**FNP Children/OB**

**SOAP NOTE 2**

Presented to:

#### Ms, Lisa Hill, RN, MSN

In Partial Fulfillment of the Requirements for the Course

**FNP GNRS 5670 FNP Children/OB**

Presented by

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The University Of Texas Medical Branch at Galveston School of Nursing

**A. Subjective:**

*Demographic data:*

TAM, SHE is a 24 years-old Hispanic female born 02/27/1988 lives in Katy.

*Chief Complaint:*

Patient came in to the clinic for initial preconception consult, but also verbalized post coital bleeding, pelvic pain and occasional dysuria the last three days. “I feel some kind of pain in my hips and bladder. I have been noticing occasional blood in the urine especially after sex and sometimes it hurts to pee. I have been dating this new guy for 2 weeks now. I hope he does not have a disease”

*History of presenting illness:*

Patient came in with the concern of post coital bleeding, pelvic and bladder pain with occasional dysuria for the last three days. She noticed blood in her urine but denies urinary frequency and urgency. She noticed whitish yellowish discharge but denies any unpleasant odor or fever. She is concerned about her recent sex partner and sounds worried about STD. She denies any contraceptive use from both of them except for withdrawal.

 *Current Health Status*

Patient had no known food & drug allergies. She denies taking any medication except for Advil as needed for minor pains. Childhood immunizations complete, denies smoking, drinking or recreational drugs. Does not drink coffee but has no restrictions with food. Diet consists of meat with tortilla, taco, kolaches and donuts and admits that she barely exercises. Patient denies performing breast exam regularly. She was seen here in the clinic last year for routine visit. She never had pap-smear and mammogram. She denies getting her flu shot last year. Her last PPD was 2008.

*Past Medical History:*

Patient considers herself as normally healthy, denies any medical problems. She denies any surgeries, blood transfusions and hospitalizations. Have not been involved in any MVA, denies any psychiatric or any serious illness. She had a normal vaginal delivery at 40 weeks four years ago.

*Social History:*

She lives with her daughter and mom in a 2 bedroom apartment in Katy. Family and friends is her social support system. Occasionally, she goes to the nearby Catholic Church. She works at Taco place as a waitress and her mom works at the kolache and donut place. Major source of income is from her and her mother and she also receives some help from welfare. Her mother helps her in taking care of her kids after school.

*Sexual History:*

Patient is G1P1AB0, LMP is 10 days ago, and cycle is 28 days lasting for 4-5 days with no abnormal bleeding. Menarche was at the age of 11 and was sexually active since the age of 15 yrs. Patient uses sanitary pads and denies the use of tampons or douching. She admits to have 5 sexual partners since the age of 15. She is dating a new guy for the last two weeks and denies any method of contraception except withdrawal. Her first pregnancy was unplanned at the age of 20 yrs and had full term, normal vaginal delivery.

*Impact on lifestyle:*

Patient complains of the symptoms being uncomfortable and is worried that it might get worst but otherwise she is able to do her regular day to day activities.

*Patient Explanatory Model:*

Patient states “I think I have an infection down there and I am concerned about STD”.

*Family History*

Father: Denies any medical problems.

Mother: Denies any medical problems.

 Other members of the family: unknown medical history

*Review of Symptoms*:

General: Good sense of well being, no ADL limitations

Diet: High in carbohydrates especially tacos, donuts, beans.

Skin: no discomfort, denies any itching in her vaginal area.

Head and neck: denies any headache or abnormalities

Eyes: denies visual problems nor wearing any corrective lenses

Ears: denies hearing difficulty

Nose: denies congestion nor difficulty breathing

Throat & mouth: denies dysphagia, gingivitis and sores

Breasts: denies pain nor fullness

Cardiovascular: denies palpitations, chest or back pain

Lungs: denies difficulty in breathing

Gastrointestinal: complain of lower abdominal pain but denies nausea, vomiting, anorexia and weight loss. Normal BM average of 1 daily

Genital: Dyspareunia with post coital bleeding and noticed whitish yellowish discharge.

GU: Dysuria with occasional hematuria accompanied with bladder and pelvic pain. Denies nocturia or frequency.

Musculoskeletal: extremities optimal functioning, denies any leg swelling and denies any joint pain

Neuro/Psych: no fainting, seizures, motor or sensory loss.

Endocrine: No known thyroid issues, temperature intolerance, sweating average. No symptoms or history of diabetes.

