

Patient Information

Patient Name: Franks, Steven Luke
DOB: 1980-12-03
Age: 44
Gender: male
MRN: 00000100

Admission ID: 8df568bb-c026-4ea1-ba7d-035e9d7763a5
Date of Admission:
Date of Discharge:

Address: 7094 Morris Thomas Road
City: Allenville
State: PA
ZIP: 90101



Admission

DM (A1C 7.4%), Psoriatic Arthritis on Etanercept, CAD s/p stent, left foot ulcer/cellulitis with recent admission to for IV antibiotics, presenting with ongoing chills/rigors, sweats, and worsening left calf swelling and left foot pain.

History Of Present Illness

44-year-old male with PMH of DM (A1C 7.4%), Psoriatic Arthritis on Etanercept, CAD s/p stent, presents to the ED with chief complaint of worsening left foot ulcer/cellulitis, ongoing chills/rigors, sweats, and left calf swelling. HPI: Patient reports onset of a blister on the lateral aspect of his left foot near the MTP joint approximately 6-8 weeks ago. He attributes this to new sandals. The blister opened a few weeks later, and patient reports ocean water exposure with the open wound. Shortly after, he developed swelling and pain in his left foot, accompanied by chills, shaking rigors, and profuse night sweats. Pain progressed from the foot to the left calf. Patient was admitted to [Hospital] about 2 weeks ago for a 4-day course of IV antibiotics (Vancomycin confirmed, possibly Ciprofloxacin). Wound cultures reportedly grew 'Staph and Strep.' He was discharged on PO Clindamycin, but symptoms worsened after discontinuation of IV antibiotics. Patient saw a surgeon yesterday who recommended return to [Hospital], but due to dissatisfaction with care, he presented to our ED. Podiatry consultation in ED expressed small amount of purulent drainage and recommended admission for IV antibiotics and MRI. In the ED, patient received 1500mg IV Vancomycin. Onset: ~6-8 weeks ago Location: Left foot, progressing to left calf Duration: Ongoing for several weeks, worsening recently Character: Pain, swelling, associated with systemic symptoms Alleviating/Aggravating Factors: Worsened after switching from IV to PO antibiotics Radiation: From foot to calf Timing: Progressive Severity: Not specified, but significant enough to seek emergency care Associated Symptoms: Chills, rigors, night sweats Review of Systems: General: Positive for chills, rigors, night sweats Respiratory: Denies SOB or cough Cardiovascular: H/o CAD s/p stent, denies chest pain Musculoskeletal: Left foot pain and swelling, left calf swelling Neurological: Alert and oriented, no focal deficits noted Endocrine: H/o DM with recent A1C 7.4% Psychiatric: No acute issues noted Patient is alert, in mild distress due to left lower extremity pain and systemic symptoms.

Assessment

Summary Of Findings

44-year-old male with PMH of DM (A1C 7.4%), Psoriatic Arthritis on Etanercept, CAD s/p stent, presenting with worsening left foot ulcer/cellulitis, ongoing chills/rigors, sweats, and left calf swelling. Recent admission for IV antibiotics. Wound cultures previously grew Staph and Strep. Podiatry consult in ED noted purulent drainage.

Differential Diagnosis

1. Cellulitis with possible progression to necrotizing fasciitis 2. Osteomyelitis 3. Deep vein thrombosis 4. Septic arthritis 5. Diabetic foot infection

Primary Diagnosis

Left foot cellulitis with possible deep tissue infection

Secondary Diagnoses

1. Poorly controlled diabetes mellitus (A1C 7.4%) 2. Psoriatic arthritis 3. CAD s/p stent 4. Possible sepsis

Plan

Diagnostic Plan

1. CBC with differential, CMP, CRP, ESR, blood cultures x2 2. MRI left foot and ankle to evaluate for osteomyelitis or deep tissue infection 3. Doppler US of left lower extremity to r/o DVT 4. Wound culture and sensitivity 5. X-ray left foot to evaluate for osteomyelitis

