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9/26/2001 12:00:00 AM
FEVER
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DIS
Admission Date :
09/26/2001
Report Status :
Signed
Discharge Date :
10/06/2001
PRINCIPAL DIAGNOSES :
1. NEUTROPENIA
2. CELLULITIS .
3. FEVER .
HISTORY OF PRESENT ILLNESS :
The patient is a 60-year-old male with a past medical history notable for corona ry artery disease and CABG x2 in 2001 .
The patient has felt unwell since 7/21 after his non-Q wave MI .
The patient , at this time , was started on Statin and developed in arthritis ap proximately one month later with joint pain , myalgia and fatigue .
No clear diagnosis was made .
The patient was presumed to have a rheumatoid factor negative , rheumatoid arthr itis and he was prescribed Naprosyn , prednisone and sulfasalazine .
He had a CABG review in 2/21 .
His first CABG was in 02/89 .
Since 2/21 , he has had increasing weight loss of 30-49 pounds , night sweats wh ich he attributed to the prednisone and increased fatigue and myalgias .
The patient has gradually taken to bed with decreasing activity .
In late 7/22 , sulfasalazine was started at one tab three times a day .
The patient subsequently developed diffuse abdominal pain , nausea , vomiting , and decreased p.o. intake .
A guaiac positive stool was also noted in the month of July .
10 days prior to admission , the patient 's primary care physician increase d his sulfasalazine dose to two tabs three times a day .
The patient 's prednisone was increased to 60 mg q.d. as the patient was di agnosed with an arthritis flare .
The prednisone dose was gradually tapered to 20 mg q.d.
The day before admission , the patient developed a fever to 102 degrees and incr easing abdominal pain .
He presented to an outside hops where he was noted to be leukopenic with a white blood cell count of 0.6 , 0 neutrophils , a hematocrit of 32 , platelets of 326 , a MCV of 79 , and RDW of 22 .
The patient was given IV fluids and treated with imipenem , transferred to Ca Va lley Hospital ED , where it was noted that the patient had face and neck swellin g , as well as erythema and cervical lymphadenopathy .
The patient states that his swelling of his face began two days prior to admissi on and has doubled since then .
In the emergency department , CT of head , neck and abdomen were performed .
The CT of the abdomen was without lymphadenopathy , revealed a right renal cyst , otherwise unremarkable .
The CT of head and neck was likewise unremarkable showing no evidence of fasciit is or deep tissue thread .
No abscesses were noted .
REVIEW OF SYSTEMS :
The patient denies shortness of breath , chest pain , orthopnea , no dysuria , h ematuria , no visual changes , no rashes , no blurry vision .
PAST MEDICAL HISTORY :

Coronary artery disease , status post MI x2 , CABG x2 in 02/89 and 2/21 , histor y of arthritis , history of bilateral rotator cuff degeneration and tears , hist ory of hypertension , history of hyperlipidemia .
MEDICATIONS :
Sulfasalazine , prednisone 20 mg q.d. , Naprosyn 500 mg t.i.d. , Zestril 10 mg q .d. , Lopressor 50 mg b.i.d. and iron supplementation .
SOCIAL HISTORY :
The patient lives with wife .
He is a realtor .
The patient has history of heavy cigar smoking , no cigarettes .
Social use of alcohol .
FAMILY HISTORY :
Positive for coronary artery disease and MI .
No history of cancer .
PHYSICAL EXAMINATION :
VITAL SIGNS :
The patient 's temperature was 102 , heart rate 118 , blood pressure 111/56 , respiratory rate 28 , satting 92% on room air .
HEENT :
Pupils equal , round , and reactive to light , extraocular movements , fundi bil aterally without exudate or hemorrhage .
On the left nasolabial , there was a boil with pus and surrounding erythema and tenderness .
Left eye with conjunctivae injected , no exudate or pus .
Dentition very poor , large bilateral neck and submandibular swelling very tende r to palpation .
CHEST :
Scattered bibasilar rales , no wheezes .
CARDIAC :
Regular rhythm , tachycardia , no murmurs , no JVD .
