Patient Case #1

CC: Phantom limb pain

HPI: 84-year-old female, with a sensation of pain in right lower extremity (primarily forefoot) for approximately 8 years, and in left lower extremity (primarily ankle) for approximately 6 months. S/P right above knee amputation 10 years ago, left below knee amputation 8 months ago, revised to above knee 1 week later for septic joint. Non-diabetic; amputations done for PAD with non-healing wounds, dry gangrene. Proprioceptive sensation is always present in phantom limbs, but pain is intermittent (can go months without significant pain). Episodes of pain are not always predictable; they can be associated with prolonged sitting in her wheelchair or with psychoemotional distress.

PMH:

- PAD
- Chronic heart failure
- Dyslipidemia
- HTN

Surgical Hx.:

- Multiple lower extremity arterial bypasses and endovascular procedures
- Bilateral AKA
- Aortic valve replacement (tissue valve)

FH:

- CAD (father)
- HTN (parents)
- Gout (father)

SH:

- Distant ex-smoker, smoked for about 7 years
- Moderate alcohol, no illicit drugs
- Retired nurse
- Vietnam veteran
- Single, lives alone
- Enjoys reading

Allergies: Penicillin, Sulfa, Statins

Medications:

- Furosemide
- Duloxetine
- Isosorbide Mononitrate
- Metoprolol Succinate
- Sacubitril/Valsartan
- Aspirin

ROS:

- Fatigue
- Dyspnea on exertion (chronic)
- Phantom limb pain as above

Exam:

HEENT unremarkable

Neck supple, no JVD

Lungs clear bilaterally

Heart regular rate, III/VI systolic, II/VI diastolic murmur,

Well-healed bilateral AKA sites

Tongue: Pale, swollen, scalloped edges. Thin coating.

Pulses: Weak at proximal position on the left, middle position on the right.

Patient Case #2

63-year-old AA male presents with his wife with complaints of:

Chief Complaint: Transient left leg numbness and weakness, blurred vision, headache, fatigue, palpitations, chest pain with right arm weakness.

History of Present Illness:

He attributes these symptoms to a work-related electrocution with brief loss of consciousness nearly 1 year ago. Pt was under care of workman's comp for approximately 2 weeks after incident but was cleared thereafter. Recent example of pt's transient L leg weakness occurred where he experienced a 30 second period where he was dragging his leg around The Dollar Store. Pt has been referred to neurosurgery; however, has been unable to establish d/t finances and insurance issues.

MRI brain + CT angio stroke (May 2025) shows no evidence of recent ischemic changes or other acute intracranial process. Mild cerebral volume loss.

CT C-spine w/o contrast (May 2025) shows no acute osseous abnormality identified. Alignment and vertebral body heights are maintained. Status post C3-5 ACDF. Mild multilevel degenerative changes at nonsurgical levels. Multilevel mild-to-moderate foraminal narrowing.

CT L-spine w/o contrast (Feb 2025) Stable small posterior disc bulges from L3 through S1. No evidence of large acute disc herniation. Stable mild loss of vertebral body height at L5 when compared to CT in July 2023.

Past Medical History:

- CVA
- T2DM with microalbuminuria and polyneuropathy
- HTN
- h/o pancreatitis and hepatic steatosis
- Angioedema/allergies
- Lumbar radiculopathy with bulging lumbar disc
- Vitamin D deficiency
- R inguinal hernia (established with surgeon but was unable to get surgery done d/t uncontrolled DM)
- h/o elevated PSA with urinary bladder wall thickening

Surgical History:

- Anterior cervical discectomy w/fusion (ACDF x3), posterior cervical laminectomy x1

Family History:

- HTN (mother)
- Heart Failure (mother)
- DM (mother)

Lifestyle/Social History:

- Never-smoker
- Drinks approx. 64 oz beer/night, which has increased d/t recent stressors.

- Filed for SS disability after electrocution but was working in the interim and has returned to his previous work where the electrocution occurred

Allergies: Lisinopril

Medications:

- Amlodipine 5mg daily
- ASA 81mg daily
- Cholecalciferol 1000 unit tablet
- Duloxetine 20mg daily
- EpiPen 2-Pak
- Etodolac 400mg tablet
- Famotidine 20mg BID
- Gabapentin 300mg TID
- Hydrocodone-APAP 5-325mg Q6H PRN
- Glargine 20 units daily
- Rosuvastatin 5mg daily
- Tamsulosin 0.4mg daily

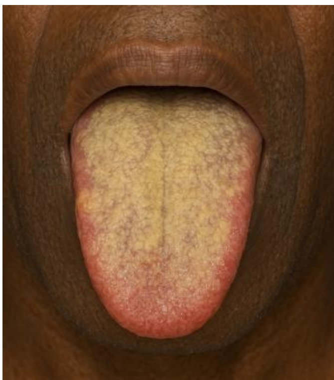
Review of Systems: See HPI above

Vital signs:

BP:	(!) 134/81
Pulse:	77
Resp:	16
Temp:	97 °F (36.1 °C)
TempSrc:	Skin
SpO2:	98%
Weight:	160 lb 12.8 oz (72.9 kg)
Height:	6' 1" (1.854 m)

Physical exam: No acute distress; RRR S1/S2, Chest wall tenderness, Lungs clear B/L, R groin/inguinal mass, paraspinal hypertonicity, negative SLR B/L

Tongue:



(Image generated from ChatGPT)

Pulse: Weak and slow at middle position on L hand (deep and superficial), thin and wiry at proximal position on R hand (deep and superficial)

Patient Case #3

CC:
Headache with nausea and photophobia.

