NURS 7446
Clinical SOAP Note #4
Heather Curtis

Subjective Data

Patient Demographics:

- SN-WH, 34-year old Caucasian female, came to appointment alone

Chief Complaint (CC):

- Patient C/O pain in left breast

History of Present Illness (HPI):

- Patient C/O pain in left breast that continues to worsen
- Pt. states they have been experiencing symptoms for approximately 3-4 months
    - **Location**: Left upper breast tissue
    - **Quality**: achy, uncomfortable, "feels like a bruise"
    - **Severity**: chronic condition, "7 out of 10" at worse but on average "3-4 out of 10"
    - **Timing**: started 3-4 months ago and progressively getting worse
    - **Setting**: at home taking a shower
    - **Alleviating and aggravating factors**: Pt. states that she has tried OTC ibuprofen/Tylenol with no relief and nothing specifically aggravates the breast pain.
    - **Associated signs and symptoms**: Pt. states that whenever using arms to talk, shop, or pick up children pt. notices it more.

Past Medical History (PMH):

- **Current Meds:**
    - Multivitamin Daily
    - Tylenol 325mgX2 PO PRN
    - Ibuprofen 200mgX2 PO PRN

  Pt. states that she is aware that the meds can lead to liver and kidney problems if taken a high dose for a long duration and thereby only uses the meds occasionally, not in continuous for days.
- **Health Status:** Pt. appears in good health. Pt. sees PCP as needed for well check and if necessary, sick appointments. Last well check was approx. 1 yr. ago.
- **Allergies:** PCN
- **Acute/Chronic health problems:** None to date except for problem presented this visit. Pt. denies any childhood illnesses.
- **Prior illnesses and injuries:** Denies hx of heart disease, MI, kidney disease, GI disease, pulmonary disease, CA, TB, STIs, HIV/AIDs, urological problems, drug/ETOH abuse, and psychiatric illness. Denies any injuries
- **Previous operations:** None
- **Hospitalizations:** None. No surgical history.

- **Immunization status:** Pt. states that she is up-to-date on immunizations as needed for work in the healthcare field; she does receive the annual fly vaccine. If she did not, it would be recommended to receive annual flu vaccine
- **Screening/Diagnostic test:** Pt. states she had a PAP smear last year and does SBE monthly.

Family History (FH):

- Pt. is adopted and has no information regarding biological parents health history. Her adopted parents are both alive and in good health. She has 2 adopted siblings: 1 older brother in good health, 1 older sister in good health.
- Pt. denies knowledge of any family history of asthma, glaucoma, MI, HF, CA, TB, DM, hemophilia, STIs, HIV/AIDs, urological problems, drug/ETOH abuse, family violence, mental retardation, epilepsy, congenital abnormalities, or psychiatric illness

Social History (SH):

- Marital status: Single
- Occupation: RN
- Education: graduated college
- Lifestyle: lives alone, enjoys daily walks and hanging out with family and friends.
- Religion: Catholic
- Habits: denies tobacco use, denies illicit drug use, admits to occasional glass of wine with dinner ("once per week; maybe every other week"), admits to daily caffeine intake to include at minimum of once large cup of coffee and at maximum 3 large cups of coffee
- Resources: BCBS

Review of Systems (ROS):

- **Constitutional symptoms:** Pt. states SXs have worsened over the last 3 weeks, denies fever, chills, fatigues, infections, loss of appetite, denies unintentional weight loss or weight gain
- **Eyes:** Pt. does not wear eye glasses, uses corrective lenses to see ("20/25" vision without corrective lenses as stated by pt.), denies eye pain. Last eye exam ~ 6mos. ago (encouraged to continue having yearly eye screenings), denies vision changes, and denies poor eyesight.
- **Ears, nose, mouth, and throat:**
    - **Ears:** Denies hearing loss or changes in hearing, denies pain. Denies use of assistive hearing device, tinnitus, or vertigo.
    - **Nose:** Denies sense of smell, denies drainage, denies congestion, denies pain, denies epistaxis.
    - **Mouth**: Denies cigarette use, last dental exam ~ 6mos. Ago without any problems (encouraged to continue regular dental exams), denies pain, denies dentures, denies gum bleeding or ulcers, and denies change in sense of taste.
    - **Throat**: Denies throat pain, denies dysphagia, no hoarseness
- **Cardiovascular:** Denies chest pain, denies palpitations, denies SOB, denies activity intolerance, denies swelling, no recent diagnostic test or studies

performed, denies hypertension, denies murmurs, denies varicose veins, denies swelling. Pt. states that she engages in a moderate activity level twice weekly, goes on "long" walks almost daily. Would recommend baseline cholesterol levels been drawn since nothing has been taken yet.

