Soap Note Critique #3

*On my honor as a student, I have neither given nor received aid on this assignment.*

Vital Signs

T: 97.8 °

P: 64

RR: 18

BP: 124/76

CC: Patient is a 50 – year old who presents with the chief complaint of sinus congestion that has been ongoing for 5 days.

S: This is a 50 – year old female seen in the clinic for complaints of *sinus congestion*, *sinus pressure*, *mild sore throat*, *post nasal drip*, intermittently productive *cough* and rhinorrhea that was thin and creamy – white. Patient unsure of color of sputum, “I just didn’t want to look at it.” At the onset of her symptoms, patient took Mucinex D with little to no improvement. She states that her symptoms started Friday afternoon and has gotten better with the recent help of Claritin and Delsym. Her symptoms are associated with *ear fullness* and paroxysmal coughing. She took two Biaxin tablets (what was leftover from a previous upper respiratory infection) on Saturday. She is using Nasonex daily, but would like a generic of the same class, as Nasonex is very expensive. Negative for night sweats, fever, chills, appetite or weight change, visual disturbances, epistaxis, chronic cough, pleuritic chest pain, orthopnea or increasing shortness of breath, ischemic chest pain, sinus tenderness, palpitations, syncope, dysphagia, pyrosis, dyspepsia, abdominal pain, change bowel habits or blood/mucous in stool, urinary symptoms and unusual headaches.

Deletions and revisions:

1. I should have inquired when the patient was seen for an upper respiratory
infection and what was diagnosed (was it sinusitis, pharyngitis, bronchitis?). I could have used that information to determine the presence of “double worsening” which will be discussed later. I should have asked if the patient was had been experiencing cold/rhinitis symptoms before onset of illness.

2. “The common cold and allergic and idiopathic rhinitis are common antecedents to an acute sinus infections” (I did not inquire how ill, in general, the patient felt. Did she have to call in to work? Was her illness affecting her activities of daily living?)

   a. The degree of illness and slowness of recovery has been found to be associated with a more severe illness associated with sinusitis (Worrall, 2011).

   b. The patient being constitutionally ill is indicative of acute bacterial infections or of spread of disease from the sinusitis (Worrall, 2011).

3. I did not inquire about any neurologic signs other than headache nor did I ask about head/neck abnormalities.

   a. The spread of sinusitis to the central nervous system will produce lethargy or neurologic signs (Worrall, 2011).

   b. Complications of acute sinusitis include: bacterial meningitis and subdural abscess (Beach, 2008).

   c. Particular attention should be paid to the presence or absence of the following: signs of extrasinus involvement (e.g., orbital or facial cellulitis, orbital protrusion, abnormalities of eye movement, neck stiffness) (Rosenfeld et al., 2007).

4. Nor did I inquire about facial pain or dental pain associated especially with bending forward at the waist.

   a. With acute/bacterial sinusitis, “sensations of pain in the teeth and forehead are worse in the morning and when the patient bends forward from the waist” (Beach, 2008).

5. Based on the Journal of Otolaryngology–Head and Neck Surgery’s Clinical Practice Guidelines for Adult Sinusitis, I should have addressed the three cardinal symptoms of acute rhinosinusitis and determined if the
symptomatology was of viral or bacterial etiology. I should have written the history of presenting illness like this:

a. Patient is a 50-year-old woman who presents to the clinic with a 5-day-old complaint of creamy-white, thin rhinorrhea, mild sore throat, intermittent productive cough, sinus congestion and pressure. Patient unable to describe sputum. Her symptoms are associated with bilateral ear fullness, postnasal drip, and paroxysmal coughing. Patient denies purulent nasal drainage and facial pain. Patient has tried Mucinex, Claritin and Delsym, which have contributed to mild to moderate relief. Symptoms have not worsened over the duration of illness. Denies fever, chills, nausea, vomiting, night sweat, chest pain, appetite or weight change, epistaxis, sinus tenderness, headache, visual disturbances, chronic cough, shortness of breath, diaphoresis or dizziness.

6. Added on to the history of presenting illness, should have been the statement addressing the presence of “double worsening,” (e.g., Patient did not experience a period of symptom improvement during the duration of illness) to help validate a high suspicion of acute bacterial rhinosinusitis.

a. Symptoms or signs of acute rhinosinusitis that worsen within 10 days after an initial improvement (double worsening) are indicative of acute bacterial sinusitis (Rosenthal et al., 2007).

b. King & Lipsky (2011) explained many patients might experience “double sickening” with improvement in their cold symptoms followed by a relapse with increased pain and nasal drainage (p. 96).

O:
HEAD/FACE: Normocephalic/traumatic, symmetric. (I should have addressed that the facies were symmetric.)
EYES/EARS/NOSE: Eyes: PERRLA. EOMI. No nystagmus is noted. Ears: TMs intact. Ear canals are clear. Nose: **Nasal turbinates erythematous and swollen.** No sinus tenderness palpated.

