco every 6 hours as needed for moderate pain, Dilaudid 0.2 Mg every 4 hours for severe
pain

#Uncontrolled diabetes mellitus
A1c 5 years ago: 10.1
Home regimen: Patient is supposed to be on metformin 1000 Mg twice daily and insulin glarginelixisenatide however endorses noncompliance for more than 1 year
Upon arrival BGL around 700s, not meeting criteria for DKA

Patient received 10 units IV of insulin regular and started on IV fluids with subsequent improvement of BGM
Endocrinology consulted: Started on insulin glargine 35 units twice daily Plan:
-Will continue with insulin glargine 35 units twice daily and insulin moderate dose sliding correctional scale -Continue with IV fluids
-BGM AC and nightly
-Clear liquid diet CCD
-Pending A1c
-Endocrinology consulted, appreciate recommendations

#Possible AKI:
Baseline creatinine in 2018 0.7, upon admission creatinine at 1.42 with GFR of 44
Unable to determine if this only AKI, or AKI on CKD given no recent labs
My inclination at this point is that patient may have a CKD secondary to diabetes mellitus given no compliance with treatment Plan:
-Continue with IV fluids
-CTM

#Normocytic normochromic anemia:
Baseline hemoglobin back in 2018 12.6 with MCV of 88.8 MCH of 30.6
Upon admission hemoglobin of 9 with MCV of 89.5 and MCH of 28.6
Possibly secondary to anemia of chronic disease [p.m.]
Vitamin B12, folic acid and iron studies ordered in the ED
Could be also a component of bleeding given patient reported bloody stools 1 month ago [possible hemorrhoids] Plan:
-CTM
-Will follow iron studies, vitamin B12 and folic acid results
-GI consulted in the ED, appreciate recommendation

Chronic Medical Conditions:
Depression: Patient is on fluoxetine 10 Mg daily, will continue. Patient is not reporting any depression symptoms
Type 2 diabetes mellitus: Patient is supposed to be on metformin 1000 Mg twice daily and Soliqua, reports noncompliance, with
stresses during this admission reviewed regimen
Medication reconciliation completed by patient interview and by reviewing external pharmacy records. Medication reconciliation completed to the best of my ability given these 2 resources.

Professional Services
Credentials Title and Author
Perianal phlegmon-discussed from surgery. The previous CT pelvis had limitations due to nonvisualization of the area of phlegmon completely. He has ordered CT of the pelvis without contrast for follow- up and to visualize the whole area. Continue Zosyn. Infectious disease consulted.

Uncontrolled diabetes mellitus. Due to noncompliance. Endocrine consulted. Follow-up A1c. Continue insulin
AKI-improving
DVT prevention-patient is ambulatory

Endocrine Progress (PDI):

Assessment and Plan Diagnosis:
T2DM.

1. T2DM - BG levels with some improvement
-significant hyperglycemia on admission; not in DKA
-Lantus 35u subq BID
-if patient remains NPO for prolonged period, recommend 28u BID
-Humalog 10u TID meals - hold if not eating
-Humalog mow dose SSI TID meals/HS
-clears -> NPO today; rec 60g consistent CHO modifier once cleared for PO
outpatient regimen prior to admission: metformin 1000mg PO BID; previously had also been on Soliquia 60u? subq daily, however has
been out of this for some time
outpatient endo: note patient has not been seen since 05/2021
Hba1c pending - do note patient with anemia

2. perianal phlegmon -surg and ID following
-on abx
-plans for OR for I&D today
3. AKI - improved, on IVF

4. anemia - follow H/H, workup/management per primary team
d/w nursing

Professional Services
Credentials Title and Author

Pt seen examined and agree with evaluation

General Surgery Progress Note (PDI):

Assessment and Plan
Diagnosis: perirectal infection.
Plan
Yesterday when I looked at her CT on the computer, the scan seemed to stop at the top of the sacrum and was not adequate for evaluation, but looking at it again today, I am able to scan much lower (seems to have been a computer issue). the repeat CT is cancelled.
On exam, it suggests fluid and I believe I and D is warranted. Will take to the OR today for I and D.

Gen Med Progress Note (PDI):

52-year-old lady with past medical history of obesity and type 2 diabetes mellitus with no medication compliance who presents to the ED at with complaints of rectal pain. She was found to have uncontrolled diabetes mellitus complicated by neuropathy and retinopathy. As part of the workup done in the ED patient was found to have a perianal phlegmon, recent for which she is admitted for further management.

