1 Patient Information

1 PATIENT DETAILS

Name:	Carolyn B. Mitchell	**Date of Service:**	04/22/2026
DOB / Age:	09/14/1977 / 48 years	**Provider:**	Dr. Rachel A. Goldstein, MD, FACE — Endocrinology & Diabetes
MRN:	ENDO-2026-048203	**Visit type:**	New patient consultation — referred by PCP (Dr. W. Collins, Family Medicine) for hyperglycemia evaluation and probable LADA

CC Chief Complaint

2 PRIMARY PRESENTING SYMPTOM

"I was just diagnosed with diabetes last month but my doctor thinks it might be a different type. I've lost about 20 pounds in 3 months without trying and I'm thirsty all the time. I feel exhausted — it's been going on for about 3 to 4 months."

H History of Present Illness

3a ONSET, DURATION & COURSE

Onset / circumstances:	Insidious — symptoms began approximately 3-4 months ago (January 2026); no acute precipitating event; noted at annual wellness visit bloodwork (random glucose 348 mg/dL by PCP on 03/14/2026)	**Prior episodes:**	No prior diabetes diagnosis; PCP wellness labs in 2023 and 2024 showed fasting glucose 94 and 98 mg/dL respectively — previously non-diabetic; no prior DKA episodes; no prior hypoglycemia
Duration since onset:	3-4 months of progressive symptomatic hyperglycemia; formal diagnosis by PCP 03/14/2026 (6 weeks ago)	**Timing / pattern:**	Symptoms constant and progressive — no clear diurnal variation; polyuria most prominent overnight (nocturia x3-4); polydipsia throughout day; fatigue worst in afternoon
Course (improving/worsening/intermittent):	Progressive and worsening despite 6-week trial of metformin 1000 mg BID initiated by PCP on 03/14/2026 — minimal glycemic improvement (fasting glucose 280-310 mg/dL on home monitoring); PCP recognizing inadequate response prompted referral to endocrinology	**Context (rest/exertion/trauma):**	No triggering illness, surgery, or trauma prior to onset; no recent steroid use; no pancreatitis history; symptoms developed during period of high work stress but no acute stressor identified

3b LOCATION, QUALITY & SEVERITY

Location: Generalized fatigue and malaise; polyuria and polydipsia without specific anatomical localization; no focal pain complaint; blurred vision noted bilaterally (hyperglycemia-related osmotic changes)

Severity (0-10): Fatigue 7/10 (limiting daily function); polydipsia/polyuria: significant lifestyle disruption; blurred vision intermittent 4/10; 20 lb unintentional weight loss over 3 months (BMI declined from 24.1 to 21.8)

Radiation or spread: No radiation; symptoms are systemic rather than focal

Functional limitation: Unable to complete full workday without significant fatigue; driving limited due to intermittent blurred vision; social activities curtailed; sleep disrupted by nocturia x3-4/night

Character / quality: Fatigue described as "bone-deep exhaustion" — not relieved by rest; polydipsia as "unquenchable thirst" drinking 8-10 liters of water daily; polyuria approximately q1-2h day and night

Quantified impact: 20 lb weight loss in 3 months; HbA1c 11.8% at diagnosis; fasting glucose 280-310 mg/dL on home monitoring despite metformin 1000 mg BID x6 weeks

3c MODIFYING FACTORS & ASSOCIATED SYMPTOMS

Aggravating factors: Fasting (glucose rises further); carbohydrate intake (exaggerated postprandial glucose excursion per home monitoring); inadequate sleep (worsens fatigue); stress

Alleviating factors (incl. medications): Metformin — minimal effect (glucose 280-310 mg/dL despite adherence); hydration temporarily relieves thirst; rest provides mild fatigue improvement but incomplete; no insulin exposure yet

