REASON FOR CONSULTATION: , Questionable need for antibiotic therapy for possible lower extremity cellulitis.,HISTORY OF PRESENT ILLNESS: , The patient is a 51-year-old Caucasian female with past medical history of morbid obesity and chronic lower extremity lymphedema. She follows up at the wound care center at Hospital. Her lower extremity edema is being managed there. She has had multiple episodes of cellulitis of the lower extremities for which she has received treatment with oral Bactrim and ciprofloxacin in the past according to her. As her lymphedema was not improving on therapy at that facility, she was referred for admission to Long-Term Acute Care Facility for lymphedema management. She at present has a stage II ulcer on the lower part of the medial aspect of left leg without any drainage and has slight erythema of bilateral lower calf and shin areas. Her measurements for lymphedema wraps have been taken and in my opinion, it is going to be started in a day or two.,I have been consulted to rule out the possibility of lower extremity cellulitis that may require antibiotic therapy.,PAST MEDICAL HISTORY:, Positive for morbid obesity, chronic lymphedema of the lower extremities, at least for the last three years, spastic colon, knee arthritis, recurrent cellulitis of the lower extremities. She has had a hysterectomy and a cholecystectomy in the remote past.,SOCIAL HISTORY: , The patient lives by herself and has three pet cats. She is an ex-smoker, quit smoking about five years ago. She occasionally drinks a glass of wine. She denies any other recreational drugs use. She recently retired from State of

Pennsylvania as a psychiatric aide after 32 years of service.,FAMILY HISTORY: , Positive for mother passing away at the age of 38 from heart problems and alcoholism, dad passed away at the age of 75 from leukemia. One of her uncles was diagnosed with leukemia.,ALLERGIES: , ADHESIVE TAPE ALLERGIES.,REVIEW OF SYSTEMS:, At present, the patient is admitted with a nonresolving bilateral lower extremity lymphedema, which is a little bit more marked on the right lower extremity compared to the left. She denies any nausea, vomiting or diarrhea. She denies any pain, tenderness, increased warmth or drainage from the lower extremities. Denies chest pain, cough or phlegm production. All other systems reviewed were negative.,PHYSICAL EXAMINATION:,General: A 51-year-old morbidly obese Caucasian female who is not in any acute hemodynamic distress at present.,Vital signs: Her maximum recorded temperature since admission today is 96.8, pulse is 65 per minute, respiratory rate is 18 to 20 per minute, blood pressure is 150/54, I do not see a recorded weight at present.,HEENT: Pupils are equal, round, and reactive to light. Extraocular movements intact. Head is normocephalic and external ear exam is normal.,Neck: Supple. There is no palpable lymphadenopathy.,Cardiovascular system: Regular rate and rhythm of the heart without any appreciable murmur, rub or gallop. Heart sounds are little distant secondary to thick chest wall.,Lungs: Clear to auscultation and percussion bilaterally.,Abdomen: Morbidly obese, soft, nontender, nondistended, there is no percussible organomegaly, there is

no evidence of lymphedema on the abdominal pannus. There is no evidence of cutaneous candidiasis in the inguinal folds. There is no palpable lymphadenopathy in the inguinal and femoral areas.,Extremities: Bilateral lower extremities with evidence of extensive lymphedema, there is slight pinkish discoloration of the lower part of calf and shin areas, most likely secondary to stasis dermatosis. There is no increased warmth or tenderness, there is no skin breakdown except a stage II chronic ulcer on the lower medial aspect of the right calf area. It has minimal serosanguineous drainage and there is no surrounding erythema. Therefore, in my opinion, there is no current evidence of cellulitis or wound infection. There is no cyanosis or clubbing. There is no peripheral stigmata of endocarditis.,Central nervous system: The patient is alert and oriented x3, cranial nerves II through XII are intact, and there is no focal deficit appreciated.,LABORATORY DATA: , White cell count is 7.4, hemoglobin 12.9, hematocrit 39, platelet count of 313,000, differential is normal with 51% neutrophils, 37% lymphocytes, 9% monocytes and 3% eosinophils. The basic electrolyte panel is within normal limits and the renal function is normal with BUN of 17 and creatinine of 0.5. Liver function tests are also within normal limits.,The nasal screen for MRSA is negative. Urine culture is negative so far from admission. Urinalysis was negative for pyuria, leucocyte esterase, and nitrites.,IMPRESSION AND PLAN:, A 51-year-old Caucasian female with multiple medical problems mentioned above including history of morbid obesity and chronic lower extremity lymphedema. Admitted for inpatient

management of bilateral lower extremity lymphedema. I have been consulted to rule out possibility of active cellulitis and wound infection.,At present, I do not find evidence of active cellulitis that needs antibiotic therapy. In my opinion, lymphedema wraps could be initiated. We will continue to monitor her legs with lymphedema wraps changes 2 to 3 times a week. If she develops any cellulitis, then appropriate antibiotic therapy will be initiated. ,Her stage II ulcer on the right leg does not look infected. I would recommend continuation of wound care along with lymphedema wraps.,Other medical problems will continue to be followed and treated by Dr. X's group during this hospitalization. Dr. Y from Plastic Surgery and Lymphedema Management Clinic is following.,I appreciate the opportunity of participating in this patient's care. If you have any questions, please feel free to call me at any time. I will continue to follow the patient along with you 2-3 times per week during this hospitalization at the Long-Term Acute Care Facility.