#Perianal phlegmon:
No concern for sepsis given absence of SIRS criteria, no fever, no tachycardia, no lactate
CT A-P: Extensive peri-rectal stranding with questionable soft tissue around the anal verge which may suggest a perianal phlegmon.
There is no evidence of a low attenuation area to suggest loculated fluid collection/abscess
ID, surgery and GI consulted
Blood cultures: NGTD
Superficial wound culture: Few GPC, few GPR, few
GNR Vancomycin added yesterday night Plan:
-Continue with Zosyn 4.5 GM IV every 8 hours [2/17-] and vancomycin [2/17-]
-General surgery consulted: Patient is getting I&D today
-ID consulted, appreciate recommendations
-IBD panel ordered in the ED pending will follow
-Will follow blood cultures, wound culture and MRSA swab
-Pain regimen Tylenol as needed for mild pain, Norco every 6 hours as needed for moderate pain, Dilaudid 0.2 Mg every 4 hours for severe
pain

#Uncontrolled diabetes mellitus
A1c 5 years ago: 10.1
Home regimen: Patient is supposed to be on metformin 1000 Mg twice daily and insulin glarginelixisenatide however endorses noncompliance for more than 1 year
Upon arrival BGL around 700s, not meeting criteria for DKA
Patient received 10 units IV of insulin regular and started on IV fluids with subsequent improvement of BGM
Endocrinology consulted: Started on insulin glargine 35 units twice daily Plan:
-On insulin glargine 35 units twice daily and insulin lispro 10 units 3 times daily with meals plus moderate dose sliding correctional
scale, if patient not eating will reduce glargine to 28 and will hold insulin lispro with meals -Continue with IV fluids
-BGM AC and nightly
-Clear liquid diet CCD
-Pending A1c, reordered today
-Endocrinology consulted, appreciate recommendations

#Possible AKI:
Baseline creatinine in 2018 0.7, upon admission creatinine at 1.42 with GFR of 44

Unable to determine if this only AKI, or AKI on CKD given no recent labs most likely diabetic nephropathy
Creatinine is improving at 1.13 today
Plan:
-Continue with IV fluids
-Will order albumin creatinine ratio
-CTM

#Normocytic normochromic anemia:
Baseline hemoglobin back in 2018 12.6 with MCV of 88.8 MCH of 30.6
Upon admission hemoglobin of 9 with MCV of 89.5 and MCH of 28.6
Most likely secondary to mixed etiology: IDA and anemia of chronic disease
However given 1 episode of bloody stool 1 month ago concern for possible hemorrhoid patient will need to get a colonoscopy as
outpatient Plan:
-CTM
-GI on board, appreciate recommendations
Chronic Medical Conditions:
Depression: Patient is on fluoxetine 10 Mg daily, will continue. Patient is not reporting any depression symptoms
Type 2 diabetes mellitus: Patient is supposed to be on metformin 1000 Mg twice daily and Soliqua, reports noncompliance, with
stresses during this admission reviewed regimen
Medication reconciliation completed by patient interview and by reviewing external pharmacy records. Medication reconciliation completed to the best of my ability given these 2 resources. CHECKLIST:
Code: FULL
Diet: N.p.o. for now, will start CCD after I&D
Activity: Up ad lib
Access: PIV
Tubes: none
GI PPX: -
DVT PPX: SCD
Dispo: Hospitalist team B
Consultations to endocrinology, general surgery, ID and GI

Addendum on February 18, 2024 2:58 PM EST:
I have personally interviewed and examined this patient, and have reviewed the electronic patient chart, as well as the laboratory work, ekgs, and imaging studies. I have discussed it with the Resident who recorded the above, link my note to theirs, and agree with their findings, assessment, and recommendations with following addition/addendum.
Patient 52-year-old female with history of obesity type 2 diabetes mellitus which was uncontrolled due to noncompliance who presented with pain around the buttock area. She was unable to set. Patient was found to have perianal phlegmon on the imaging.

CT of the abdomen and pelvis although listed as with contrast was done without contrast was indicative of phlegmon. No drainable fluid identified but limited study. Patient going for incision and drainage. Vancomycin was added overnight

Assessment plan
Perianal phlegmon-going for incision and drainage. On Zosyn and vancomycin.
Uncontrolled diabetes mellitus. Due to noncompliance. Endocrine consulted. A1c again ordered. Continue insulin
AKI-improving
DVT prevention-patient is ambulatory

Endocrine Progress (PDI):

Assessment and Plan Diagnosis:
T2DM.
1. T2DM
-significant hyperglycemia on admission; not in DKA
-Lantus increased to 40 units BID
-Humalog increased to 14 units TIDmeals - hold if not eating
-Humalog mow dose SSI TID meals/HS
- NPO this am; rec 60g consistent CHO modifier once allowed PO
outpatient regimen prior to admission: metformin 1000mg PO BID; previously had also been on Soliquia 60u? subq daily, however has been out of this for some time outpatient endo: Dr. V Bahl - note patient has not been seen since 05/2021 hold on checking a1c in setting of significant anemia
2. perianal phlegmon -surg and ID following
-on abx
-s/p I&D
3. AKI - on IVF
4. anemia - follow H/H, workup/management per primary team

Professional Services
Credentials Title and Author

GI Gastroenterology Progress (PDI):
Visit Information
Patient seen on 2/19/2024 .