Therapeutic Plan

1. Admit to medicine service 2. IV antibiotics: Continue Vancomycin, add Zosyn 3.375g IV q6h 3. Diabetic management: Continue home insulin regimen, monitor BG q6h 4. Pain management: Morphine 2-4mg IV q4h PRN 5. DVT prophylaxis: Enoxaparin 40mg SQ daily 6. Hold Etanercept during acute infection

Patient Education And Counseling

1. Discuss severity of infection and need for hospitalization 2. Educate on importance of glycemic control in wound healing 3. Review proper foot care and wound management for diabetic patients

Follow-Up Plan

1. Daily wound assessment and dressing changes 2. Infectious Disease consult for antibiotic management 3. Endocrinology consult for diabetes management 4. Podiatry follow-up for wound care and possible debridement

Disposition

Admit to medical floor with telemetry monitoring

Consultations

1. Infectious Disease 2. Podiatry 3. Endocrinology 4. Wound care specialist



Medical History

Past Medical History

Chronic Conditions

Diabetes Mellitus Type 2 (diagnosed ~5 years ago, current A1C 7.4%)

Psoriatic Arthritis (diagnosed ~8 years ago)

Coronary Artery Disease (diagnosed ~3 years ago)

Past Illnesses

Recurrent skin infections (related to psoriasis)

Diabetic foot ulcers (2 previous episodes in the last 3 years)

Surgeries

Coronary artery stent placement (3 years ago)

Appendectomy (age 12)

Hospitalizations

Recent admission for IV antibiotics (2 weeks ago, 4-day course)

Coronary artery stent placement (3 years ago, 3-day stay)

Allergies

No known drug allergies

Medications

Metformin 1000mg twice daily

Etanercept 50mg subcutaneous injection weekly

Aspirin 81mg daily

Atorvastatin 40mg daily

Lisinopril 10mg daily

Family History

Father Type 2 Diabetes, Myocardial infarction at age 60

Mother Rheumatoid arthritis

Siblings Brother with psoriasis

Social History

Occupation Office manager

Marital Status Married

Children Two children, ages 10 and 12

Smoking Former smoker, quit 5 years ago

Alcohol Social drinker, 1-2 beers per week

Exercise Limited due to recent foot issues, previously walked 30 minutes 3 times per week

Preventive Care

Last Eye Exam 6 months ago (diabetic retinopathy screening)

Last Foot Exam 3 months ago

Last Lipid Panel 4 months ago

Vaccinations Up to date on influenza, pneumococcal, and COVID-19 vaccines



Physical Examination

General Appearance

44-year-old male in mild distress due to left lower extremity pain. Well-developed, well-nourished.

Vital Signs

Blood Pressure	138/82 mmHg
Heart Rate	92 bpm
Respiratory Rate	18 breaths/min
Temperature	38.2°C
Oxygen Saturation	97% on room air

Heent

NCAT. PERRLA. EOMI. Oropharynx clear. No cervical LAD.

Cardiovascular

RRR. S1, S2 normal. No murmurs, rubs, or gallops. No JVD.

Respiratory

CTAB. No wheezes, rales, or rhonchi.

Abdomen

Soft, NT/ND. BS+. No hepatosplenomegaly.

Musculoskeletal

Left foot with ulcer on lateral aspect near MTP joint. Surrounding erythema and edema extending to left calf. Left calf swollen and tender. ROM limited in left ankle due to pain.

Neurological

A&Ox3. CN II-XII intact. Strength 5/5 in all extremities except left lower extremity 4/5 due to pain. Sensation intact.

Skin

Warm and dry except for left foot. Psoriatic plaques noted on elbows and knees. Left foot ulcer approximately 2cm x 2cm with purulent drainage. Surrounding erythema and warmth extending to mid-calf.

