Tala Saleh

HISTORY

1- Patient Profile

Mrs. [redacted] (File no.: [redacted]) is a 61-year-old divorced woman who lives in Amman and is a retired university professor. She was admitted to the hospital via the ER on the 16th of August at 4:00 pm. History was taken from the patient herself in the Family medicine clinic on the 22nd of August at 1:00 pm.

2- Chief Complaint

The patient presented with knee pain of 1 week duration.

3- 7 DDx:

a- Osteoarthritis
b- Muscle spasm
c- Osteochondritis
d- Disc herniation
e- Rheumatoid arthritis
f- Trauma
g- Psoriatic arthritis

4- Hx of presenting illness:

The patient complained of right knee pain of gradual onset that increased in intensity a week ago that radiated sometimes to her right hip and ankle joints rating the severity 4/10. It was continuous throughout the day, stiffening especially in the morning of less than 30mins duration and decreasing in the night. The pain increases with rest and relieved by movement.

The patient had no other joint pain, stiffness or swelling with no Hx of trauma. She had no muscle pain, fever, chills, rigors, chest pain, cough, or incontinence.

5- 4 D's

- ***Disease***

Previous similar attacks

- The pain was reported to be from a long ago but increased in intensity the past week.

Past Medical Hx

- In 2012, patient c/o hip joint pain and had images done but there was nothing significant.
- She has HTN, Dyslipidemia, but not DM.

Past Surgical Hx

- Hysterectomy in 2016
- Incisional hernia repair in 2018

- ***Drugs***

  For the current complaint

  Muscodal taken as needed for 4 days. Relieved knee pain temporarily.

  Others/herbs

  Rosuvastatin, Candesartan, Natrelix (Sept, 2019)

  Allergies: NKDA

  Vaccines: All taken, (COVID vaccine in April) // **Addiction**: -

- ***Diet***

  Appetite: Normal // **Specific diet**: nothing specific

  Current weight and significant changes: no significant changes

  Celiac disease or others: None

- ***Dokhan (Social Hx)***

  Smoking: Never

  Level of education: Bachelor's degrees

  Alcohol: None // **Insurance**: الجامعة

  Family Hx: Sister (HTN), Mother died at 46 and dad at 80 (both sudden).

6- Patient-centered medicine (*ICEE*)

Ideas
Patient thinks it might be due to muscle spasm or osteoarthritis.

Concerns
Afraid of immobility as she lives alone with no one to help.

Expectation
Patient expected to get an x-ray or DEXA scan.

Effects
Feeling depressed for lack of activity and social life.

PHYSICAL EXAM

1- General appearance

Patient was alert, conscious, and oriented to time, place, and person. She seemed fatigued with a slight limp in gait but not in distress.

2- Vitals:

a- Temp: -
b- BP: 131/91
c- HR: 92
d- O2Sat: 96

3- Focused PE (Knee physical examination)

Upon inspection

No erythema, bruising, scars, skin changes, or varus and vulgus deformities were noticed on both left and right knees. Both knees were symmetrical and with no visible dilated veins or any noticeable swellings or cysts.

Upon palpation

Both knees felt warm with no irregularities felt upon palpating the joint lines of both knees. No palpable lymph nodes, cysts, or aneurysms were sensed. The patient did not experience joint tenderness and had a negative sweep test for effusion.

The patient had a normal range of motion in both knees, and denied the presence of knee popping, however she experienced slight pain posterior to the right knee upon full extension of the right knee. Power assessment of both knees was 5/5. The patient has negative posterior and anterior drawer test, no posterior sag, negative collateral ligament test, and active passive knee extension and flexion in both knees.

MANAGEMENT PLAN (RAP RIOP)

- **Reassurance (only if appropriate) and/or explanation of the problem.**
  Degenerative joint damage (osteoarthritis) was explained to the patient.

- **Advice**
  Patient was advised to reduce weight, increase physical activity, and have occasional walks.

- **Prescription (Therapeutics)**
  Ibuprofen, Loratan, Muscodal, D3, B12, Paracetamol

- **Referral (To … and why?)**
  No need

- **Investigations (Labs and/or imaging)**
  HbA1c, KFT, CBC, and ESR

- **Observation (Follow-ups or advise to return if there is no improvement)**
  The patient was asked to follow-up for lab checks.

- **Prevention (Screening & Modifying risk factors)**
  HbA1c was ordered to check for DM and PHQ2 to screen for depression.

PATIENT-DOCTOR INTERACTION

We explained the DDx, the cause, course, and available management options agreeing on a final decision regarding labs to do and medications to take, keeping in mind the patient's concerns and worries.