Subjective
confirms one hematochezia this past month prior to admission, no nausea, tolerating po

Objective
Vital Signs:
Vital Signs Most Recent (Vitals in past 36 hrs; Dosing Wt and BMI this visit)

TempC 36.7 (36.0-38.5) SBP 116 (85-168) DBP 75 (57-107) Pulse 115 (90-124) RR 22 (12-26) SaO2 96 (77-100) FiO2-O2(L/m) 3 L/m (3 L/m-3 L/mL/m) Dosing Wt 104 kg BMI 36.4
.
General: No acute distress.
Eye: Pupils are equal, round and reactive to light.
HENT: Normocephalic.
Respiratory: Respirations are non-labored.
Cardiovascular: Normal rate.
Gastrointestinal: Non-distended.
Neurologic: Alert & Oriented.
Psychiatric: Cooperative.

Assessment and Plan
Diagnosis: Phlegmonous cellulitis : ICD10-CM L02.91, Working, Diagnosis, Perianal abscess : ICD10-CM K61.0, Working, Diagnosis.
Procedural Plans: No Procedure Planned. consult
for LGIB
52 y/o female with h/o DM2, DJD presented with rectal pain, found with phlegmon and anemia, reported one hematochezia weeks ago.
1. blood in stools: one episode as OP prior to admission
-in setting of perirectal phlegmon s/p I&D: abx per ID, IBD panel in process, OP colonoscopy in few weeks when healed
-with anemia, occult neg, B12 folate not low, iron sat/TIBC low with elevated ferritin: ?consider hematology consult
will discuss with GI attending who will follow
total time spent on today's visit including history, examination, documentation: 35 minutes

General Surgery Progress Note (PDI):

Assessment and Plan
Diagnosis: perirectal abscesses.
Course: Improving. Plan
s/p I and D bilateral Await
cx start daily packing
changes.

ID Progress Note:

Impression and Plan Diagnosis:
.

52 yof with poorly controlled DM who presetned with 1 week of rectal pain with purulent malodorous drainage, CT with extensive perirectal stranding with questionable perineal phlegmon without loculated fluid collection, she had leukocytosis, afebrile and hemodynamically stable. ID consulted to evaluate,

Perianal phlegmon
– Seen on CT 2/16, noncontrasted study
–2/17 superficial wound culture group B strep
– GI and surgery consulted- OR on 2/18 for complex I&D bilaterally with expression large amounts of purulence # Leukocytosis
– Secondary to above
– 2/16 blood cultures negative to date
– 2/16 urine culture no growth
– No hypoxia
DM–not adherent to treatment
AKI
Recommendation:
Cr worsening, OK cx gm stain many gram-positive rods, rare GPC, MRSA screen is negative, would continue Zosyn and stop
vancomycin in setting of worsening function, will continue to follow wound cx

Professional Services
Credentials Title and Author

Gen Med Progress Note (PDI):

52-year-old lady with past medical history of obesity and type 2 diabetes mellitus with no medication compliance who presents to the ED at with complaints of rectal pain. She was found to have uncontrolled diabetes mellitus complicated by neuropathy and retinopathy. As part of the workup done in the ED patient was found to have a perianal phlegmon, recent for which she is admitted for further management.

#Perianal phlegmon/abscess s/p I&D 12/18:
WBC 14.9--> 19.7
CT A-P: Extensive peri-rectal stranding with questionable soft tissue around the anal verge which may suggest a perianal phlegmon. There is no evidence of a low attenuation area to suggest loculated fluid collection/abscess ID, surgery and GI consulted
Blood cultures: NGTD
Superficial wound culture–Group B streptococci, light lactobacillus
Deep wound culture 2/18 growing GPR and GPC
MRSA swab negative
Plan:
-Continue Zosyn [2/17-]. DC vancomycin
-ID consulted, appreciate recommendations
-IBD panel ordered in the ED pending will follow
-Will follow blood cultures, wound culture

#Elevated liver enzymes
ALT 73/AST 152/alk phos 352 today. Normal bilirubin
R factor–0.6, cholestatic in nature

No fever. No abdominal tenderness or Murphy sign on physical examination
Planning to get an ultrasound abdomen
Continue to monitor LFTs

AKI
Differentials–post renal, renal, vancomycin related, other
Baseline creatinine in 2018 0.7, upon admission creatinine at 1.42 --> 1.68
Repeat BMP with creatinine 1.6
Patient had urinary retention overnight and was placed on Foley
Planning to consult nephrology. Urology consulted for urinary retention
Avoiding nephrotoxins
Vancomycin discontinued
Will appreciate nephrology recommendations

#Nocturnal hypoxemia
She was hypoxemic overnight and was requiring 3 L nasal cannula
Sleep studies and follow-up with sleep medicine recommended outpatient. Patient was extensively counseled regarding sleep apnea

#Uncontrolled diabetes mellitus
A1c 5 years ago: 10.1. Repeat A1c in process
Home regimen: Patient is supposed to be on metformin 1000 Mg twice daily and insulin glarginelixisenatide however endorses noncompliance for more than 1 year
Upon arrival BGL around 700sPatient received 10 units IV of insulin regular and started on IV fluids with subsequent improvement of BGMEndocrinology consulted
Inpatient regimen–Lantus 35 units twice daily, lispro 10 units 3 times daily meals, lispro moderate dose sliding scale 3 times daily meals, nightly

