Case Report (Primary Care 2)

History of Present Illness:
A 72year-old patient presents to the GP office in the morning with pain in the right lower extremity. Mr. XY went skiing in the mountains a week ago. His leg has been gradually swelling, his calf hurts, and it is difficult to walk. He denies any injury.

Personal Details:

- Mr. XY, year of birth...

Medical History:

Family History:

- Father: died of Alzheimer's disease
- Mother: died of breast cancer at 57
- Sister: committed suicide at 35
- 2nd sister: had a stroke at 78
- 1 daughter: healthy

Personal History:

- Never seriously ill, had common respiratory infections without complications
- Scoliosis of the spine
- Nephrolithiasis in the left kidney
- Benign prostatic hyperplasia (referred to urology)
- Diverticulosis of the colon
- Myopia levis bilaterally with astigmatism in the left eye

Surgery:

- Left knee arthroscopy and medial meniscectomy in 2005
- Exostosis of the right external auditory meatus in 2005

Allergies:

- Pollen

Medications:

- Levocetirizin 5 mg, 1 pill daily

Epidemiological History:

- No contact with any infectious disease
- Had COVID-19 in November 2021
- Vaccinated against COVID-19 three times (last dose June 2022)
- Last flu shot: Influvac Tetra in November 2022
- Last tetanus shot: April 2015

Social History:

- Married, lives with family in a house

Professional History:

- University education, formerly a business manager, now self-employed, retired

Abusus:

- Non-smoker, occasional alcohol consumption, coffee twice a day

Status Praesens:

- Height/weight: 183 cm/95 kg
- Blood Pressure: 150/95 mmHg
- Pulse: 80/min
- SatO2: 96%

Physical Examination:

The patient is conscious, oriented to place, time, and person, cooperative, answers questions appropriately, and has fluent and intelligible speech. Gait is limited by calf pain in the right lower extremity. The patient has a normosthenic habitus with pink, warm skin, no icterus or cyanosis, no skin efflorescence, and normal skin turgor. Resting eupnoea is observed, and the patient is afebrile. The skull is mesocephalic with symmetrical innervation of n. VII. Tapping of the calva and over paranasal sinuses is painless, and trigeminal processes are painless. The eyelids show no leakage, and the eyeballs are in the middle position, free, and movable in all directions without nystagmus. Conjunctivae are pink, sclerae white, pupils round, anisocoric (long term, neurologically examined without pathology findings), and responsive to illumination and convergence. The tongue is midline, moist, without coating, and the tonsils are symmetrical, normotrophic without inflammatory changes, with quiet palatine arches and posterior pharyngeal wall. The neck has free movement in all directions, no signs of neck opposition, jugular veins are not enlarged, carotid pulsations are palpable symmetrically and auscultatory without murmur, lymph nodes are not palpable, and the thyroid is not palpable. The chest is symmetrical, evenly developing on respiration with clear chest breathing and a regular heartbeat, with 2 circumscribed echoes and undifferentiated murmur. The abdomen is above niveau, soft on palpation, not painful, with the liver and spleen not palpable, and tapotement bilaterally negative. Lower extremities show swelling of the right tibia + 1 cm compared to the left, with mobility of the right lower extremity limited by pain, the right lower extremity slightly warmer, skin color bilaterally unchanged, no trophic changes, maximum pain in the popliteal area, peripheral pulsation +, Homans sign +, and plantar sign +/-.

Differential Diagnosis:
a) Deep vein thrombosis
b) Lymphedema (Stemmer bilaterally negative)

c) Swelling after trauma, traumatic disability – muscle or ligament rupture, contusion (trauma negated by patient)
d) Subcutaneous cysts, tumors, hematomas
e) Neuropathy of peripheral nerve, lumbar spine disease with root irradiation to one lower extremity
f) Arthritic disorders (gonarthrosis)
g) (Erysipelas – no history of fever, chills, skin discoloration on lower extremities)

Recommended Investigations:

- Due to the presence of ultrasound in the adjacent office, the patient is immediately referred to angiologist for duplex sonography to assess the presence of thrombosis

Conclusion from the Angiologist:

- Distal provoked thrombosis in the right calf (2-3 intramuscular veins)
- Baker's cyst present in the right popliteal fossa
- Started on Eliquis 2x10mg for 5 days and then 2x5mg
- Blood count check in 10 days at GP
- Follow-up with vascular specialist in 3 months or immediately if necessary
- Elastic bandage recommended during the day

Other Possible Investigations:

- Wells score (4 points in our patient = high probability of phlebothrombosis)
- D-dimer (negative predictive value, increased in phlebothrombosis, postoperative conditions, after trauma, in pregnancy, in malignancy, infectious diseases, elevated bilirubin levels, etc.)

Suggested Therapy:

- Elastic bandage during the day, not at night
- Anticoagulation: Eliquis (apixaban) 10 mg twice daily for the first 5 days, then 5 mg twice daily for 3 months
- Active physical rehabilitation
- Follow-up with GP in 10 days
- Follow-up with angiologist in 3 months