MOUTH/THROAT: Mouth/Throat: moist mucous membranes. Oropharynx clear without exudates. **Uvula with mild erythema.**

NECK: Neck reveals no bruits, no JVD or evidence of thyromegaly. **Tonsilar lymphadenopathy present.**

CHEST/LUNG: Chest expansion is symmetrical. Lungs are clear to auscultation and percussion bilaterally.

HEART: Apical pulse is normal. Heart has a regular rate and rhythm. Normal S1 and S2. No extra heart sounds are on auscultation.

ABDOMEN: Abdomen is soft, benign, non-tender, and non-distended. Bowel sounds are normoactive. Palpation reveals no palpable masses, no organomegaly and no CVS tenderness.

EXTREMITIES: Extremities reveal no clubbing, no cyanosis and no edema. Peripheral pulses are palpable. Skin is intact. No signs of paronychia or onychomycosis are present. There is no discomfort with palpation /ROM.

MUSCULOSKETAL: Musculoskeletal exam reveals no joint effusions. Gait is on-antalgic.

NEUROLOGIC: Speech is clear. Cranial nerves II – XII are grossly intact without any focal deficits noted. DTRs symmetric.

**Deletions and Revisions:**

1. A thorough head and neck examination that focuses on the nasal cavity may provide contributory evidence of the underlying disease process (Hwang & Gwetz, 2011).
   
   a. I should have documented a more detailed description of the appearance of the face, nasal turbinates, eyelids, conjunctiva and sclera.

   b. I should have assessed and documented the presence or absence of diffuse mucosal edema, narrowing of the middle meatus, inferior turbinate hypertrophy, and copious rhinorrhea or purulent discharge.
Examination evaluation of the eyes, noting periorbital swelling, allergic shiners, and erythema is important in determining a sinus infection (Beach, 2008). I did not address that in the history and physical.

**Diagnostics:**

**Deletions and Revisions:**

1. Usually upper respiratory infections are diagnosed clinically.
   a. “Acute sinusitis can be diagnosed empirically from the history and physical exam” (Beach, 2008).

2. Nothing the patient’s history and physical indicated that further diagnostic evaluation should be pursued.
   a. Examples of complications that warrant imaging include orbital, intracranial, or facial soft tissue spread of infection. If imaging is considered, CT is preferred over plain films or magnetic resonance imaging (MRI) because of improved visualization of the paranasal sinus anatomy (Ryan, 2010). A sinus aspiration procedure can be performed at this point.

3. The definitive diagnosis of acute bacterial rhinosinusitis is made by sinus aspiration. It is an invasive procedure not typically performed in the office setting (Mostov, 2007).
   a. Throughout my literature review, a diagnosis of acute sinusitis can be derived without performing sinus aspiration since this procedure is so invasive. Most acute sinusitis conditions are mild to moderate. I believe such an invasive procedure provides more risks than benefits.

**A: Acute Sinusitis**

**Deletions and Revisions:**

1. I believe the patient had **Acute Viral Rhinosinusitis Infection** or the common cold based on the clinical evidence. This was what I considered to be the leading diagnosis after reading the literature.
a. Supporting - The diagnosis of viral rhinosinusitis is based primarily upon history of the quality, duration, and progression of symptoms. Partial or complete resolution of symptoms within seven to ten days following the onset of an upper respiratory tract infection is indicative of AVRS (Ryan, 2010). The duration of illness totaled 5 days, we should have told her to call or come back in 10 days or earlier if symptoms persist.

b. Supporting – The patient had these symptoms <10 days. She had thin, creamy colored rhinorrhea, sinus congestion/pressure, red, swollen nasal tissue, edematous turbinates, ear fullness, sore throat, cough associated with postnasal drip.

- Three major signs or symptoms are consistently cited in all the guidelines. The primary diagnostic indicators for AVRS include nasal congestion, obstruction, or blockage; anterior and/or posterior purulent rhinorrhea (doesn’t have to be purulent) and facial pain or pressure (Meltzer & Hamilos, 2011).

c. Supporting - The common cold usually causes nasal congestion, runny nose, and sneezing. A sore throat may be present on the first day but usually resolves quickly. If a cough occurs, it generally develops on about the fourth or fifth day of symptoms, typically when congestion and rhinorrhea are usually resolving (Sexton & Friedman, 2011). Patient experiencing very mild sore throat and cough symptoms and have improved slightly. The cough appeared on the second and third (maybe because of the postnasal drip) and appears concomitantly with the congestion and rhinorrhea.