#Normocytic normochromic anemia:
Baseline hemoglobin back in 2018 12.6 with MCV of 88.8 MCH of 30.6
Hemoglobin 8.3 today
However given 1 episode of bloody stool 1 month ago concern for possible hemorrhoid patient will need to get a colonoscopy as
outpatient Plan:
-CTM
-GI on board, appreciate recommendations
Chronic Medical Conditions:
Depression: Patient is on fluoxetine 10 Mg daily, will continue. Patient is not reporting any depression symptoms CHECKLIST:
Code: FULL
Diet: Consistent carb
Activity: Up ad lib
Access: PIV
Tubes: none
DVT PPX: Heparin subcu 3 times daily
Dispo: Hospitalist team B

Discussed with attending

Addendum on February 20, 2024 3:38 PM EST:
I have personally interviewed and examined this patient, and have reviewed the electronic patient chart, as well as the laboratory work, ekgs, and imaging studies. I have discussed it with the Resident who recorded the above, link my note to theirs, and agree with their findings, assessment, and recommendations with following addition/addendum.

Patient 52-year-old female with history of obesity type 2 diabetes mellitus which was uncontrolled due to noncompliance who presented with pain around the buttock area. She was unable to set. Patient was found to have perianal phlegmon on the imaging.
CT of the abdomen and pelvis although listed as with contrast was done without contrast was indicative of phlegmon. No drainable fluid identified but limited study.
Patient complained of pain at the I&D site. Denies any abdominal pain
On exam she is alert awake and orient x 3, chest clear to auscultation heart regular rhythm abdomen soft nontender.

Assessment plan
Perianal phlegmon-going for incision and drainage. On Zosyn and vancomycin.
Uncontrolled diabetes mellitus. Due to noncompliance. Endocrine consulted. Greater than 14. Continue insulin

AKI-hold vancomycin. Foley catheter placed for retention. Urine sodium less than 5. Renal input appreciatedElevated transaminases cholestatic pattern. Right upper quadrant ultrasound did not reveal any evidence of obstruction. Likely intrahepatic cholestasis. GI following
DVT prevention-start on heparin as patient has limited ambulation now.

Endocrine Progress (PDI):

Diagnosis: T2DM.
1. T2DM
-significant hyperglycemia on admission; not in DKA
-Lantus 40 units BID
-Humalog increase to 16 units TIDmeals - hold if not eating
-Humalog mod dose SSI TID meals/HS
- NPO this am; rec 60g consistent CHO modifier once allowed PO
outpatient regimen prior to admission: metformin 1000mg PO BID; previously had also been on Soliquia 60u? subq daily, however has
been out of this for some time
outpatient endo: - note patient has not been seen since 05/2021
Hba1c >14% - note taken in setting of anemia
2. perianal phlegmon -surg and ID following
-on abx
-s/p I&D
3. AKI - s/p IVF; renal following

4. elevated LFTs - unclear etiology, GI following, ongoing workup
5. anemia - follow H/H, workup/management per primary team
6. hypercalcemia - corrected Ca 11.3 on labs today. iCa has been ok - will repeat in AM. -check PTH, PTHrP, vitamin D panel

Professional Services
Credentials Title and Author

GI Gastroenterology Progress

Procedural Plans: Outpatient Procedure Planned.
consult for LGIB
52 y/o female with h/o DM2, DJD presented with rectal pain, found with phlegmon and anemia, reported one hematochezia weeks ago.

1. blood in stools: one episode as OP prior to admission
-in setting of perirectal phlegmon s/p I&D: abx per ID, IBD panel in process, OP colonoscopy in few weeks when healed
-with anemia/HH trending down, occult neg 2/17, B12 folate not low, iron sat/TIBC low with elevated ferritin: suggest hematology consult, started PPI
will discuss with GI attending who will follow
total time spent on today's visit including history, examination, documentation: 35 minutes

Addendum on February 20, 2024 9:26 AM EST:
we are asked to address LFT elevation:
ALT 90<73<NL, AST 102<152<NL
ALP 448<<331, bili NL
lact NL WBC
20<<14.9 INR
NL alb low
US 2/19 NL liver no bili dilatation no liver lesions gallstones without cholelithiasis
had 2 doses IV acetaminophen 2/18, not taking prn acetaminophen
iron studies not consistent with hemochromatosis
ordered acute hep panel, acetaminophen level, ANA AMA ASMA, LKM, ceruloplasmin, GGT, celiac, US duplex

ID Progress Note:
Impression and Plan
Diagnosis: .