Progress Notes

Progress Notes

Date

2023-05-01

Time

14:00

Patient Identification

Medical Record Number

MRN67890

Subjective

44-year-old male with history of DM, Psoriatic Arthritis, and CAD presents with worsening left foot ulcer/cellulitis, chills, rigors, sweats, and left calf swelling. Patient reports onset of blister 6-8 weeks ago, which opened and was exposed to ocean water. Recent hospitalization for IV antibiotics with brief improvement, but symptoms worsened after switching to oral antibiotics.

Objective

Vital Signs

Temperature

38.2°C

Blood Pressure

138/82 mmHg



Heart Rate

92 bpm

Respiratory Rate

18/min

Oxygen Saturation

97% on room air

Physical Exam

Left foot with 2cm x 2cm ulcer near MTP joint, purulent drainage. Erythema and warmth extending to mid-calf. Left calf swollen and tender. Psoriatic plaques on elbows and knees.

Labs

Pending

Assessment

1. Left foot cellulitis with possible osteomyelitis 2. Diabetic foot ulcer 3. Poorly controlled diabetes (A1C 7.4%) 4. Psoriatic arthritis 5. CAD, stable

Plan

Admit for IV antibiotics: Start Vancomycin and Piperacillin-Tazobactam

Obtain blood cultures, CBC, CMP, ESR, CRP

MRI left foot/ankle to evaluate for osteomyelitis

Wound care consult

Endocrinology consult for diabetes management

Hold Etanercept during acute infection

Continue home medications except Etanercept

DVT prophylaxis

Date

2023-05-02

Time

09:00

Patient Identification

Medical Record Number

MRN67890

Subjective

Patient reports slight improvement in pain and swelling. Chills and sweats have decreased. Denies new symptoms.

Objective

Vital Signs

Temperature

37.5°C

Blood Pressure

132/78 mmHg

Heart Rate

86 bpm

Respiratory Rate

16/min

Oxygen Saturation

98% on room air

Physical Exam

Left foot ulcer unchanged. Slight decrease in erythema and swelling of left calf.

Labs

WBC: 14.2, Hgb: 11.8, Platelets: 245 CRP: 85, ESR: 62 Blood cultures: No growth at 24 hours

Assessment

rated by Cynthia, a synthetic data generator - learn more at www.bacclabs.io

1. Left foot cellulitis, improving on IV antibiotics 2. Diabetic foot ulcer 3. Poorly controlled diabetes



Plan

Continue IV Vancomycin and Piperacillin-Tazobactam
MRI left foot/ankle scheduled for today
Daily wound care per wound care team recommendations
Await endocrinology consult
Monitor inflammatory markers

Date

2023-05-03

Time

10:00

Patient Identification

Medical Record Number

MRN67890

Subjective

Patient reports continued improvement in symptoms. No fever or chills overnight.

Objective

Vital Signs

Temperature

36.8°C

Blood Pressure

128/76 mmHg

Heart Rate

80 bpm

Respiratory Rate

16/min

Oxygen Saturation

99% on room air

Physical Exam

Left foot ulcer with decreased purulent drainage. Further reduction in erythema and swelling of left calf.

Imaging

MRI left foot/ankle: No evidence of osteomyelitis. Soft tissue edema and inflammation consistent with cellulitis.

Assessment

1. Left foot cellulitis, improving on IV antibiotics 2. Diabetic foot ulcer 3. Diabetes management - A1C improved to 7.1% after insulin adjustments

Plan

Continue IV antibiotics for 2 more days, then transition to oral antibiotics
Continue daily wound care
Diabetes management per endocrinology recommendations
Physical therapy for gait training and proper footwear education
Plan for discharge in 2-3 days if continued improvement

