FNP Role Practicum SOAP Example

SOAP

SUBJECTIVE DATA

CHIEF CONCERN: Right lower abdominal/right flank pain

HPI: 24 yo F patient presents to the primary care clinic with a complaint of right lower abdominal pain lower back pain that started yesterday and worsened throughout the day and night. Pain is rated 7/10 and described as aching and sharp at times. Patient states that she also nauseated and started vomiting this morning with one loose bowel movement. She said her pain was sudden that started around her umbilical area and now is mostly on her RLQ and right flank. Reports laying on her side with a heating pad seemed to help as well as taking two Aleve every 6 hours. She states she has had a low appetite and pain increases when she ambulates.

PMH: Tonsillectomy age 6 years, seasonal allergies

SH: Denies tobacco use or vaping. Drinks socially 1-2 glasses of wine or beer weekly. Monogamous relationship with boyfriend for 2 years. Lives in an apartment with her cat. Currently a second-year law student and teaching assistant.

CURRENT MEDICATIONS: Depo Provera shot every 3 months with next injection due now

ALLERGIES: NKDA

FAMILY HISTORY: Denies family history of cancer. Mother age 54 alive with no chronic history. Father age 57 alive with history of asthma. Brother age 18 alive with history of asthma. Paternal and maternal grandparents alive with history of high blood pressure and asthma.

FOCUSED ROS:

General: Denies fever, chills, night sweats, weight loss or gain. Reports decreased appetite x 2 days.

Skin: Denies rashes, wounds, or lesions. Denies easy bruising.

HEENT: Denies headache, sore throat, vision changes, congestion, neck pain or stiffness.

Resp: Denies dyspnea, wheezing, chest tightness or cough.

Cardio: Denies chest pain or epigastric pain, no edema. Reports feeling palpitations she relates to anxiety about condition.

GI: Reports change in appetite and bowel habit changes x 2 days with decreased appetite and loose stool this am. Reports nausea with one episode of vomiting. Reports right flank and lower back pain. No bloating or flatulence. Denies constipation or anal bleeding. Reports regular BMs every day or two with no change in color, size, or shape. Denies personal or family history of colon cancer, IBS or stomach surgery or abdominal aneurysms. Drank some Sprite to take Aleve and ate a few crackers before coming to clinic. Denies anal intercourse or penetration.

GU/GYN: Denies urinary frequency, urgency, burning, incontinence or odor. Had one UTI at age 16 years. Sexually active engaging in vaginal and oral sex with one partner for past 2 years. Denies genital

lesions or vaginal discharge. Last vaginal intercourse 2 weeks ago. LMP 4 weeks ago 07/01/2021. Denies history of pregnancy.

Musculoskeletal/Neurologic: Reports lower back pain radiating to right lower abdomen. She cannot say which pain started first. Pain is rated 4-7/10. Pain is worse with ambulation. Denies weakness, tremors, numbness, tingling, or change in bladder habits. Change in bowel habits with one loose stool this am. Denies trauma or straining of back. Denies history of back injury or surgery. Normal gait but it does hurt to stand up.

OBJECTIVE DATA

PHYSICAL EXAM

Vital Signs: BP 128/76, HR 102, Temp. 99.1 F, RR 18, SpO2 98%, Ht. 5”6, Wt. 142 lbs.

General: Appears uncomfortable sitting on exam table with shoulders hunched bending over. Asks if she can lay down and gets in fetal position.

Skin: No rashes or bruising noted. Turgor brisk.

HEENT: PERLA, mucous membranes moist, sclera and conjunctiva clear, tonsils 1+ without erythema or exudate.

Cardio: Tachycardic, rate regular, S1 and S2, no murmurs or gallops. No abdominal bruit. No pedal edema. Radial and pedal pulses 2+ and strong.

Resp: No adventitious breath sounds. Air entry normal with normal effort.

Abdomen: Flat, all quadrants have normoactive bowel sounds; tenderness upon palpation to RLQ and umbilical area, tenderness at McBurney’s point with grimacing and guarding, positive Psoas sign, positive right CVA tenderness. No masses, distention, or bruits noted. Rectal exam deferred due to discomfort.

GU: Pelvic exam deferred due to discomfort

Neurologic: Patient is alert and oriented to person, place, time, and situation. Gait is steady but walking hunched over holding abdominal area. Sensation intact to lower extremities.

Musculoskeletal System: Full ROM of extremities.

Tests: ● Urinalysis ● Urine pregnancy test ● CBC and CMP ● Abdominal and pelvic CT with contrast

DIAGNOSES

5 PLAUSIBLE DIFFERENTIAL DIAGNOSES WITH ICD CODES AND RULE IN /RULE OUT SUBJECTIVE AND OBJECTIVE SUPPORTING DATA

1. K35 - Acute appendicitis a. Due to the patient having abdominal pain that started in her umbilical area then now having localized RLQ pain and vomiting, appendicitis should be ruled out. b. Patient had rebound tenderness upon palpation of her RLQ, she tested positive for McBurney’s point, positive for Psoas sign, and positive obturator sign. c. CBC was drawn to determine if there are any signs of infection and a CMP to determine kidney and liver function. CMP had no abnormalities. Patient’s CBC showed an

elevated WBC which was 19.2. d. Abdominal and pelvic CT was ordered to rule out appendicitis, which the patient was positive for. e. Patient was instructed to not drink or eat anything, she was told to go to ED where she will be seen by a surgeon and be started on IV antibiotics. (Hollier, 2021) Clinical practice guidelines: https://wjes.biomedcentral.com/articles/10.1186/s13017-020-00306-3