52 yof with poorly controlled DM who presetned with 1 week of rectal pain with purulent malodorous drainage, CT with extensive perirectal stranding with questionable perineal phlegmon without loculated fluid collection, she had leukocytosis,
afebrile and hemodynamically stable. ID consulted to evaluate
Perianal abscess

– Seen on CT 2/16, noncontrasted study
–2/17 superficial wound culture group B strep and lactobacillus rhamnosus
– Surgery following-OR on 2/18 for complex I&D bilaterally with expression large amounts of purulence, OR cx -lactobacillus jensenii,
lactobacillus rhamnosus, only 1 colony staph hominis (likely contamination)
Leukocytosis and fever
– Secondary to above- fever last 2/22
– New blood cultures 2/22: NGTD x 1
– WBC 19.2 (2/22) --> 17.5
– 2/16 blood cultures negative to date
– 2/16 urine culture no growth
– No hypoxia
DM–not adherent to treatment, A1C >14
AKI- improving
Urinary retention- GU following, + foley placed
Transaminitis–RUQ without acute cholecystitis
Recommendation:
Continue Zosyn, will observe blood cultures x 1 more day, trend WBC.
If blood cultures remain negative and WBC downtrending, no more fevers on 2/24, okay to DC on PO Augmentin -
dosing dependent on renal function, suspect bump today d/t contrast 2/22, anticipate 875-125mg BID dosing - through 3/2 for 2 full weeks of abx post-op.
Follow up in Wound Clinic in 1 week, d/w patient, she will call for f/u

Professional Services Credentials
Title and Author Credentials:
PA-C.
Title: PA-C.
Addendum on February 24, 2024 4:13 AM EST:
Case discussed on 2/23 with Lauren Ison PA-C. I agree with assessment and plan.

Gen Med Progress Note (PDI):

Assessment and Plan
52-year-old lady with past medical history of obesity and type 2 diabetes mellitus with no medication compliance who presents to the ED at with complaints of rectal pain. She was found to have uncontrolled diabetes mellitus complicated by neuropathy and retinopathy. As part of the workup done in the ED patient was found to have a perianal phlegmon, recent for which she is admitted for further management.

#POD 5 of I&D for Perianal phlegmon/abscess
CT A-P: Extensive peri-rectal stranding with questionable soft tissue around the anal verge which may suggest a perianal phlegmon. There is no evidence of a low attenuation area to suggest loculated fluid collection/abscess ID, surgery and GI consulted
Blood cultures collected on 2/16//24: Negative

Superficial wound culture collected on 2/17/24: Show rare group B streptococci, Lactobacillus rhamnosus Deep wound culture collected on 2/18/2024: Heavy Lactobacillus jensenii, Moderate Lactobacillus rhamnosu
Will repeat blood cultures yesterday after episode
CT of the pelvis done yesterday: Marked perianal acute inflammatory changes, possibly infectious etiology, but without evidence of a distinct fluid collection to suggest abscess formation within the perianal region. Similarly, there is no evidence of a perirectal abscess.

Plan:
-Continue Zosyn [2/17-], will continue until discharge, will transition to Augmentin 875-175 Mg through 3/2
-Per surgery no need for more I&D's
-Per ID okay to discharge tomorrow if blood cultures remain negative and no more fever

#Elevated liver enzymes: Downtrending
Today trending down: ALT: 82, AST: 70
Upon admission ALT: 26 and AST: 25, 2 days later on 2/19 ALT: 73 and AST: 152 showing a cholestatic patternR factor–0.6, cholestatic in nature
CT abdomen and pelvis show unopacified liver, cholelithiasis with no evidence of cholecystitis.
Abdominal ultrasound: Show noncirrhotic liver, Cholelithiasis without specific sonographic signs of cholecystitis GI on board
Tylenol as needed: Negative, anti-HAV IgM: Nonreactive, HBcAb IgM nonreactive, anti-HCV antibody: Nonreactive, hepatitis B surface
antigen: Nonreactive
CA 19-9 at 60, CT abdomen and pelvis review pancreas with no abnormalities Plan:
-CTM
-Will follow alpha-1 antitrypsin, celiac panel, smooth muscle antibody, intercondylar antibody, ANA, liver kidney microsomal antibody

AKI: Creatinine 1.17--> 1.39
Upon admission creatinine 1.42 at some point increased to 1.68, currently 1.17
No recent increase in creatinine from yesterday to today most likely secondary to contrast received Renal consulted, most likely in the setting of diabetic nephropathy Plan:
-CTM
#Nocturnal hypoxemia:
Possibly OSA
Patient-presented hypoxemic episodes while sleeping
Plan:
-Sleep studies and follow-up with sleep medicine recommended outpatient. Patient was extensively counseled regarding sleep apnea

#Uncontrolled diabetes mellitus
A1c 5 years ago: 10.1. Inpatient A1c> 14
Home regimen: Patient is supposed to be on metformin 1000 Mg twice daily and insulin glargine-lixisenatide however endorses .noncompliance for more than 1 year

Upon arrival BGL around 700s
Endocrinology consulted Plan:
-Inpatient regimen–Lantus decreased to 30 units twice daily, continue lispro 16 units 3 times daily meals, lispro moderate dose sliding scale 3 times daily meals, nightly -BGM's needs to be strictly controlled