HPI:
M.L. is a 47-year-old financial analyst presenting with recurrent throbbing headaches that began several months ago and have gradually increased in frequency. The pain typically starts behind one eye and radiates to the temporal and occipital regions. During severe episodes, she experiences nausea, mild photophobia, and noise sensitivity. Symptoms initially worsened after a period of poor sleep, increased work stress, and frequent skipped meals. Over-the-counter medications offered only partial relief, and she noticed associated neck and shoulder tightness. Over the next two weeks, the acute throbbing pain decreased but was followed by persistent bilateral temporal pressure and upper-back tension that worsened with emotional stress or missed meals. At six weeks, she reported fewer severe episodes but continued to have intermittent premenstrual neck tightness and occasional low-grade headaches. She seeks evaluation to improve symptom control and prevent recurrence.

PMH:
Unremarkable.

Surgical Hx.:
None.

FH:
Mother with history of migraine.

SH:
Sedentary occupation with long hours at a computer; high stress; irregular eating schedule.

Allergies:
No known drug allergies.

Medications:
Intermittent NSAIDs; occasional acetaminophen.

ROS:
Positive for nausea, photophobia, and neck tension during headache episodes. Denies aura, weakness, paresthesia, vision loss, fever, or recent infection.

Exam:
Forward-head posture with hypertonicity of the upper trapezius, splenius capitis, and sternocleidomastoid. Tenderness to palpation at Gallbladder 20 and mild bilateral temple tenderness. Cervical motion intact with mild discomfort on extension. Neurologic exam normal. No focal deficits.

Tongue:
Red body with thin yellow coat.

Pulse:
Wiry and rapid.

Patient Case #4

Chief complaint: acute flare of regional enteritis (Crohn's)

29-year-old, Caucasian woman -
abdominal pain, abdominal cramping

-bloody diarrhea 8-9 times/day, waking 2-3 times/night
-weight loss
-loss of appetite, food intolerances
-fatigue
-abdominal pain worse with compression, worse with heat
-better with lying in the fetal position.

History of present illness:
-Onset age 16, in high school, she missed a lot of school
-Lost 15# over 3 months, started on corticosteroids, Sulfsalazine, and later Azathioprine inducing a remission lasting 2-3 years, during which her weight improved, as did her energy
-flare-ups every 3-6 months, lasting for 3-9 months
-tried on repeat courses of corticosteroids, Azathioprine, Infliximab and Adalimumab. None of the medications remained effective and most were associated with undesirable side effects
-used Ciprofloxacin when febrile, Metamucil for diarrhea, Acetaminophen for pain
She presents this flare with:
-acute onset beginning 2 weeks ago.
-Started on steroid, Budesonide.
-Esophagogastroduodenoscopy, colonoscopy, and computerized tomography of the abdomen and pelvis showed inflammation in the terminal ilium, and in the ascending and transverse colon
-Biopsy showed inflammatory changes and some scattered ulcerations.
-Hemoglobin was 11 grams.

Past medical history:
-Crohn's disease
-Intermittent low back pain
-Mild scoliosis
-Intermittent depression.
-Varicella as a child.

Surgical history:
-Intestinal biopsies

Family history:
-Low Back Pain
-Depression
-Hypercholesterolemia

Lifestyle/social history:
-She was eating rice, potatoes, occasionally, some poached fish. She was avoiding dairy, fried foods, fatty foods, spicy foods, and caffeine.
- She had been jogging 3 miles 4 times a week but had to stop when her flare began.
- Her sleep was disrupted by explosive, bloody diarrhea 2-3 times/night.

- Graduated from college, taking 7 years to accomplish, due to multiple extended medical leaves, degree in Psychology.
- Works in her family’s clothing business when she can and lives at home with her parents. They are very supportive.
- Does not smoke, drink, or take illicit drugs.

Allergies:

-None

Medications

- Budesonide
-Calcium
-Vitamin D
-Vitamin B12
-Iron supplement

Positive review of systems

-weight loss of 8-10#
-fatigue
-occasional lightheadedness
-abdominal pain and cramping
-explosive, bloody diarrhea
-loss of appetite, and food intolerances
-mild developmental scoliosis
-mild, episodic low back pain
-insomnia due to disruption from pain and/or diarrhea

Focused Physical examination:

Pale, underweight woman looking fatigued, with dark circles under her eyes. She was 5’ 10”, weight 120#, BMI 17.22, blood pressure 110/70 without orthostatic drop upon standing, pulse 96
-Mood generally upbeat, but signs of easy frustration and mild depression
-Abdomen was scaphoid, tender to palpation diffusely, especially in the peri-umbilical region bowel sounds mildly hyperactive.
-Mild, well compensated, biphasic, thoraco-lumbar scoliosis.
-Bright and alert, appeared in some distress
-Tongue: thin, red, moderately thick, yellow-white coating, most prominent on the posterior third of the tongue -
Pulses: decreased Spleen and Kidney pulses -
Structural-bio-psycho-type Yang Ming Metal. Her presentation was acute Yang, Excessive, Internal, and Hot

Diagnoses:

-Crohn’s Disease
-Anemia, Iron deficiency
-Hypovitaminosis Vitamin B12
-Mild depression
-Episodic low back pain
-Scoliosis