Ian Wert

Pediatrics H/P #1

April 24th, 2024

Chief Complaint : "My nose is runny X 4 days and my right ear hurts X2 days"

HPI: 8 y/o male with no significant PMH presents to the outpatient pediatric clinic with his father with complaints of nasal congestion for the past 4 days and right ear pain for the past 2 days. The boy's father states that his son had presented with a cold roughly one week ago which first presented with a sore throat and mild fever (100.6F) which progressed into nasal congestion, and he has now been complaining of right ear pain and has been pulling at his right ear for the past 2 days. His father states that his son has had numerous ear infections in the past. The boy reports that his pain feels like a burning sensation and denies any radiating pain. The father reports that they have been using Tylenol since he initially presented with a fever and now for his ear complaints. The boy denies any changes in hearing, recent swimming, drainage, foreign body sensation, current fever, nausea, vomiting, diarrhea, changes in appetite, headaches, sick contacts, and recent travel.

Past Medical History: Denies, Father states his son is up to date on all immunizations

Past Surgical History: Denies

Past Hospitalizations : Denies

Medications: None

Allergies: NKDA

Family History:

Mother 37 – living, no significant PMH

Father 41- living, no significant PMH

Younger brother 4 – no significant PMH

Grandparents – unknown

Social History:

Patient lives in a smoke free, pet free house in Queens with his parents and younger brother. He is currently in 3rd grade and has many friends at school. His exercise consists of recess and riding his bicycle with his friends. His diet consists of the school lunch program and his mothers home-cooked meals.

Review Of Systems:

General – Denies fever, chills, night sweats, changes in appetite, weight gain/loss, or fatigue.

Skin, Hair, and Nails- Denies rashes, bruises, or discolorations.

Head: Denies headaches, recent head trauma, or dizziness

Eyes: Denies any changes in vision, eye pain, pruritis.

Ears: **Reports right ear pain,** denies, discharge, tinnitus, loss of hearing

Nose/ Sinus: **Reports nasal congestion and discharge,** denies epistaxis, swelling, sinus pressure

Mouth and Throat: Denies sore throat, dysphagia, hoarseness, cough, bleeding gums

Neck: Denies swelling, denies limits in range of motion

Pulmonary system: Denies cough, shortness of breath, wheezing.

Cardiovascular system: Denies chest pain, palpitations, syncope, cyanosis.

Gastrointestinal System: Denies vomiting, diarrhea, constipation, loss of appetite, abdominal pain, or blood in stool.

Genitourinary System: Denies urinary frequency, dysuria, oliguria, hematuria.

Musculoskeletal: Denies joint pain

Nervous System: Denies seizures, loss of consciousness

Physical Exam:

General: Well-groomed male who appears his stated age. He is active and appears well-nourished. He is in no apparent distress. He is dressed appropriately for the weather.

Vitals:

Temp- not performed

BP- not performed

HR- 92 BPM, regular rate and rhythm

RR- 22 breaths/min, unlabored

SPO2- 100% on room air

WT- 25kg

Skin- Warm and moist, good turgor. No scars, erythema, discoloration, or lesions.

Hair: Appropriate quantity, texture, and distribution. No lice or dandruff.

Nails: No clubbing, cyanosis, paronychia.

Eyes: Symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera are white, cornea clear, conjunctiva pink. EOM's intact.

Ears: Symmetrical AU. No masses, trauma, or lesions noted to the external ears. No discharge/foreign bodies noted in external auditory canals AU. **Right erythematous, bulging TM with lack of light reflex**. Left ear TM pearly gray and intact with light reflex.

Nose: **Bilateral nasal mucosa erythema with non-purulent watery discharge.** No deformities or trauma. Septum midline.

Mouth & Pharynx: Oral mucosa is pink and moist. Good dentition. No masses or lesions. Tonsils present with no erythema or exudates. Uvula is midline.

Neck: No cervical lymphadenopathy. Trachea is midline. Supple and non-tender to palpation. Thyroid non tender to palpation.

Cardiac: Regular rate and rhythm. Distinct S1 and S2 without murmurs, gallops or rubs.

Lungs: No signs of respiratory distress. No accessory muscle use. Clear to auscultation bilaterally. No adventitious lung sounds.

Abdomen: No lesions, masses, discoloration, swelling upon inspection. Non-tender to palpation with no rigidity, guarding, or rebound tenderness noted.

Differential Diagnosis:

1. Acute Otitis Media
2. Acute Otitis Externa
3. Foreign Body in right ear

Assessment:

8 y.o male with no significant PMH presents with right ear pain and nasal congestion secondary to viral URI for the past 2 days. Significant findings upon physical examination was right ear bulging and erythematous TM with lack of light reflex. The patients history, chief complaint, and physical examination findings indicate acute otitis media secondary to a viral URI.

Plan:

1. Start amoxicillin 10mL (2 teaspoons) BID of 400mg/5mL X 10days (80-90 mg/kg/day)
2. Patients father advised on the importance of his son hydrating with fluids as well as completing the prescribed antibiotic medication even if his sons symptoms have resolved.
3. Patient advised to contact office if symptoms worsen or do not improve within 10 days.