#Normocytic normochromic anemia:
Baseline hemoglobin back in 2018 12.6 with MCV of 88.8 MCH of 30.6
Hemoglobin 8.3 today
However given 1 episode of bloody stool 1 month ago concern for possible hemorrhoid patient will need to get a colonoscopy as outpatient GI on board Plan:
-CTM

Chronic Medical Conditions:
Depression: Patient is on fluoxetine 10 Mg daily, will continue. Patient is not reporting any depression symptoms

Addendum on February 23, 2024 2:50 PM EST:
I have discussed it with the resident who recorded the above, link my note to theirs. I have personally interviewed and examined this patient, and have reviewed the electronic patient chart, as well as the labs, EKG, and imaging studies. I agree with their findings, assessment, and recommendations with following addition/addendum. Pt doing okay. no complaints
no resp distress chest
clear
abd soft, non tender
CT pelvis did not show abscess. Inflammation noted
cont antibiotics await blood cultures
d/c to home tomorrow with HH

Renal Progress Note (PDI):

Assessment and Plan
Diagnosis: Acute kidney injury : ICD10-CM N17.9, Working, Diagnosis.
52F with diabetes, DJD and neuropathy who presents to the hospital with perirectal pain and bleeding. She initially took preparation H at home but symptoms continued to progress. We are asked to see her for acute renal failure. Initially her creatinine was 1.42 and she did not receive contrast with her CT even though it was ordered due to the increased creatinine. The CT did seem to show a perirectal abscess. She has been on vancomycin and Zosyn since that time. No skin rash, eosinophilia or allergic stigmata noted.
Her vitals have been stable. She was started on IV fluid 2 days ago and also is eating and drinking. Her white blood cell count has increased from 14.9 up to 19.7 despite antibiotics. She was having difficulty urinating yesterday and a Foley catheter was placed.
She is making urine. No hypotension. No vomiting. No other antibiotics prior to the hospitalization. She has perirectal discomfort. Her creatinine was down to 1.13 yesterday but increased all the way to 1.68 today. She had a vancomycin level in the middle of the night that was 29.9. This really does not appear to be a trough based on the recent dosing.

Impression and Diagnosis:
Acute renal failure
-Foley catheter was in place and she was making urine so obstruction seems unlikely. Her fractional excretion of sodium is extremely low a urine sodium of less than 5 and a urine creatinine of 266. However, she has been receiving IV fluid and is eating and drinking okay. Have seen this with vancomycin toxicity. She had not received contrast which also can give a low fractional excretion of sodium. She was on vancomycin and Zosyn.
These seem to be the likely causes. An infection related glomerulonephritis seems unlikely as no rbc on UA.
-UPCR 537 mg/g, UA small protein, 5 WBC, no rbc
-CT on admit with symmetric kidneys, normal aorta

Possible CKD/DM Nephropathy
-UPCR 537 mg/g
Hyperkalemia- resolved
-On low K diet
Hyponatremia- resolved
Perirectal abscess
-On vancomycin and Zosyn. White blood cell count is increasing. Vanco stopped after 2/19 dose
Diabetes
-Over 20 years, has retinopathy
Osteoarthritis

Comments/Recommendations:
Renal function worsened to 1.39 today from 1.17 after receiving IV contrast yesterday
Off IVF, she is eating and drinking adequately
Now off of Vancomycin, still on IV Zosyn
Do not think that Zosyn is affecting kidney function
Monitor renal function closely for contrast induced nephropathy
Foley catheter removed yesterday, patient voiding good amounts but reports still retaining some on bladder scans
- Urology following, may start on Flomax
Will reassess renal function in the AM
On low potassium diet
Daily labs

I/O Summary

I & O (Summary)

_____

I&O (02/22) 7a-3p 3p-11p 11p-7a Total (02/23) 7a-3p 3p-11p 11p-7a
Intake: 720 1020 1740 68
Output: 2825 2150 4975 1000
Balance: -2105 -1130 -3235 -932

Addendum on February 23, 2024 2:57 PM EST:
Seen with CRNP. This is a shared split service. Seen and examined independently and independently reviewed all pertinent data including labs and Xrays. I link my note to her note. She is eating and drinking well. No new skin rash.

Acute renal failure
-Foley catheter is in place and she is making urine so obstruction seems unlikely. Her fractional excretion of sodium is extremely low a urine sodium of less than 5 and a urine creatinine of 266. However, she has been receiving IV fluid and is eating and drinking okay. I have seen this with vancomycin toxicity. She has not received contrast which also can give a low fractional excretion of sodium. She remains on vancomycin and Zosyn. These seem to be the likely causes. An infection related glomerulonephritis seems unlikely as no rbc on UA. Dialysis today negative for red cells.
-UPCR 537 mg/g, UA small protein, 5 WBC, no rbc
-CT on admit with symmetric kidneys, normal aorta

Possible CKD/DM Nephropathy
-UPCR 537 mg/g
Hyperkalemia improved
Hyponatremia
Perirectal abscess
-was on vancomycin and Zosyn. White blood cell count is finally decreasing. Vanco stopped after 2/19 dose
Diabetes
-over 20 years, has retinopathy
Osteoarthritis