- **Respiratory:** Denies cough, denies difficulty breathing, denies wheezing, denies phylum, denies history of recurrent respiratory infections, denies exposure to TB; last TB test was this past August 2015 and results were negative, denies exposure to second hand smoke.
- **GI:** Denies loss of appetite, pt. states she usually has a good appetite that usually includes an adequate amount of fruits, veggies, whole grains and meats, denies tenderness, denies N/V, denies constipation or diarrhea, denies any bloating, denies heartburn denies any food intolerances, Pt. admits to having a normal bowel movement daily to include a soft appearance, denies hemorrhoids, denies mucous in stools.
- **GU:** denies dysuria, denies problem with urination (nocturia and incontinence), denies history of stones, sexually active in a monogamous relationship, denies any discharge from genitals, denies any history of STI's or kidney stones.
    - **Women:** pt. states that her onset of menses was at age 13 **Time:** pt. states that her cycle is regular and occur every 30 days **Duration:** bleeding cycle last 7 days. **Amount:** pt. states that she usually goes through one large box of tampons per cycle (approx. 36 tampons) pt. states that bleeding is usually moderate on day 1-2 and then becomes mild days 3-4 and on days 5-7 are light days that turn to spotting (pt. states that she will usually wear a panty liner on the last day of period d/t scant blood flow), denies clots.
    - Pt. denies any pregnancies and has no children (G0P0), LMP 9/14/2015. Pt. uses a period tracker app to keep up with cycles. Pt. uses condoms as form of birth control. Pt. admits to having a PAP smear within the last year with no abnormal results. (Recommendation to have PAP every three years if had two normal PAP results back to back)
- **Musculoskeletal:** walks daily, pt. states she gets 30-45 minutes of exercise twice a week, wears safety belt, denies neck pain and stiffness, denies any joint swelling, denies changes in ROM, denies back pain, denies back injury, denies any osteoporosis history.
- **Integumentary:** denies any changes in skin and hair, pt. uses moisturizer with sunscreen in it. **Breast**: pt. states that she performs SBE monthly in the shower. Admits to feeling a small pea sized lump on left breast at 3'oclock point that is painful if touched ("feels like you are pushing in on a bruise"). Says that she began to feel it 3-5 months ago. Denies discharge, denies dimpling of breast. Pt. has not received a mammogram yet (pt. states that she is aware that the 40 is the age at when to have annual mammograms
- **Neuro:** denies weakness or pain, denies syncope, denies numbness or tremors, denies loss of memory, denies severe headaches, and denies any involuntary movements.
- **Psych:** denies mood changes, denies depression, anxiety, nervousness, or insomnia. Pt. denies any suicidal ideations.

- **Endocrine:** denies any problems with temperature intolerance, denies polydipsia, polyphagia, polyuria, and/or changes in skin, hair, or nails, denies unexplained wt. loss
- **Hematologic/lymphatic:** denies anemia, denies bruising, denies fatigue, denies history of blood transfusions, and denies swollen or tender glands. Unknown family history of anemia
- **Allergic/immunologic:** pt. denies seasonal allergies, denies allergy testing, denies use of steroids, pt. is up-to-date on immunizations.

Objective Data:

- **Constitutional symptoms:**
  - Alert with normal affect, no acute distress, no respiratory distress. Well hydrated and appears healthy. Appearance, behavior and speech are appropriate.
  - Temp: 98.7, 132/76 sitting left arm**,** Pulse 66, Wt. 130 lbs, Ht. 66 inches, BMI 21.0, O2 sat 98%
- **Eyes:** EOMs intact, conjunctivae clear, sclera white, no lesions, PERRLA noted, no nystagmus, no periorbital edema.
- **Ears, nose, mouth, and throat:**
  - **Ears:** No masses, lesions or tenderness. TMs pearly gray with landmarks intact.
  - **Nose:** No deformity of the nose noted, mucosa pink, nasal cavities clear, clear turbinates, no sinus tenderness.
  - **Throat:** Neck is supple with good ROM, thyroid normal, no masses or lymphadenopathy noted. Mouth mucous membranes pink and moist, no masses or lesions, denies dentures, teeth are white with no dental caries noted, tongue midline. Throat is pink, no lesions, uvula midline.
  - No sign of enlarged thyroid upon inspection/palpation
- **Cardiovascular:**
  - Apical pulse noted at 66 per minute, regular rate and rhythm, no murmur, S1 and S2 noted with S2 louder at the base of heart, no abnormal heart sounds.
  - Negative JVD, neck is supple, no bruits heard over carotids, no peripheral edema, radial and pedal pulses +2 bilaterally
- **Respiratory:**
  - Respirations 16, no distress noted, no SOB
  - Auscultation - clear breath sounds anterior and posterior, no rhonchi, rales, wheezing, retractions or distress.
  - Inspection and palpation – chest is symmetric with good expansion, equal wall expansion, appropriate fremitus vibrations throughout, resonance on percussion
- **GI:**
  - Inspection **-** No evidence of mass or hernia.
  - Auscultation - Bowel sounds are normal.
  - Percussion & Palpation: No tenderness noted. No CVA tenderness, non distended, not enlarged and no guarding or rebound tenderness.