ABDOMEN :
Obese , non-distended , positive bowel sounds , mild diffuse tenderness .
EXTREMITIES :
No edema , positive dorsalis pedis pulses .
NEUROLOGICAL :
Non-focal , alert and oriented x3 , 5/5 motor strength in the upper extremities and lower extremities , Babinski reflex , toes are downgoing .
LABORATORY DATA :
Remarkable for a white cell count of 0.4 , with 0 neutrophils , 0 bands , 19 lym phs , 0 monos , hematocrit 28.8% , platelets 300,000 .
ALT 141 , AST 40 , alk phos 108 , and a total bili of 1.0. Total protein was 5.7 , albumin 2.5 and globulin 3.2 .
His electrolyte panel of sodium 135 , sodium 4.1 , chloride 99 , bicarb 30 , BUN 15 , creatinine 2.1 , blood glucose of 196 .
Iron studies included a ferritin of 607 , an iron of 10 , and a TIBC of 239 .
EKG showed tachycardia with a sinus rhythm of 103 , normal axis , normal interva ls , no Q-waves , no ST-T wave changes .
The patient had a history from 7/12/01 of a normal white blood cell count , with a normal absolute neutrophil count .
The patient 's chest x-ray at the outside hospital was unremarkable .
HOSPITAL COURSE :
The patient was started on ceftazidime , nafcillin and Flagyl for concern of a s oft tissue infection .
Neutropenic precautions were taken .
The patient had a bone marrow biopsy which showed myeloid arrest and probable ne utropenia from a drug-related cause presumed to be the sulfasalazine .
Over the course of the hospitalization , the patient 's white blood cell co unt rose from 0.4 to 6.3 after he was given G-CSF , a course lasting from 9/28/0 1 until 9/30/01 .
After the G-CSF , the absolute neutrophil count was greater than 8000 .

On 10/3/01 , the patient had a repeat head and neck CT , which showed a right pa rotitis and left submandibular lymphadenopathy with some necrosis .
No frank abscesses .
The patient 's antibiotics were changed to clindamycin 300 mg q.i.d. and pa tient was also put on sialagogue .
Over the course of the hospitalization , the swelling and tenderness and erythem a have steadily decreased .
Recommendations on antibiotics were made by infectious disease team , who was co nsulted .
Rheumatology was also consulted for patient and after workup , it was believed t hat arthritis may be a rheumatoid factor negative , rheumatoid polyarthritis .
Rheumatology recommended a taper of his prednisone to 20 mg q.d. and the patient will be followed by the rheumatology service .
The oncology service was also consulted for patient and performed a bone marrow biopsy .
Throughout his course during this hospitalization , the patient was also followe d by the ENT service .
The ENT physicians did not recommend any procedures , incision and drainage for his right parotitis or left submandibular cervical lymph node necrosis .
The ENT team recommended watching patient in-house for two days after his repeat imaging on 10/3/01 , and to continue antibiotic coverage with clindamycin .
The patient had no positive blood cultures during his hospitalization and remain ed afebrile after the second day of admission .
DISCHARGE MEDICATIONS :
Topical Bactroban to be applied three times a day to affected naris , prednisone 5 mg p.o. q.a.m. , K-Dur 10 mEq x2 p.o. q.d. , OxyContin 10 mg p.o. q.12h. , cl indamycin 300 mg p.o. q.i.d. , lisinopril 10 mg p.o. q.d. , atenolol 25 mg p.o. q.d. , trazodone 100 mg p.o. q.h.s. , Prilosec 40 mg p.o. q.d , clotrimazole 1% cream topical to be applied b.i.d.
DISCHARGE FOLLOW-UP :
The patient was arranged for follow-up appointment with Dr. Scarvzine of rheumat ology on 10/11/01 .
Also , with Dr. Fyfe of ENT scheduled for Halloween .
Dr. Twada , his primary care physician at the SBH clinic for 10/11/01 and Dr. Fy fechird , gastroenterologist , on 10/13/01 .
COMPLICATIONS :
There were no complications during the patient 's hospitalization and he wa s discharged in stable condition .
Dictated By :
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