Comments/Recommendations:
Off vancomycin
Off IVF, she is eating and drinking adequately
Creatinine increased a little today after the contrast CT up to 1.39. I am not sure if this is significant. She is encouraged to orally hydrate overnight. Check labs in AM.
CT scan yesterday showed continued inflammation but no abscess formation or extension
I do not think that Zosyn is affecting kidney function

Urology Progress Note (PDI)
Assessment and Plan
52 y/o female with PMHx of DM type 2, who presented with rectal pain, found to have hyperglycemia and perirectal abscesses s/p I&D by Dr. Willis on 2/18, found to have urinary retention up to 1700 mL. Foley was removed on 2/22, and she is voiding but with elevated bladder residuals despite double voiding. She denies any suprapubic discomfort, and suspect she has baseline incomplete bladder emptying possibly related to diabetic cystopathy. Continue to monitor voided volumes and PVRs. Will add Flomax 0.4 mg daily to see if residuals improve. She

wishes to defer catheterizations unless she becomes uncomfortable or unable to void.
Encourage ambulation and bowel regimen as needed for constipation.

Diagnosis: Perianal abscess : ICD10-CM K61.0, Working, Diagnosis, Acute urinary retention : ICD10-CM R33.8, Working, Diagnosis.

Professional Services
Credentials Title and Author

Addendum on February 23, 2024 7:32 PM EST:
I saw and evaluated the patient. Discussed with CRNP/PA and agree with the CRNP/PA's findings and plan as documented. I have personally performed...
Patient was seen and examined
She has been voiding well with the documented volumes of 300 to 1000 mL
PVR documented earlier today was 456 mL
The patient is on Flomax which should be continued at discharge
She has uncontrolled diabetes and likely has some component of diabetic cystopathy
She will follow-up with urology in the outpatient setting.

Endocrine Progress (PDI):

Assessment and Plan Diagnosis:
T2DM.
1. T2DM - BG levels improving
-significant hyperglycemia on admission; not in DKA
-Lantus 30u BID (start 2/23 AM) -> recommend 27 units BID for discharge
- given 23 units last night
-Humalog 16 units TIDmeals - hold if not eating
-Humalog mod dose SSI TID meals
outpatient regimen prior to admission: metformin 1000mg PO BID; previously had also been on Soliquia 60u? subq daily, however has been out of this for some time outpatient endo: Dr. - note patient has not been seen since 05/2021 Hba1c >14% - note taken in setting of anemia anticipate use of basal/bolus regimen on discharge - d/w patient

2. perianal phlegmon -surg
and ID following
-on abx
-s/p I&D 3.
AKI -
s/p IVF; renal following
4. elevated LFTs
- unclear etiology, GI following, ongoing workup
- imaging overall unremarkable
5. anemia - follow H/H, workup/management per primary team
6. hypercalcemia - corrected Ca up to 11.8 on labs today - iCa has been ok - PTH, PTHrP, vitamin D panel pending

- follow

Professional Services Credentials
Title and Author Title:
Attending.

General Surgery Progress Note (PDI):

Assessment and Plan Diagnosis: buttock abscess continue abtx and wd care packing changes recheck cbc in am.

Discharge Summary/Day of DC Note:

Discharge Information
Discharge Summary: Discharge Date: 2/24/2024.

Discharge Medications: (As of 02/24/24 13:21)
AMOXICILLIN-CLAVULANATE (AUGMENTIN 875 MG-125 MG ORAL TABLET) 1 TAB BY MOUTH EVERY 12 HOURS FOR 7 DAYS;
Dispense Quantity: 14 TABS; Prescription Electronically Submitted to GIANT EAGLE #2409
CETIRIZINE (ZYRTEC 10 MG ORAL TABLET) 1 TAB BY MOUTH ONCE A DAY AS NEEDED FOR ALLERGIES; PRN FOR SEASONAL ALLERGIES
FERROUS SULFATE (325 MG (65 MG ELEMENTAL IRON) ORAL TABLET) 1 TAB BY MOUTH ONCE A
DAY; Dispense Quantity: 30 TABS;
Prescription Electronically Submitted to GIANT EAGLE #2409
FLUOXETINE (PROZAC) 10 MG BY MOUTH ONCE A DAY
GLUCOSAMINE (HYDROCHLORIDE 1500 MG ORAL TABLET) 1 TAB BY MOUTH ONCE A DAY
INSULIN GLARGINE (LANTUS 100 UNITS/ML SUBCUTANEOUS SOLUTION) 30 UNITS BENEATH THE SKIN 2 TIMES A DAY; Dispense
Quantity: 10 ML; Prescription Electronically Submitted to GIANT EAGLE #2409
INSULIN LISPRO (HUMALOG 100 UNITS/ML INJECTABLE SOLUTION) SEE INSTRUCTIONS; 1 SEENOTES SUBQ; Dispense Quantity: 3 ML;
Prescription Electronically Submitted to GIANT EAGLE #2409
INSULIN LISPRO (HUMALOG 100 UNITS/ML INJECTABLE SOLUTION) 16 UNITS BENEATH THE SKIN 3 TIMES A DAY (WITH MEALS);
Dispense Quantity: 3 ML; Prescription Electronically Submitted to GIANT EAGLE #2409
MISCELLANEOUS MEDICATION ONCE A DAY; COLLAGEN SUPPLEMENT
MULTIVITAMIN 1 TAB BY MOUTH ONCE A DAY
OMEGA-3 POLYUNSATURATED FATTY ACIDS (FISH OIL 500 MG ORAL CAPSULE) 2 CAPS BY MOUTH 2 TIMES A DAY
OXYCODONE (5 MG ORAL TABLET) 1 TAB BY MOUTH EVERY 6 HOURS AS NEEDED FOR SEVERE PAIN FOR 5 DAYS; Dispense Quantity:

