Diary of a Family Physician

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9:00 a.m.

My first patient is a 13-year-old boy with abdominal pain. He had a fever of 102.6°F (39.0°C) last night and is in significant distress this morning. He has no appetite and has not vomited. He has not had a bowel movement for three days. On examination, he has right lower quadrant tenderness but no rebound. I direct him to the ED with concern for appendicitis.

10:00 a.m.

A postmenopausal woman arrives for a wellness visit. She is excited to pull down her face mask to show me her clear skin. She presented a few months ago with longstanding rosacea, and I suggested a facial towelette recommended by my ophthalmologist friend. It contains 4-terpineol, the ingredient of tea tree oil that kills the Demodex mite and has been used to treat blepharitis, meibomian gland dysfunction, and rosacea.

11:45 a.m.

A 12-year-old boy is here for a follow-up visit. Last week he presented with exquisite right testicular pain, and I was worried about torsion. Ultrasonography at the ED demonstrated a torsion of the testicular appendage, which was treated symptomatically. Surgery was not required in this case, and the patient has fully recovered.

1:30 p.m.

I see a beautiful two-week-old infant who is jaundiced and failed her hearing test in the hospital. I suspect breastfeeding jaundice because her conjugated bilirubin is not elevated. Her evoked brainstem response test at the hospital confirmed sensorineural hearing loss, and this week she is being fitted for hearing aids. There is no family history of hearing loss, and the parents, although concerned, are eager for their daughter to hear their voices.

1:45 p.m.

A woman presents with a swollen elbow. Last week, I drained a large olecranon bursitis, but the fluid re-accumulated. The mass is not painful, but the woman tells me her left calf is sore. She is also a little short of breath. Four months ago, she was hospitalized for COVID-19 and still requires oxygen at night. Her lungs are clear and her calf is not red or swollen, but she has a history of deep venous thrombosis (DVT). I send her for a stat venous Doppler.

3:30 p.m.

A woman is concerned that one of her medications is causing an allergic reaction. She had recently been hospitalized for a cerebrovascular accident and was started on four new medications. She opens her shirt to reveal a vesicular rash across her right anterior chest wall. I treat her for zoster and tell her to continue to take the new medications.

4:00 p.m.

Radiology calls about the woman with the olecranon bursitis and calf pain. She has a DVT. I send her to the ED and call to ask them to perform chest computed tomography (CT).

6:30 p.m.

I review the report from the ED about the 13-year-old with right lower quadrant pain. Ultrasonography was nondiagnostic, so CT of the abdomen and pelvis was performed. His CT scan shows mesenteric adenitis, and he also tests positive for COVID-19! My medical student quickly reviews mesenteric adenitis on her phone and finds that it mimics appendicitis and is mainly caused by adenovirus. I guess we can add coronaviruses as an etiologic agent.

6:45 p.m.

I receive the ED report about the patient with olecranon bursitis, calf pain, and dyspnea: she has a saddle pulmonary embolus. I am happy that I caught this because the patient did not seem to be in much distress. My intuition was raised today because I had a similar case two months ago and missed it. Fortunately, that woman went to the ED when her dyspnea worsened, and she was treated appropriately for her pulmonary embolus. ■

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