Endocrine Scenarios

Scenario 1 of 6:
Reason for Visit: Follow-up and medical management

HPI: The patient is a 28-year-old woman being seen for follow-up. She has a 6-year history of hypothyroidism, stable on meds for years. She is now 7 weeks pregnant with her first child.

Past Medical History: As above.

Review of Systems: As above.

Physical Exam: Noncontributory.

Laboratory results from a month ago showed a serum thyroid-stimulating hormone (TSH) level of 2.0 mU/L and a free thyroxine level of 1.1 ng/dL.

Assessment and Plan: Hypothyroidsim in pregnant patient - recheck serum TSH level.

Scenario 2 of 6:
Reason for Visit: Annual physical examination

HPI: The patient is a 32-year-old woman presenting for her annual physical. The patient is without complaints, she denies weight change, sweating, change in bowels or appetite. No anxiety or palpitations.

Past Medical History: None.

Review of Systems: As above.

Physical Exam: Vital signs are WNL. Physical exam is normal except for a small, palpable mass in the thyroid gland. Mass is nontender. All other findings are normal.

Laboratory results show a thyroid-stimulating hormone (TSH) level of 2.0 mU/L and a free thyroxine (T_4) level 2.1 ng/dL.

An ultrasound of the thyroid gland reveals a normal-sized gland with a 1.8-cm hypoechoic right midpole nodule.

Assessment and Plan: Solitary thyroid nodule - refer for final needle aspiration/biopsy.

Scenario 3 of 6:
Reason for Visit: Follow up and medical management

HPI: Patient is a 42-year old female with a long history of Type 1 diabetes mellitus who presents for follow up of blurred vision. Patient presented to the office a week ago with complaints of mild blurring of her central vision bilaterally. She was referred for a retinal exam which revealed macular edema and new neovascularization. Recent hemoglobin A_{1c} values have ranged between 7.2% and 8.0%.

Past Medical History: Hypertension, on meds. Type 1 diabetes, on insulin regimen.

Review of Systems: As above.

Physical Exam: BP= 112/68. Physical exam is unremarkable.

Assessment and Plan: Proliferative diabetic retinopathy and macular edema - refer patient for laser photocoagulation.

Scenario 4 of 6:
Chief Complaint: Recurrent urinary tract infections

HPI: Patient is a 45-year old woman with history of poorly controlled Type 1 diabetes mellitus being evaluated for recurrent urinary tract infections. Over the past 5 months, she has had six urinary tract infections. Home blood glucose readings range between 150 and 300 mg/dL (8.3 and 16.7 mmol/L) and hemoglobin A_{1c} values are typically greater than 8.7%.

Past Medical History: Type 1 diabetes, on insulin regimen.

Review of Systems: Urination of small volumes, difficulty initiating urination, and urinary dribbling.

Physical Exam: BP= 140/86, P= 88. There is no abdominal pain. She has decreased sensation to both pin-prick and vibration below the knees.

Assessment and Plan: Uncontrolled Type 1 diabetes mellitus, bilateral lower extermity diabetic neuropathy, and recurrent UTIs. Refer for EMG testing, start suppressive antibiotics, and adjust insulin regimen.

Scenario 5 of 6:
Reason for Visit: Follow up and medical management

HPI: Patient is a 64-year old man with a 20-year history of type 2 diabetes mellitus who presents to the office for follow-up. He has diabetic nephropathy, peripheral neuropathy, and has previously required laser surgery for his retinopathy.

Past Medical History: Hypertension, on meds. Type 2 diabetes, on insulin regimen.

Review of Systems: As above.

Physical Exam: BP= 142/80, P= 70. Results of cardiopulmonary and abdominal exams are normal. There is 2+ edema below the knees bilaterally.

Laboratory results:

Potassium	5.7 meq/L (5.7 mmol/L)
Creatinine	2.4 mg/dL
GFR	34
24-hour urine albumin	200

Assessment and Plan: Progressive diabetic nephropathy - add diuretic, consult nephrologist.

Scenario 6 of 6:
Reason for Visit: Foot ulcer

HPI: Patient is a 52-year old woman with a history of type 2 diabetes mellitus who presents complaining of a painful ulcer on the heel of her left foot. This has been present for three days. There is redness, but no discharge. No previous history of diabetic foot infections.

Past Medical History: Type 2 diabetes on oral medications.

Review of Systems: As above. No fever or chills. No left foot swelling or discoloration.

Physical Exam: Afebrile, BP= 120/72, P= 78, and RR= 14. Well-developed, middle-aged female. Left heel exam reveals a round 1.2 cm ulcer with surrounding erythema, but no purulent discharge. It appears to be approximately 2 mm deep without tunneling. Subcutaneous fat is visible. There is no necrosis or other skin lesions apparent on the foot. No lymphadenopathy. Remainder of exam is normal.

Laboratory studies are significant only for a leukocyte count of 14,000/mL (14×10^9/L).

A radiograph of the foot shows no evidence of bone involvement and a minimal amount of edema.

Assessment and Plan: Diabetic foot ulcer - start antibiotics.