20 TABS; Prescription Printed
PANTOPRAZOLE (PROTONIX 40 MG ORAL DELAYED RELEASE TABLET) 1 TAB BY MOUTH ONCE A DAY; Dispense Quantity: 30 TABS;
Prescription Electronically Submitted to GIANT EAGLE #2409
POLYETHYLENE GLYCOL 3350 (MIRALAX ORAL POWDER FOR RECONSTITUTION) 17 GM BY MOUTH ONCE A DAY FOR 5 DAYS;
Dispense Quantity: 85 GM; Prescription Printed
SENNA ((SENNOSIDES) 8.6 MG ORAL TABLET) 2 TABS BY MOUTH AT BEDTIME FOR 5 DAYS;
Dispense Quantity: 10 TABS;
Prescription Printed
TAMSULOSIN (FLOMAX 0.4 MG ORAL CAPSULE) 1 CAP BY MOUTH ONCE A DAY (AFTER A MEAL); Dispense Quantity: 30 CAPS;
Prescription Electronically Submitted to GIANT EAGLE #2409

Hospital Course

52-year-old lady with past medical history of obesity and type 2 diabetes mellitus, no medical compliance, presents to the ED at with a chief complaint of buttocks pain.
She was found to have a perianal phlegmon and uncontrolled diabetes mellitus. During her stay patient was managed for the following main problems:

Perianal phlegmon/abscess: Patient underwent an I&D on 02/18, received Zosyn IV from 2/17 until day of discharge. Surgery, ID on board, recommended:
-Upon discharge continue with Augmentin 875-175 Mg through 3/2

Weights (Last 5 in past 7 days)
Dosing Wt = 104 kg (As of: 02/17 03:25) No additional weights found.

I & O (Summary)

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I&O (02/23) 7a-3p 3p-11p 11p-7a Total (02/24) 7a-3p 3p-11p 11p-7a
Intake: 920 360 1280 240
Output: 1700 2400 4100
Balance: -780 -2040 -2820 240

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Gen: Awake, alert, no acute distress, obese
CV: Regular, nl S1 nl S2, no audible murmurs rubs or gallops
Lungs: Clear to auscultation bilaterally; no audible crackles
GI: Normal bowel sounds; non-distended; no palpable organomegaly
Skin: Buttocks: less induration in perianal region, less erythema, dressing more clear today.
Neurologic: Alert and oriented on person, time and place. No focal deficit, strength: 5 out of 5 in upper extremities, 4 out of 5 in

lower extremities limited by limitation on mobilization no numbness, intact sensation to touch

Discharge Plan
Discharge Summary Plan
Discharge disposition: discharge to home with home health care.
Discharge instructions given: to patient.
Patient/Family Response to Instruction: able to recall/perform demonstration.
Discharge Status: improved.
Physical Activities: no restrictions.
Dietary Restrictions: no restrictions.
Prescriptions: sent electronically to pharmacy.
Follow Up Instructions: patient will follow-up with Primary Care Physician, in 1 - 2 weeks.
Time Spent Discharging Patient: Total time spent discharging patient was 40 minutes.

Professional Services
Credentials and Title of Author
Addendum on February 24, 2024 5:00 PM EST:
I have discussed it with the resident who recorded the above, link my note to theirs. I have personally interviewed and examined this patient, and have reviewed the electronic patient chart, as well as the labs, EKG, and imaging studies. I agree with their findings, assessment, and recommendations with following addition/addendum.
Pt doing better. no complaints.
no resp distress chest clear abd
soft, non tender pt medically
stable for discharge cont
augmentin x 7 days daily
dressing changes cont insulin
for uncontrolled DM
discharge time: 35 min
Addendum on February 25, 2024 2:31 PM EST:
Pt called me today, reporting that she did not get her meds as the pharmacy is offline and could not process online prescriptions. I called in her scripts today. Lantus changed to 27U bid per endocrine recs. No changes were made to other orders .

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Discharge Disposition

DischargeService: Home Health Care Services
DischargeServiceName: ADVANCED PERSONAL CARE HH