Blurred vision bilaterally (intermittent, consistent with osmotic lens changes in hyperglycemia — not new-onset retinopathy; optometry to evaluate). Unintentional weight loss 20 lbs in 3 months (significant catabolism — concerning for absolute insulin deficiency). Polydipsia and polyuria (classic osmotic diuresis). Generalized fatigue and weakness. Mild nausea without vomiting (past 3 weeks). No DKA symptoms (no abdominal pain, Kussmaul breathing, or altered consciousness).
PERTINENT NEGATIVES: No fever or chills. No chest pain. No skin rash or joint pain (against autoimmune polyendocrine syndrome requiring screening). No recurrent infections (yeast, UTI) beyond mild intermittent vaginal yeast x1. No prior thyroid disease. No family history of Type 1 diabetes. No pancreatic disease history. No Cushingoid features. No recent corticosteroid use. No anorexia or eating disorder. No alcohol abuse.

9 Review of Systems

4 SYSTEM-BASED SYMPTOM REVIEW

Constitutional: Fatigue 7/10 (progressive, 3-4 months); 20 lb unintentional weight loss (3 months); no fever or night sweats

Genitourinary: Polyuria (q1-2h, including nocturia x3-4); one episode vaginal yeast (1 month ago, self-treated); no dysuria or hematuria

Cardiovascular: No chest pain, palpitations, or edema; hypertension absent; no orthostatic symptoms

Musculoskeletal: Generalized weakness; no myalgia; no arthropathy or Charcot joint

Respiratory: No dyspnea; no Kussmaul respirations (DKA excluded clinically)

Neurological: Fatigue-related concentration difficulty; intermittent bilateral distal foot tingling (mild, past 6 weeks — peripheral neuropathy screening indicated); no syncope or focal deficits

Gastrointestinal: Mild nausea x3 weeks; polydipsia; polyuria; no vomiting, diarrhea, or abdominal pain; no gastroparesis symptoms

Psychiatric: Mild anxiety regarding new diagnosis; no depression; no prior psychiatric history

Document additional systems as relevant to the presenting complaint — include pertinent positives and pertinent negatives...

V Vital Signs

5 MOST RECENT VITAL SIGNS

Temperature:	98.3°F (36.8°C)
Blood Pressure:	108/68 mmHg — no orthostatic hypotension on standing (108/70 after 2 minutes)
Heart Rate:	88 bpm, regular
Respiratory Rate:	16 breaths/min; respiratory pattern normal — no Kussmaul breathing
O2 Saturation:	99% on room air
Height / Weight (if relevant):	Height 5'6" (168 cm); Weight 142 lbs (64.5 kg); BMI 22.9 kg/m² — down from 162 lbs (BMI 26.2) 3 months ago per PCP records

E Physical Examination

6 FOCUSED OR COMPREHENSIVE EXAM FINDINGS

General Appearance:	Thin-appearing Caucasian female; appears fatigued; no acute distress; well-dressed and cooperative; mild temporal wasting; no Cushingoid features (no moon face, no buffalo hump, no striae)
HEENT:	Sclerae clear; no exophthalmos; thyroid non-palpable, no goiter; no cervical lymphadenopathy; no oral thrush
Cardiovascular:	Regular rate and rhythm; S1/S2 normal; no murmurs; peripheral pulses 2+ bilaterally radial and dorsalis pedis
Respiratory:	Clear to auscultation bilaterally; normal respiratory pattern; no Kussmaul breathing
Abdomen:	Soft, non-tender, non-distended; normal bowel sounds; no hepatosplenomegaly; no epigastric tenderness; no lipodystrophy injection sites (no prior insulin)
Musculoskeletal:	Mild diffuse muscle bulk loss consistent with catabolism; no joint swelling; no Charcot changes; normal gait
Neurological:	Alert, oriented x4; CN II-XII intact; monofilament testing bilateral feet: 8/10 sites intact (decreased at right 1st and 5th metatarsal heads — early small fiber neuropathy suspected); vibration sense mildly decreased bilateral ankles; DTRs 2+ symmetric
Skin:	No acanthosis nigricans; no Cushingoid striae; no necrobiosis lipoidica diabeticorum; no vitiligo; no skin infections; mild subcutaneous fat loss consistent with catabolism
Psychiatric (if relevant):	Alert and cooperative; mildly anxious about diagnosis; appropriate emotional responses; no thought disorder

