

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

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



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

Report Date

2023-05-01

Report Time

10:49

Test Name

Differential



Results

Neutrophils	Test	Value 65.8	Units %	Reference Range 40-70	Flag None
Monocytes	Test	Value 8.8	Units %	Reference Range 2-10	Flag None
Eosinophils	Test	Value 0.9	Units %	Reference Range 1-6	Flag L
Basophils	Test	Value 0.6	Units %	Reference Range 0-2	Flag None
Absolute Neutrophils	Test	Value 6.52	Units K/uL	Reference Range 1.8-7.7	Flag None
Absolute Lymphocytes	Test	Value 2.33	Units K/uL	Reference Range 1.0-4.8	Flag None
Absolute Monocytes	Test	Value 0.87	Units K/uL	Reference Range 0.1-1.0	Flag None
Absolute Eosinophils	Test	Value 0.09	Units K/uL	Reference Range 0-0.5	Flag None
Absolute Basophils	Test	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
BUN	11	mg/dL	7-20	None
Creatinine	0.6	mg/dL	0.6-1.2	None
Sodium	139	mmol/L	135-145	None
Potassium	4.0	mmol/L	3.5-5.0	None
Chloride	99	mmol/L	98-107	None
CO2	27	mmol/L	22-30	None
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	Value	Units	Reference Range	Flag
WBC	5.5	K/uL	4.5-11.0	None
RBC	3.92	M/uL	4.5-5.9	L
Hemoglobin	12.3	g/dL	13.5-17.5	L
Hematocrit	33.8	%	41.0-53.0	L
MCV	86	fL	80-100	None
MCH	31.4	pg	26-34	None
MCHC	36.4	g/dL	31-37	None
RDW	12.5	%	11.5-14.5	None
RDW-SD	38.9	fL	39-46	L
Platelets	Not reported	K/uL	150-450	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
BUN	9	mg/dL	7-20	None
Creatinine	0.6	mg/dL	0.6-1.2	None
Sodium	143	mmol/L	135-145	None
Potassium	4.5	mmol/L	3.5-5.0	None
Chloride	100	mmol/L	98-107	None
CO2	27	mmol/L	22-30	None
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
Culture	Staphylococcus aureus (coagulase positive), sparse growth. Mixed bacterial flora.	None	None	None
Antibiotic Susceptibility	S. aureus susceptible to: Clindamycin, Gentamicin, Oxacillin, Tetracycline, Trimethoprim/Sulfa. Resistant to: Erythromycin, Levofloxacin.	None	None	None
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