LABORATORY REPORTS

Report Date

2023-05-01

Report Time

09:15

Test Name

Complete Blood Count



Results

Test	Value	Units	Reference Range	Flag
WBC	4.0	K/uL	4.5-11.0	L
Test	Value	Units	Reference Range	Flag
RBC	3.73	M/uL	4.5-5.9	L
Test	Value	Units	Reference Range	Flag
Hemoglobin	11.6	g/dL	13.5-17.5	L
Test	Value	Units	Reference Range	Flag
Hematocrit	32.5	%	41.0-53.0	L
Test	Value	Units	Reference Range	Flag
MCV	87	fL	80-100	None
Test	Value	Units	Reference Range	Flag
MCH	31.1	pg	26-34	None
Test	Value	Units	Reference Range	Flag
MCHC	35.7	g/dL	31-37	None
Test	Value	Units	Reference Range	Flag
RDW	12.3	%	11.5-14.5	None
Test	Value	Units	Reference Range	Flag
RDW-SD	39.7	fL	39-46	None
Test	Value	Units	Reference Range	Flag
Platelets	Not reported	K/uL	150-450	None

Report Date

2023-05-01

Report Time

10:49

Test Name

Differential



Results

Test Neutrophils	Value 65.8	Units %	Reference Range 40-70	Flag None
Test Monocytes	Value 8.8	Units %	Reference Range 2-10	Flag None
Test Eosinophils	Value 0.9	Units %	Reference Range 1-6	Flag L
Test Basophils	Value 0.6	Units %	Reference Range 0-2	Flag None
Test Absolute Neutrophils	Value 6.52	Units K/uL	Reference Range 1.8-7.7	Flag None
Test Absolute Lymphocytes	Value 2.33	Units K/uL	Reference Range 1.0-4.8	Flag None
Test Absolute Monocytes	Value 0.87	Units K/uL	Reference Range 0.1-1.0	Flag None
Test Absolute Eosinophils	Value 0.09	Units K/uL	Reference Range 0-0.5	Flag None
Test Absolute Basophils	Value 0.06	Units K/uL	Reference Range 0-0.2	Flag None

Report Date

2023-05-01

Report Time

09:15

Test Name

Basic Metabolic Panel



Results

Test	Value	Units	Reference Range	Flag
Glucose	251	mg/dL	70-100	H
Test	Value	Units	Reference Range	Flag
BUN	11	mg/dL	7-20	None
Test	Value	Units	Reference Range	Flag
Creatinine	0.6	mg/dL	0.6-1.2	None
Test	Value	Units	Reference Range	Flag
Sodium	139	mmol/L	135-145	None
Test	Value	Units	Reference Range	Flag
Potassium	4.0	mmol/L	3.5-5.0	None
Test	Value	Units	Reference Range	Flag
Chloride	99	mmol/L	98-107	None
Test	Value	Units	Reference Range	Flag
CO2	27	mmol/L	22-30	None
Test	Value	Units	Reference Range	Flag
Anion Gap	13	mmol/L	8-16	None

Report Date

2023-05-01

Report Time

10:49

Test Name

C-Reactive Protein

Results

Test	Value	Units	Reference Range	Flag
CRP	78.1	mg/L	<3.0	H

Report Date

2023-05-02

Report Time

08:35

Test Name

Complete Blood Count



Results

Test WBC	Value 5.5	Units K/uL	Reference Range 4.5-11.0	Flag None
Test RBC	Value 3.92	Units M/uL	Reference Range 4.5-5.9	Flag L
Test Hemoglobin	Value 12.3	Units g/dL	Reference Range 13.5-17.5	Flag L
Test Hematocrit	Value 33.8	Units %	Reference Range 41.0-53.0	Flag L
Test MCV	Value 86	Units fL	Reference Range 80-100	Flag None
Test MCH	Value 31.4	Units pg	Reference Range 26-34	Flag None
Test MCHC	Value 36.4	Units g/dL	Reference Range 31-37	Flag None
Test RDW	Value 12.5	Units %	Reference Range 11.5-14.5	Flag None
Test RDW-SD	Value 38.9	Units fL	Reference Range 39-46	Flag L
Test Platelets	Value Not reported	Units K/uL	Reference Range 150-450	Flag None