2. Acute Bacterial Rhinosinusitis (considered in the clinic and was final decision). Later, my opinion changed after reading the literature.

a. Refuting - A diagnosis of acute bacterial sinusitis may be made in individuals with the symptoms of a viral URTI that have not
improved after 10 days or have worsened after 5 to 7 days. In some cases, a clinical diagnosis of acute bacterial sinusitis is appropriate if symptoms are out of proportion to a typical URTI (Ryan, 2010). This patient has not experienced symptoms long enough to even consider bacterial sinusitis. Her symptoms are also too mild to consider given an antibiotic. She is afebrile. If I had further inquired how constitutionally ill she was I would have more clinical data to go by. Also determining if she had “double sickening” would have helped to determine rhinosinusitis of bacterial etiology.

b. Refuting - Of several guidelines reviewed, the data suggests that unusually severe symptoms (e.g., high fever, unilateral facial/tooth pain, orbital cellulitis, intracranial expansion), particularly during the first several days of disease are indicative of ABRS (Meltzer & Hamilos, 2010). The patient did not have any of these symptoms.

4. Allergic/non-allergic rhinitis (allergic causes, considered)
   a. Refuting - Rhinitis may be defined as the presence of one or more of the following nasal symptoms: sneezing, post-nasal drainage rhinorrhea (anterior or posterior), nasal congestion and nasal itching (Sexton & Friedman, 2011). Patient is not sneezing or having nasal itching. Antigens such as mites, grass, strong perfumes, pollen, tobacco smoke, and car exhaust typically induce these symptoms. Patient is a chronic smoker and does not have a history of allergies. It is also not allergy season. Patient is middle-aged and if she has allergic/non-allergic rhinitis it would have most likely manifested by now.
   b. Refuting/inconclusive – Nasal symptoms such as congestion and rhinorrhea may be present with seasonal allergies (Chan, 2011).

5. Influenza (viral causes, considered)
   a. Refuting – Influenza symptoms included signs and symptoms of upper and/or lower respiratory tract involvement are not present, along with indications of systemic illness such as fever, headache,
myalgia, and weakness (Chan, 2011).

P:
Biaxin XL 500mg 2 tablets by mouth daily for 7 days
Rest and hydration encouraged.
Flonase 2 sprays in each nostril daily in lieu of Nasonex.
Return in 48 – 72 hours if symptoms persist.
May return to work today.

Deletions and Revisions

1. I would include instructing patient to apply warm facial packs or steam inhalation to help with sinus congestion/pressure.
2. Biaxin not indicated in this case. In fact Biaxin, not even indicated as first line antimicrobial therapy for acute bacterial sinusitis.
   a. Amoxicillin, trimethoprim-sulfamethoxazole, or erythromycin were found to be efficacious as first line treatment in acute bacterial rhinosinusitis (Hwang & Getz, 2011).
3. I should have instructed to continue Mucinex D as needed for cough and congestion to promote increased nasal secretions and thinning of nasal secretions.
   a. Guaifenesin is only effective if consumed with adequate amounts of water, usually at least two glasses of water with every meal (Rosenthal et al., 2007).
4. I should have put return in 5 – 7 days if symptoms persist or worsen.

Teaching/Education:

Deletions and Revision

1. Educate the patient the importance of utilizing supportive to help ameliorate symptoms and re-evaluate 5 – 7 days later to confirm bacterial infection. Inform them that watchful waiting will also help stave of contributing to bacterial resistance.
2. Explain to patient that acute viral sinusitis is a self-limiting disease and shouldn’t last any more than 10 days.
0. The causative agent of these infections is typically a virus (Mostov, 2007) and is usually self-limiting. With good supportive therapy, the patient will be able to tolerate the course of illness. Rosenthal et al. (2010) explain that an overwhelming majority of sinus infections will resolve in 7-10 days without antibiotic treatment.

3. Instruct patient to use Flonase consistently for at least one month to help with sinus congestion.
   a. A review suggested that intranasal steroid sprays might be modestly effective for relieving symptoms of acute sinusitis (Worrall, 2011).
   b. Topical glucocorticoids (corticosteroids) have been shown to be beneficial as monotherapy for AVRS (Hwang & Getz, 2011).

4. Practice good hand washing (e.g., using soap or alcohol-based rubs).
   a. Colds and flu are spread primarily when an infected person coughs or sneezes near someone else. A very common method for transmitting a cold is by shaking hands. Good hand washing and covering your mouth when you sneeze or cough helps to prevent the spread of transmission.

Follow up Plan

1. I would have given her a prescription to fill ONLY IF her symptoms persist greater than 5 days or she develops a fever or chills.
   a. A Cochrane systematic review found that, for acute upper respiratory tract infections, use of delayed prescriptions did not result in patient harm. It also contributed to reduced antibiotic use (Spurling, Del Mar, Dooley & Foxlee, 2007).
   b. "Watchful waiting and symptomatic relief are generally recommended initially for cases not meeting the criteria for antibiotic intervention" (Meltzer & Hamilos, 2011).

CPT code:
- Office Outpatient: Estimated 15 minutes (99213)

ICD – 9 Code:
- Sinusitis, Acute, NOS (461.9)
References