2. N39 - Urinary tract infection a. Due to the patient having abdominal/flank pain and is having right CVA tenderness, she should be ruled out for a urinary tract infection. b. Urinalysis was negative for WBCs, nitrites, or leukocyte esterase which does not support the patient having a UTI. c. If urinalysis was positive: 5 i. Urine culture with sensitivity will be sent out to make sure the patient's infection is appropriately covered with the antibiotics prescribed. ii. The patient will be started on antibiotics if it is an uncomplicated UTI, Trimethoprim-sulfamethoxazole (Bactrim) two tablets BID for three days iii. She will be instructed to drink plenty of fluids, perform good perineal hygiene, voiding after intercourse, etc. (Hollier, 2021) Clinical practice guidelines: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5895837/

3. O00.9 - Ectopic pregnancy a. Due to the patient being a woman who is in childbearing age and has a complaint of lower abdominal pain, a urine pregnancy should be ordered. b. Because the patient has unilateral abdominal pain/tenderness and has been feeling dizzy, ectopic pregnancy should be ruled out. c. Patient's urine pregnancy test was negative. d. If urine pregnancy test was positive: i. Ultrasound imaging should be ordered to determine the location of pregnancy and if it is outside of the endometrial cavity, the patient will be referred immediately to the ED for surgical/medical management. (Hollier, 2021) Clinical practice guidelines: https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/03/tubal-ectopic-pregnancy

4. N20.0 - Calculus of the kidney a. Because the patient presents with severe sudden flank pain with right CVA tenderness, kidney stones should be ruled out. b. Urinalysis was ordered which was negative for hematuria. c. There was a higher suspicion for acute appendicitis vs kidney stone, so abdominal and pelvic CT was ordered. d. KUB X-ray can be ordered to identify if there are any stones present (Spiral CT is the most sensitive test but the most expensive) i. If positive, pain management is key for this problem. The patient may need to be referred to ED for IV narcotic analgesics. ii. To prevent future kidney stones, the patient will be educated to drink plenty of fluids, increase fiber intake, decrease animal fat in diet, etc. (Hollier, 2021) Clinical practice guidelines: https://www.aafp.org/pubs/afp/issues/2019/0415/p490.html

5. K81.0 - Acute cholecystitis a. Because the patient looks ill-appearing, tachycardic, vomiting, and having mild tenderness to RUQ, the patient should be ruled out for cholecystitis. b. CBC was ordered to rule out signs of infection and the patient had an elevated WBC. 6 c. CMP was ordered to determine abnormalities in kidney and liver function which were normal. d. The gold standard to rule out cholecystitis is abdominal ultrasound. There was higher suspicion of appendicitis vs cholecystitis so abdominal and pelvic CT ordered instead. If it was determined that the patient has cholecystitis, the patient should be immediately referred to ED. (Hollier, 2021) Clinical practice guidelines: https://cags-accg.ca/wp-content/uploads/2018/11/ACS-HandbookCPG-Ch-8-Biliary-Colic-and-Cholecystitis.pdf

FINAL DIAGNOSIS WITH ICD CODE

K35 - Acute appendicitis Acute appendicitis is the most common cause of acute abdominal pain in the United States and is frequently missed by providers (Brown-Forestiere et al., 2020). Only about 50% of patients that are diagnosed with acute appendicitis present with the typical symptom of pain that started in the periumbilical area which gradually radiated to the right lower quadrant (Brown-Forestiere et al., 2020). According to Snyder and colleagues (2018), the use of clinical scoring tools, such as the Alvarado score, determine the probability a patient has acute appendicitis and can limit the utilization of CT scans. The patient can have an Alvarado score of one to ten and gets points for: migration of pain, anorexia, nausea, rebound pain, etc. (Snyder et al., 2018). Patients who score 7- 10 have a higher probability of appendicitis.

TREATMENT PLAN

NON-PHARMACOLOGICAL TREATMENT PLAN

Patient will be kept NPO in anticipation of surgery to remove appendix.

Patient will be referred directly to the emergency department for evaluation and treatment. The patient is in clinic alone. EMS was activated to transport patient to the emergency department. With permission, patient's mother was called and advised of transport to hospital and diagnosis.

PATIENT EDUCATION

Test and exam indicate acute appendicitis which will require surgical intervention. At the ED patient may have an ultrasound or CT to confirm diagnosis prior to surgery.

PHARMACOLOGIC TREATMENT PLAN WITH SUPPORTING EVIDENCE

None at this time. It is anticipated patient will receive pain medication in emergency department once diagnosis confirmed and surgery scheduled.

FOLLOW UP

We will call tomorrow to follow up on patient's condition. She will return to office as needed.

REFERRAL

Emergency department

REFERENCES

Brown-Forestiere, R., Furiato, A., Foresteire, N., Kashani, J., & Waheed, A. (2020). Acute appendicitis: Clinical clues and conundrums related to the greatest misses. Cureus, 12(5), e8051. https://doi.org/10.7759/cureus.8051

Hollier, A. (2021). Clinical guidelines in primary care. Advanced Practice Education Associates (4th ed.).

Snyder, M., Guthrie, M., & Cagle, S. (2018). Acute appendicitis: Efficient diagnosis and management.

American Family Physician, 98(1): 25-33. https://www.aafp.org/pubs/afp/issues/2018/0701/p25.html