Soap Note

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Name: Hind Errajai	Date: 01/18/2019	Time: 10:00 Am
	Age: 48	Sex: Male
SUBJECTIVE		
CC: "Urinary Tract Infection"		
HPI Hind Errajai is a 47 year old male who comes to our facility complaining about having lower abdominal pain accompanied for burning urination for several days. The patient reports that the pain has an intensity of 4/10 on the numerical scale of 0/10, relieve with Tylenol 500mg 2 tabs every 6 hours and irradiate *radiates to the low back. He says that he has frequent urge to urinate, he also states that when he goes to urinate is painful. The pain killers Tylenol?? have been giving him a temporary solution relief but have not given him a lasting solution. The patient denies presence of hematuria or penile discharge, denies fevers, vomiting or nausea. CVA Tenderness		
Medications: Currently not taking any prescribed medication OTC: Tylenol 500 mg take 2 tabs PO BID every 6 hours prn for pain		
PMH **Allergies:** No Know Allergies **Medication Intolerances:** None **Chronic Illnesses/Major traumas:** HTN		

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Hospitalizations/Surgeries: Patient has no significant past medical history
Family History Mother: HTN Father: HTN and Diabetes
Social History The patient is married lives with his wife and 2 children; he works as a cook at Denny's restaurant. Denies drinking alcohol and denies smoking cigarettes.

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ROS	
General No weight change, fatigue, fever, chills, night sweats, good energy level, good appetite.	**Cardiovascular** Denies chest pain, palpitations, orthopnea, edema.
Skin Denies rashes, bruising, bleeding or skin discolorations. No lesions.	**Respiratory** No cough, wheezing, hemoptysis or dyspnea.
Eyes No corrective lenses, no blurring vision, no visual changes.	**Gastrointestinal** No abdominal pain, denies diarrhea o constipation. Denies nausea or vomitin.No history of hepatitis, hemorrhoids, eating disorders, ulcers or black, tarry stools.
Ears Denies ear pain, hearing loss, ringing in ears, or discharge.	**Genitourinary** Refers ?? This is not clear, I do not understand what you are trying to communicate burning urination, urinary frequency and urgency, no change in color of urine. PSA done two months ago: negative
Nose/Mouth/Throat Denies Sinus problems, dysphagia, nose bleeds or sore throat.	**Musculoskeletal** Referes back pain. Denies joint swelling, stiffness, fracture osteoporosis.
Breast No lumps, bumps, or changes.	**Neurological** Denies syncope, seizures, transient paralysis, paresthesias, or black-out spells.

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Heme/Lymph/Endo	**Psychiatric**
HIV status: Negative No bruising, blood transfusion hx, night sweats, swollen glands. Denies increase thirst, increase Hunger. N cold or heat intolerance.	Denies depression, anxiety, sleeping difficulties or suicidal ideation.
OBJECTIVE	

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Weight: 220 BMI: 29.8	**Temp: 98.3**	**BP: 123/85**
Height: 6'0	**Pulse: 78**	**Resp: 20**

General Appearance

Healthy-appearing adult male in no acute distress. Alert and oriented; answers questions appropriately.

Skin

Skin is white, warm, dry, clean, and intact. No rashes or lesions noted.

HEENT

Head is normocephalic, atraumatic, and without lesions; hair evenly distributed. Eyes: PERRLA. EOMs intact. No conjunctival or scleral injection. Ears: Canals patent. Bilateral TMs pearly gray with positive light reflex; landmarks easily visualized. Nose: Nasal mucosa pink; normal turbinates. No septal deviation. Neck: Supple. Full ROM; no cervical lymphadenopathy; no occipital nodes. No thyromegaly or nodules.Oral mucosa, pink and moist. Pharynx is nonerythematous and without exudate. Teeth are in good repair.

Cardiovascular

S1, S2 with regular rate and rhythm. No extra sounds, clicks, rubs, or murmurs. Capillary refills two seconds. Pulses 3+ throughout. No edema.

Respiratory

Symmetric chest wall. Respirations regular and easy; lungs clear to auscultation bilaterally.

Gastrointestinal

Abdomen overweight; BS active in all the four quadrants. Abdomen soft, nontender. No hepatosplenomegaly.

Breast

Normal configuration, no masses or tenderness.

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Genitourinary Tenderness in suprapubic area , CVA tenderness bilateral? Left? Right? , bladder is nondistended; no tenderness in hypochondria and flanks, no palpable or depressible kidneys. Genital area: no masses or lesions, no hernia, and no uretheral discharge. Testes tender? Swollen??
Musculoskeletal Full ROM seen in all four extremities as the patient moved about the exam room. .
Neurological Speech clear. Good tone. Posture erect. Balance stable; gait normal.
Psychiatric Alert and oriented. Dressed smoothly. Maintains eye contact. Speech is soft, though clear and of normal rate and cadence; answers questions appropriately.

