

# ABMSP

AMERICAN BOARD  
MULTIPLE SPECIALTIES IN PODIATRY

## CERTIFICATION IN LOWER EXTREMITY GERIATRIC MEDICINE

### CASE STUDY

### QUESTIONS

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## Case Study #1

### History and Physical

**Chief concern:** Patient is an 85 years old female, who presents with her son with a chief concern of a painful right second digit. She is a relatively poor historian. Her son states that approximately 20 years ago she underwent hammertoe correction of the second digit. Patient states that over the last few years it has started to become difficult and painful to walk, especially barefoot.

**PMH:** NIDDM, HTN, and Dementia

**PSH:** Carotid endarterectomy, appendectomy, and hammertoe surgery

**MED:** Metoprolol, metformin, 81 mg ASA, Coumadin

**ALL:** PCN

**FH:** Arthritis, HTN, diabetes

**SH:** Denies etoh, 65 pack year smoker

### Podiatric Focused Exam

**Vascular:** Dorsalis pedis pulse ¼ B/L. Posterior tibial pulse non-palpable B/L. Capillary refill time is delayed at 10-12 seconds B/L. There is increase in proximal to distal cooling B/L.

**Neurological:** Gross epicritic sensation, 2 point discrimination and vibratory sensation is intact B/L. Deep tendon reflexes are WNL.

**Orthopedic/Musculoskeletal:** Restriction of dorsiflexion and plantarflexion is noted at B/L first MPJs, and right 2<sup>nd</sup> PIPJ. Dorsiflexed middle phalanx, in comparison to proximal phalanx of the right second digit is noted. There is also lateral deviation of the right third digit. Bilateral adductovarus of the 5<sup>th</sup> digits are noted. Ankle, STJ, and midtarsal joints are WNL.

**Dermatological:** Integument is atrophic and anhidrotic, with absence of pedal hair. Nails 1-5 are dystrophic, discolored, with varying levels of thickening. Maceration is noted in left 2<sup>nd</sup> and third interspaces. A hyperkeratotic lesion is noted on the plantar aspect of the right second PIPJ, with punctate center. No exposed bone or tendon, no malodor, no purulence identified

**Vital signs:** Blood pressure 160/112, pulse 85, respiratory rate 17, temp 98.9

**LABS:** HbA1c: 11.2, WBC: 9.8, INR: 2.8

**Radiographical analysis:** See attached plain films



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### Essay

In an essay format, please outline your descriptive diagnosis. Additionally, discuss how you would treat the described patient. This may include surgical and non-surgical treatment. Include in your discussion concerns, if any, regarding the patient's current or past medical history. This essay exercise does not have a right or wrong answer. It is an exercise in determining your medical logic for your specific treatment course.

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## Case Study #2

### History and Physical

**Chief concern:** A 75 year old male in pain arrives with his wife. He is complaining of redness and swelling of his right great toe. Patient is unable to wear a regular shoe or walk without pain. He states the pain began about a week ago. He denies any self treatment. The patient does have a fever and claims he “had pus out of my toe.” Patient claims history of raynauds.

**PMH:** Liver cancer, HTN,

**PSH:** Liver biopsy, back surgery (spinal fusion), cardiac stents

**MED:** Chemotherapy, norvausc, Lipitor, ASA, plavix

**ALL:** Penicillin, sulfa

**FH:** Father deceased – brain cancer; mother deceased - lupus

**SH:** Retired former smoker, former etoh abuse, denies recreational drugs

### Podiatric Focused Exam

**Vascular:** Bounding pulses 2/4 DP/PT bilateral, capillary refill time within normal limits b/l, edema right hallux

**Neurological:** Lt intact. SWMF 5.07 absent, vibratory absent, tendon reflexes WNL b/l

**Orthopedic/Musculoskeletal:** Range of motion a5 ankle joint, 1<sup>st</sup> MPJ, limited motion, pain on palpation right hallux; hallux malleus B/L

**Dermatological:** Right hallux medial border swollen, red distal with purulent drainage, no ascending erythema, nail ingrown

**Vital signs:** Blood pressure 145/76, pulse 85, respiratory rate 17, temp 99.1

**LABS:** ESR: 32, WBC: 11.1, INR: 3.1

**Radiographical analysis:** See attached plain films

**Radiographic examination:** No acute pathology noted

### Essay

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## Case Study #3

### History and Physical

**Chief concern:** Numbness and Falling. 73 year old male. Retired business executive. Patient relates increasing numbness over past 10 years. Recently complains of worsening balance and more frequent falls. Fell last week and sustained broken rib.

**PMH:** Hypertension, arrhythmia, gout and lower back pain

**PSH:** ORIF right ankle cardiac ablation, fusion L3 L4 L5

**MED:** Xarelto, metoprolol, diovan, allopurinol, HCTZ, gabapentin

**FH:** Cancer, heart disease, hypertension, diabetes (mother)

**SH:** non smoker, no alcohol use, previous ETOH abuse

### **Review of symptoms:**

Systemic: no fever, no chills, no recent weight change

Head: no headache

Neck: no neck pain

Otolaryngeal: no hearing loss, no tinnitus, no sore throat

**Pulmonary:** no dyspnea, no cough, and no wheezing

**GI:** normal appetite, no nausea, no vomiting, no abdominal pain, no diarrhea

**Musculoskeletal:** lower back pain

**Neurological:** occasional vertigo, no memory loss, numbness, stinging in feet, lower legs

**Skin:** no skin lesions or rash

### **Physical Finding**

#### **Vitals:**

BP-sitting L 140/80

Pulse sitting 88 BPM

Height 71 in

Weight 180 lbs

BMI 25.1

#### **Physical Exam:**

General appearance: well developed, well nourished, in no active distress

#### **Lower extremity exam:**

Vascular: Dorsalis pedis 3/4, B/L

Posterior tibial 2/4 B/L

No edema, no varicosities, normal capillary fill time

**Dermatologic:** Poor sensation to Semes-Weinstion 5.07 in 6/8 tested location. Decreased vibratory sensation

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**Labs:** Previous EMG, NCU inconclusive

**X-rays performed today:** bil feet 3 views finding no fractures, no dislocation, HAV noted B/L

**A/P:** intentionally left blank

### Essay

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