**B. Objective Information**

Vital signs: BP – 113/59; PP – 67; RR – 18; T – 97.8; Ht 5’3” Wt 128lb; BMI 22.67

**General:** Patient observed to be in her normal state of health includes proper grooming and balance gait. No SOB, nail beds are pink in color with capillary refill of less than 1 second.

HEENT**: Head**: No deformity noted nor any signs of trauma, normal shape, no bumps & scrapes, healthy hair growth, face symmetrical**. Eyes**: noted normal vision, conjunctiva clear, with no abnormal drainage. **Ears**: Bilateral ears normal in appearance, no abnormal drainage, no redness nor swelling noted in the ear canal. **Nose**: No noted mucus running down from the patient’s nose, normal mucosa, midline septum, no noted sinus tenderness. **Throat**: normal color with no swelling in appearance and no abnormal drainage noted, no dysphagia noted

**Neck**: Normal to touch, no jugular vein distension.

**Chest & Back**: Symmetrical chest rise with normal chest expansion upon breathing. Respiratory rate is normal with normal depth & pattern. No depression, bulging & crepitus in palpation. No breast nodules but noted left breast scar due to history of lumpectomy

**Skin:** Pink with no skin rash, sores & lesions noted. Palms cold and moist with good color. Nails without cyanosis and clubbing.

**Gastrointestinal:** Abdomen protuberant, bowel sounds active, mild suprapubic tenderness on palpation. Liver span 7 cm in right midclavicular line, edge smooth and palpable 1 cm below right costal margin. Spleen and kidney not felt and no costovertebral tenderness noted on palpation.

**Genitalia:** External genitalia without erythema, lesions or masses. No inguinal adenopathy. Vaginal mucosa pink, cervical redness & swelling noted with whitish yellowish homogenous discharge but no fishy or foul smelling odor, (+) chandelier sign (cervical motion tenderness). Cervix was friable upon swab sample collection and no visible discharge in the cervical os after collection. Uterus midline and no adnexal masses. Rectovaginal wall intact, without masses. Stool brown and hemoccult negative.

**Musculoskeletal:** No joint deformities and good range of motion noted.

**Assessment:**

**1. Pelvic Inflammatory Disease (PID)**

Pelvic inflammatory disease is a term for infection of the female reproductive organs such as ovaries, fallopian tubes, uterus, cervix or vagina, characterized by abdominal pain, dysuria & dyspareunia. Most common causes are STD’s (gonorrhea and Chlamydia), foreign device such as IUD and abortion. The patient in this case complained of pelvic pain, dysuria and dyspareunia. In assessment, she displayed a Chandelier’s sign, supra-pubic tenderness with yellowish discharge which leads us to a diagnosis of PID. (Hackley, 2012); (Bickley, 2009).

**2. Mucopurulent Cervicitis:**

Mucopurulent cervicitis is caused by Chlamydia trachomatis or Neisseria gonorrhoeae is charactererized by a thick,yellowish- white discharge coming from cervical os. Patient complains of pruritis, purulent discharge, dysuria, or frequency and occasional postcoital bleeding. Erythema, friability and ectocervical ulceration is present on examination. Our 1st diagnosis leads to this due to the reason that there was evidence of cervical redness, swelling, yellowish discharge, post coital bleeding and dyspareunia. She also had history of sex at an early age with multiple sexual partners. A possibility of STD from her recent sexual partner may have also caused this. (Hackley, 2012); (Goroll, 2011)

**3. Acute cystitis:**

Acute cystitis is the infection of the bladder, or of the urethra and sign and symptoms include bacteriuria `,frequency, urgency, suprapubic pain and or hematuria. It is defines as an invasion of microorganism to the bladder. Women tend to get infections more often than men because their urethra is shorter and closer to the anus. For this reason, the patient is more likely to get an infection due to unprotected sexual intercourse. Dysuria with supra-pubic tenderness and yellowish discharge was the reason why this 3rd diagnosis is chosen. Possible STD from her recent sexual partner cannot be ruled out. (Hackley, 2012), (Bickley, 2009)

**Plan:**

***1. Diagnostic***

***CBC*:** A complete blood count with differential is helpful to evaluate PID ( Goroll,2009).

 **Urinalysis** (UA): UA should be done to check WBC & RBC which signifies infection and blood in the urine. It also checks nitrites which signifies gram (-) bacteria in the urine such as E-coli (Goroll, 2009).

