Encounter Note 1

20 yr. old Asian male presents to clinic with pain in big toe of left foot.

**Subjective Information**

*Demographic:* Patient is an 20 year old Asian male who resides in Sacramento, CA. He works as stocker for Walmart. The patient has been to the clinic before. This is his 3rd visit. The patient is well groomed and is a reliable source of information.

*Chief Complaint:* Toe pain

*History of Present Illness:* Patient presents with complaint of pain in big toe of left foot. The pain has been present for the past 2 days. The onset was gradual and the symptoms have been constant. He states that he was kneeling on the ground with his toes pressed against the ground yesterday. He states he woke up with the pain in his toe this morning.

He states he has taken no pain relievers or done anything to relieve the pain. He denies using ice on the joint. Denies any relieving factors. Aggravating factors are walking.

He denies any numbness or tingling in the foot or toes. Denies injury or trauma to the toe. The patient denies history of gout. States the toe “may have been stretched too much” when he was kneeling on the ground.

**Patient explanatory Model:** “I have pain in my big toe”

He is concerned about his job at Walmart because today was his first day and the pain makes it difficult to walk. The patient states today is supposed to be his first day at work and is concerned he already had to ask for a day off. He hopes for enough pain relief to be able to return to work. He requests a work note for today’s visit to the clinic.

*Current Health Status:* Patient has no allergies and is up to date on his immunizations. Patient is a non-smoker, denies use of illegal drugs or ETOH. He is a heterosexual male and is sexually active. States he does not take any prescription or herbal medications. Denies excessive consumption of organ meats, red meats, seafood, alcohol and beer. Patient has cerebral palsy which does not influence this toe pain.

*Relevant Past Medical History:* Patient states that he is generally in good health. No previous hospitalizations. Denies having any other chronic medical conditions. Patient has had hammer toe surgery on left foot big toe 2 years ago. Denies pain at surgical site. Denies blood transfusions and/or treatment for depression or anxiety.

*Social History:* Patient lives at home with parents in a house. He is single and currently not dating.  Patient states he enjoys hanging out with friends. He denied military service and religious or cultural considerations that may affect his care.

*Family History:*

Father –alive with no known medical problems

Mother- alive with no known medical problems

Brother- alive with no known medical problems

Children- None

*Medications:*

none

*ROS of Relevant Systems:*

General:  Overall healthy, denies fevers, recent weight change or appetite change

Head/Eyes: Denies any changes in vision, diplopia, headache, or trauma to the eyes

ENT: Denies any pain, sore throat, rhinorrhea or vertigo, epistaxis, hearing loss, voice change, or loss of balance

Cardiovascular: Denies chest pain, pressure or palpitations

Respiratory: Denies cough or shortness of breath

Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, heartburn or abdominal pain, difficulty swallowing, blood in stool

GU: Denies testicular lumps or pain, denies penile discharge, denies frequent urination, incontinence, or pain with urination

Neurology: Denies dizziness, seizures or headaches

Musk: Complains of pain in left big toe. Denies back pain. Complains of big toe joint swelling

Skin:  Denies rash, moles or lesions

Psychological: Denies any feelings of depression, anxiety or use of mind altering substances.

**Objective Information**

*Physical Exam:* *BP*: 105/64 (automatic, adult cuff on left upper arm)

T: 98.5 F (oral) P: 68 R: 19 Ht: 5'6'' Wt: 140lbs

**General:** Alert and oriented x3, no acute distress.

**HEENT:** Normocephalic atraumatic, mucous membranes moist, extraocular muscles intact, pupils equally round and reactive to light and accommodation bilaterally, bilateral tympanic membrane intact and reactive to light, bilateral sclera anicteric, no conjunctival injection

**Cardiac:** Regular rate and rhythm, Normal S1/S2, no murmur noted

**Respiratory:** Clear to auscultation bilaterally, symmetrical chest expansion

**GI:** bowel sounds normal in all four quadrants, soft, non-distended/non-tender abdomen, no rebound or guarding no hepatosplenomegaly

**GU**: no rashes, no penile discharge, no masses or lesions, bilateral testicles normal

**Neurology**: face symmetrical, grip strength bilaterally equal and strong. Bilateral sensations intact and equal.

**Musk:** Right leg and foot are bent toward the left leg. He walks with a spastic gait. Joint of left foot big toe is TTP, swollen, and warm to touch. Normal range of motion,

**Skin:** No rashes, good turgor, membranes pink and moist. No lesions erythema. Patient has an incisional scar on top of left foot big toe from hammer toe surgery. Scar is approximated, flat and well appearing. Joint of left foot big toe is erythemic, warm to the touch.

**Psychological:** Normal affect, no hallucinations, normal speech

**Medical Diagnosis:** Gout

**Differential Diagnosis:**

1. Gout
   Assessment finding with severe pain, redness, swelling and warmth. Maximal severity of flare is reached within 2-24 hours as patient described onset of severe pain. Circumstances that promote gout flare include conditions that disturb extracellular urate levels i.e., surgery. Patient had surgery on that toe. According to the clinical diagnostic scoring system for the likelihood for gout without joint fluid analysis, the patient rates 6 which is an intermediate risk.

2. Sesamoiditis
   Patient presents with pain at passive dorsiflexion of the MTP. Focal pain is present over the sesamoid. Pertinent negative is that it is usually caused by repetitive injury such as dancing or playing tennis.
3. Toe fracture
   Assessment findings include: pain, difficulty walking, and swelling. Pertinent negative is that a fracture is caused by injury and is often ecchymotic and deformed.

Medical Diagnosis: Gout flare

A gout flare is typically in one joint, intensely inflamed in the lower extremity. A variety of dietary and physical factors, comorbidities, medications and other factors may predispose a patient to gout flares. Joints in other regions may be involved in patient with longstanding disease which may cause flares in multiple joints. Prolonged uric acid may eventually lead to joint injury. (UpToDate: gout flare)

**Plan:**

1. Diagnostic: Check uric acid levels.
2. Therapeutic: Ibuprofen 800mg TID with food for pain management. Allopurinol 100mg daily titrating the dose every two to four weeks to the minimum dose required to achieve and maintain the goal range of serum urate.
3. Education: Lifestyle change with diet. Diet with low-fat dairy, and reduced meat and seafood and carbohydrate intake. Increase plant-based protein such as soy and legumes.
4. Follow-up: Return to clinic for follow-up in 3 weeks to review labs and to assess effectiveness of treatment; RTC if no improvement in pain 3 days or is symptoms worsen.