- **GU:**
    - Bladder is non-distended.
    - Pelvic Exam revealed no abnormalities, bimanual exam of uterus and ovaries normal, no abnormal discharge noted, no lesions, did not perform speculum exam.
- **Musculoskeletal:** No somatic dysfunction, pain or masses noted. No swelling. Full ROM displayed. Strong strength = bilaterally
- **Integumentary:** No rash, no lesions, no abnormal moles noted. M/M moist, skin turgor good. Warm and dry to touch, no swelling noted. Pulses present +2 equal bilaterally.
    - **Breast exam -**
      Inspection: no dimpling or abnormalities noted upon inspection
      Palpation: **Left breast:** palpated small nodule on left breast at 3'oclock position; freely mobile, tender, approx. < 1cm in diameter. **Right breast:** denies tenderness, pain, no abnormalities noted.
- **Neuro:** A&Ox3 responds appropriately, normal affect, no atrophy, no weakness, no tremors noted, normal gait. Cranial nerves I-XII intact.
- **Psych:** General appearance appropriate, responses and speech are appropriate, no signs of depression or suicidal thoughts.
- **Hematologic/lymphatic:** no bruising, fever, or swelling noted, no acute bleeding or trauma to skin.

Diagnostic Testing:

1. Mammogram – will detect calcifications but cannot show if density is solid or cystic, thereby if something is noted in mammogram will need to have ultrasound.
    a. Results were normal.
2. Ultrasound – will differentiate between solid and cystic masses.
    a. Results indicated no malignancy or abnormal tissue was noted.

Assessment (A):

- **Level of visit:** 99214
- **Differential Diagnoses list:**
    a) Non-cyclical Mastalgia - d/t c/o pain and tenderness in breast.
    b) Cyclical Mastalgia – d/t c/o pain and tenderness in breast, need to assess for relation of pain and tenderness to menstrual cycle.
    c) Costochondritis - d/t c/o pain and tenderness in breast that could be mistaken for chest pain.
    d) Tietze Syndrome – could be indicated if swelling accompanied pain and it was in chest not in breast tissue.
- **ICD-9 code:** 611.71
- **ICD-10 code:** N64.4
- **Definitive Diagnosis**
    - Non-cyclical Mastalgia – d/t pain that has progressed over the last few months.
- **Justification of ordering additional data:**

- S/S warranted a need to rule out malignancy as well as no knowledge of familial history of breast cancer.
- Left breast pain that has been persistent
- Left breast nodule noted on breast exam

- **Diagnosis list**
  - **1. Acute self-limited problems:**
    - Non-cyclical Mastalgia
      - Pt. educated on mammogram and results
      - Pt. educated on the need to decrease caffeinated beverages
      - Pt. educated to wear full coverage bra (i.e. sports bra)
      - Pt. educated on the need to eat a diet rich in veggies, fruits, and whole grains and low in fat
      - Pt. educated to not put pressure (keep touching) area of tenderness.
      - Pt. educated on non-pharmaceutical therapy to include the use of vitamin supplements with A, B, or E or Primrose Oil.

        Pt. educated on the use of pharmaceutical therapy (Danazol and tamoxifen citrate) used for severe cyclic Mastalgia but pt. refused this route instantly.
  - **2. Chronic health problems:**
    - None at this time have been identified for pt.
  - **3. Health maintenance:**
    - Review pt. vaccinations and recommend any needed vaccinations. Recommend annual influenza vaccine
    - Continue to receive annual health wellness examinations
    - Continue monthly SBE
    - Decrease caffeine intake, do not quit abruptly as this can lead to withdrawal HAs therefore wean away from caffeinated beverages over a weeks time.
    - Eat a diet rich in veggies, fruits and whole grains and low in fat
    - Drink plenty of water (8 cups per day)
    - Continue yearly eye exams
    - Continue dental checks every 6 mos.
    - Track breast pain/tenderness (can use Period Tracker app) by keeping a diary/note of what foods/drinks pt. intake
    - Wear supportive bra
    - Exercise daily for 30 minutes or more
    - Avoid risk-taking behaviors such as ETOH, tobacco, and promiscuity.
    - Safe sex or abstain

Plan (P):
Pt. educated on mammogram and ultrasound and counseled regarding having a Mammogram and if something is noticed on mammogram an ultrasound will be performed the same day before she leaves. Pt. counseled on the non-pharm treatments for

mastalgia including: wearing a supportive bra, decreasing/quit caffeine intake, eating a diet that is low-fat and taking vitamin supplements with A, B, or E or Primrose Oil may be tried. Pharmacologic treatment can include hormone treatment to include birth control or Danazol (Pt. expressed that she did not want to go this route, “end of story”) Pt. can continue to take Ibuprofen or Tylenol PRN

Medication prescribed: No medication was prescribed at this visit

Follow-up: Pt. called and verified results of mammogram and ultrasound. Pt. was reassured that pt. doesn’t have a serious illness. Discussed taking Ibuprofen as needed and if pain worsens, nodule hardens, or any other abnormalities (discharge, dimpling, new symptoms, etc.) to follow-up with PCP. Also mammograms should be done at the age of 40 and annually after that.