Report Date

2023-05-02

Report Time

08:35

Test Name

Basic Metabolic Panel



Results

Test	Value	Units	Reference Range	Flag
Glucose	172	mg/dL	70-100	H
Test	Value	Units	Reference Range	Flag
BUN	9	mg/dL	7-20	None
Test	Value	Units	Reference Range	Flag
Creatinine	0.6	mg/dL	0.6-1.2	None
Test	Value	Units	Reference Range	Flag
Sodium	143	mmol/L	135-145	None
Test	Value	Units	Reference Range	Flag
Potassium	4.5	mmol/L	3.5-5.0	None
Test	Value	Units	Reference Range	Flag
Chloride	100	mmol/L	98-107	None
Test	Value	Units	Reference Range	Flag
CO2	27	mmol/L	22-30	None
Test	Value	Units	Reference Range	Flag
Anion Gap	16	mmol/L	8-16	None

Report Date

2023-05-01

Report Time

12:00

Test Name

Wound Culture

Results

Test	Value	Units	Reference Range	Flag
Gram Stain	No polymorphonuclear leukocytes seen. No microorganisms seen.	None	None	None
Test	Value	Units	Reference Range	Flag
Culture	Staphylococcus aureus (coagulase positive), sparse growth. Mixed bacterial flora.	None	None	None
Test	Value	Units	Reference Range	Flag
Antibiotic Susceptibility	S. aureus susceptible to: Clindamycin, Gentamicin, Oxacillin, Tetracycline, Trimethoprim/Sulfa. Resistant to: Erythromycin, Levofloxacin.	None	None	None
Test	Value	Units	Reference Range	Flag
Anaerobic Culture	No anaerobes isolated	None	None	None



Discharge Summary

Patient Information

Medical Record Number

MRN67890

Reason For Admission

44-year-old male with history of diabetes mellitus, psoriatic arthritis, and coronary artery disease admitted for left foot cellulitis with diabetic foot ulcer, presenting with worsening left calf swelling, chills, rigors, and sweats.

Hospital Course

Patient was admitted on 2023-05-01 with left foot cellulitis and diabetic foot ulcer. Initial management included IV antibiotics (Vancomycin and Piperacillin-Tazobactam), wound care, and diabetes management. MRI on 2023-05-02 showed no evidence of osteomyelitis. Wound culture grew Staphylococcus aureus, sensitive to current antibiotic regimen. Patient's symptoms improved over the course of hospitalization, with decreased pain, swelling, and resolution of systemic symptoms. Diabetes management was optimized with endocrinology consultation.

Discharge Diagnosis

- Left foot cellulitis, improving
- Diabetic foot ulcer
- Type 2 diabetes mellitus
- Psoriatic arthritis
- Coronary artery disease, stable

Medications At Discharge

Name	Dosage	Route	Frequency
Cephalexin	500 mg	Oral	Every 6 hours for 7 days
Name	Dosage	Route	Frequency
Metformin	1000 mg	Oral	Twice daily
Name	Dosage	Route	Frequency
Insulin glargine	As per sliding scale	Subcutaneous	Once daily at bedtime
Name	Dosage	Route	Frequency
Aspirin	81 mg	Oral	Once daily

Follow Up Plans

- Follow up with primary care physician in 1 week
- Podiatry appointment in 2 weeks for wound check
- Endocrinology follow-up in 1 month
- Rheumatology follow-up in 1 month to discuss restarting Etanercept

Discharge Instructions

- Continue oral antibiotics as prescribed
- Perform daily wound care as instructed by the wound care team
- Monitor blood glucose levels 4 times daily and adjust insulin as directed
- Keep left foot elevated when resting
- Avoid weight-bearing on left foot; use crutches or walker as instructed by physical therapy
- Wear diabetic shoes and avoid walking barefoot
- Monitor for signs of worsening infection (increased pain, redness, swelling, fever)
- Follow diabetic diet as recommended by the nutritionist

Additional Notes

- Patient educated on proper foot care and importance of glycemic control
- Provided with glucometer and supplies for home blood glucose monitoring
- Instructed to hold Etanercept until cleared by rheumatologist
- Home health services arranged for wound care and diabetes management support