**Pregnancy Test**: Serum Beta HCG should be done to rule out ectopic pregnancy (Goroll, 2009).

**Wet mount examination**: Increased WBCs on wet mount is strongly associated with bacterial vaginosis or the presences of gonorrhea or Chlamydia (Hackley, 2012).

**Cervical cultures**: DNA probe is the standard in determining the presence of Chlamydia and Gonorrhea (Dunphy, 2011).

**Imaging:** Laparoscopy and imaging can be used to obtain definitive diagnosis for PID when indicated. (Hackley, 2012).

 ***2. Therapeutic***

The CDC recommends empiric treatment for young, sexually active women with pelvic pain and exhibits uterine, adnexal tenderness or cervical motion tenderness on bimanual examination. The empiric treatment should be started for PID should be started waiting for the lab results (Hackley).

a). Ofloxacin 400mg orally twice daily for 14 days and Metronidazole 500mg orally twice daily for 14 days ( Hackley).

b). Azithromycin 1gram x 1 PO + Doxycycline 100mg PO BID x 7 days if suspected cervicitis. (Hackley) (Dunphy)

c). Motrin 600 mg q 8 for pain as needed for three days.

d). Bactrim (Sulfamethoxazole & Trimethoprim) 400/80mg q 12 hours x 7 days for cystitis. (Hackley, 2012), (Bickley, 2009)

***3. Education***

1 Avoid [chemical irritants](http://www.ncbi.nlm.nih.gov/pubmedhealth/n/pmh_adam/A000059/) such as douches and deodorant tampons.

2 . A monogamous sexual relationship with someone who is known to be free of any STD can reduce the risk. Monogamous means you and your partner do not have sex with any other people.

3 Consistent use of condoms greatly reduces the risk of transmission of STDs. Condoms are available for both men and women. A condom must be used properly every time.

4. Drink lots of fluids and urinate more. Recommend cranberry juice to acidify the urine. Educate effects and side effects of prescribed medications. Encourage proper nutrition and regular physical activity.

5. Discuss other methods of contraception and inform that she is at increased risk of unplanned pregnancy and STDs.

***4. Follow-up***

Return to the clinic immediately if worsening of symptoms such as persistent fever, chills, abnormal discharge or other signs of infection. Otherwise follow up in two weeks. Call for any questions.

**Reference:**

Hackley, B., & Rousseau, M. (2012).  Primary Care of Women: A guide  for Midwives and Women’s Health providers.Boston: Jones and Bartlett.

Dunphy, L.M., Winland-Brown, J.E., Porter, B. O., & Thomas, D. J. (Eds.). (2011)  *Primary care:  The art and science of advanced practice nursing.* Philadelphia:  F.A. Davis.  Chapter 9, Respiratory problems.pp. 331-417.

Goroll, A.H. and Mulley, A.G. (2009). *Primary Care Medicine Office Evaluation and Management of the Adult Patient*. Philadelphia: Lippincott. Part IV Respiratory Problems:  Chapters 39, 43,44,45,50,51.

Hackley, B., & Rousseau, M. (2012).  *Primary Care of Women: A guide  for Midwives and Women’s Health providers.*Boston: Jones and Bartlett. Chapters 12 & 13

 Bickley, L. S., & Szilagyi, P. G. (2009). *Bates’ Guide to Physical Examination and History Taking* (10th ed.). Philadelphia: Wolters Kluwer Lippincott Williams and Wilkins.

Dains, J.E., Ciofu Baumann, L. & Scheibel, P. (2012). Advanced health assessment and clinical diagnosis in primary care. St. Louis, MO: Mosby.

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|  | Diagnosis 1 | Diagnosis 2 | Diagnosis 3 |
| Subjective Data | * Multiple sexual partners
* Sex at an early age
* Suspected STD
* Dyspareunia
* Bleeding after intercourse
 | * Dysuria
* Dyspareunia
* Pelvic dull pain
 | * Dysuria
* Pelvic dull pain
 |
| Objective Data | * **Friable cervix**
* Whitish to yellowish discharge
* Inflamed cervix
 | * Tenderness on the supra-pubic area
* Whitish to yellowish discharge
* **Chandelier sign** (cervical motion tenderness)
 | * Tenderness on the supra-pubic area
* White to yellowish discharge
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| Laboratory/Diagnostic Data | * CBC – to check for elevated
* BMP – to check for Na and K; also renal function represented by creatinine & BUN
* UA- to check WBC, RBC & nitrites
* Pap smear
* STD Panel: gonorrhea, chlamydia, syphilis, HIV, hepatitis and herpes
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