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Lab Tests

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Urinalysis dipstick: Done 1/18/2019

- Color: yellow dark
- Blood: negative
- Leukocyte esterase: Positive
- Nitrites: negative

Urine Culture: sent to lab pending for results
PSA: Pending for results
Abdominal Ultrasound: pending for results

Special Tests

None at this time

Diagnosis

Diferential diagnoses

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1. **Acute bacterial Prostatitis**

The clinical presentation of acute prostatitis is generally not subtle. Patients are typically acutely ill, with spiking fever, chills, malaise, myalgia, dysuria, irritative urinary symptoms (frequency, urgency, urge incontinence), pelvic or perineal pain, and cloudy urine. Men may also complain of pain at the tip of the penis. Swelling of the acutely inflamed prostate can cause voiding symptoms, ranging from dribbling and hesitancy to acute urinary retention. No specific characteristics of urinary symptoms (eg, end-stream dysuria) have been clearly associated with prostatitis. Rarely, patients lack these local symptoms and present instead with constitutional symptoms or a flu-like illness. On exam, the prostate is often firm, edematous, and exquisitely tender. Common laboratory findings include peripheral leukocytosis, pyuria, bacteriuria, and, occasionally, positive blood cultures. Inflammatory markers (erythrocyte sedimentation rate, C-reactive protein) are elevated in most cases. Inflammation of the prostate can also lead to an elevated serum prostate specific antigen (PSA) level.(Coker TJ,

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Dierfeldt DM, Am Fam Physician. 2016;93(2):114.) Excellent!!!! What are your patients pertinent postives and negatives that compare with each of these diagnosis?

2. Urethritis

Urethritis must be considered in sexually active men; examination for penile ulcerations and urethral discharge, evaluation of a urethral swab specimen Gram stain, and diagnostic tests for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* are warranted. A urethral Gram stain demonstrating leukocytes and predominant gram-negative rods suggests *E. coli* urethritis, which may precede or accompany urinary tract infection. Dysuria, or discomfort with urination, is usually the chief complaint in men with urethritis and is reported in the majority of men with gonorrhea and over half of patients with nongonococcal urethritis (NGU).Other complaints include pruritus, burning, and discharge at the urethral meatus. Urethral discharge can range from mucoid or watery to frankly purulent and may be present throughout the day or may be scanty and only present on the first morning void. Some men notice grossly visible mucous threads in their morning urine stream. The incubation period is variable, but is typically four to seven days after exposure for gonococcal urethritis and five to eight days for NGU. (United States Department of Health and Human Services; 2017.) Excellent!

3. Pyelonephritis

The clinical spectrum of acute complicated urinary tract infection (UTI) encompasses both cystitis with complicating features and pyelonephritis:

Symptoms and signs of cystitis include dysuria, urinary frequency and urgency, suprapubic

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pain, and hematuria. Patients with acute complicated UTI also have fever or other features of systemic illness (including chills, rigors, or marked fatigue or malaise beyond baseline), which suggest that infection has extended beyond the bladder.Symptoms and signs of pyelonephritis classically include fever, chills, flank pain, costovertebral angle tenderness, and nausea/vomiting. Symptoms of cystitis are often but not universally present. Atypical symptoms have also been described, with some patients complaining of pain in the epigastrium or lower abdomen.(Walker E, Lyman A, Gupta K, Mahoney MV, Snyder GM. 2016)

Presumptive diagnosis.

- Urinary Tract Infection, site non specified(N39.0)

Urinary tract infection (UTI) should be suspected in men who have dysuria, urinary frequency or urgency, and/or suprapubic pain. Men should be asked about fevers, chills, and other systemic symptoms, as well as, pelvic, or perineal pain. If symptoms are suggestive of extension of infection outside of the bladder, physical examination should include assessment for fever, costovertebral angle tenderness, abdominal examination, and, if pelvic or perineal pain are present, a cautious digital rectal examination to evaluate for a tender prostate.(Hooton TM, Naber KG, Wullt B, Clin Infect Dis. 2011)

Plan/Therapeutics

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- Diagnosis: Urinary Tract Infection (UTI).

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- Medication:

Ciprofloxacin, 500 mg PO, BID for 7days.how many tabs for each of these medications????

Phenazopyridine 200mg PO, TID for 2 days

Tylenol 500mg 2 tab PO as needed for pain.

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- Non-medication:
- Drink plenty of water: Water helps to dilute the urine and flush out bacteria.
- Avoid drinks that may irritate the bladder**:** Avoid coffee, alcohol, and soft drinks containing citrus juices or caffeine until the infection has cleared. References?
- Follow up in 7 days. Why? references
- Education:

The patient is educated on empty his bladder when he feel the urge to urinate and before going to sleep. Urine that stays in his bladder promotes infection. References.

- Use condoms during sex. These help prevent UTIs caused by sexually transmitted bacteria.
- Keep follow-up appointments with his healthcare provider. He or she can may do tests to make sure the infection has cleared. If needed, more treatment can be started.

You must include the references for each of these treatments

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