L Lab & Imaging Results

7a LABORATORY STUDIES

HbA1c (03/14/2026, Quest Diagnostics via PCP): 11.8% — severely elevated, confirming diabetes for minimum 3 months.
Fasting glucose (03/14/2026): 318 mg/dL. Random glucose at PCP office (03/14/2026): 348 mg/dL.
Home fasting glucose (past 7 days, provided by patient): range 278-314 mg/dL — minimal improvement on metformin 1000 mg BID x6 weeks.
C-peptide (03/28/2026, ordered by PCP): 0.4 ng/mL (LOW — reference 1.1-4.4 ng/mL) — indicates significant beta-cell destruction and absolute or near-absolute insulin deficiency.
GAD-65 antibody (03/28/2026): 482 IU/mL (strongly POSITIVE — reference <5 IU/mL) — confirms autoimmune pancreatic beta-cell destruction; consistent with LADA (Latent Autoimmune Diabetes in Adults) / Type 1 diabetes in adult.
IA-2 antibody (03/28/2026): POSITIVE (97th percentile) — second autoantibody confirming autoimmune etiology.
TSH (03/28/2026): 3.2 mIU/L — normal; anti-TPO antibody: PENDING (ordered by PCP).
CMP (03/28/2026): No ketoacidosis — CO2 22 mEq/L, BUN 14, Cr 0.78; no electrolyte abnormalities; LFTs normal.
CBC (03/14/2026): Hgb 13.2 g/dL — mild anemia of chronic disease; WBC and platelets normal.
Lipid panel (03/28/2026): LDL 142 mg/dL (elevated in hyperglycemia context), HDL 48, TG 210 (mildly elevated — hyperglycemia effect).

7b IMAGING & OTHER DIAGNOSTICS

No imaging ordered or reviewed at this visit. Optometry referral for diabetic retinopathy baseline exam — ordered today (no prior ophthalmology evaluation since diabetes diagnosis). No cardiac imaging indicated at this time (no cardiovascular symptoms). Renal ultrasound not indicated at baseline without microalbuminuria or CKD.

A Assessment

8 WORKING DIAGNOSIS & CLINICAL IMPRESSION

PRIMARY DIAGNOSIS: Latent Autoimmune Diabetes in Adults (LADA) / Type 1 Diabetes Mellitus — adult onset (E10.9).
DIAGNOSTIC CERTAINTY: High — confirmed by (1) GAD-65 antibody strongly positive (482 IU/mL), (2) IA-2 antibody positive (2 autoantibodies = definitive T1DM/LADA), (3) markedly low C-peptide (0.4 ng/mL) indicating severe beta-cell loss, (4) inadequate response to metformin (expected in absolute insulin deficiency), (5) rapid weight loss and classic osmotic symptoms consistent with absolute insulin deficiency.
DIFFERENTIALS EXCLUDED: T2DM — excluded by positive autoantibodies, low C-peptide, BMI 22.9, age of presentation with rapid beta-cell decline; MODY — low probability (autoantibody-positive, no clear monogenic family pattern); Drug-induced hyperglycemia — no steroids or diabetogenic medications; Pancreatogenic diabetes — no pancreatitis history, no structural pancreatic disease.
COMORBIDITIES TO ASSESS: Autoimmune thyroid disease (anti-TPO pending); celiac disease (anti-tTG ordered today); Addison disease (screening not indicated at this time unless clinical signs develop). Peripheral neuropathy — likely early distal symmetric polyneuropathy from hyperglycemia duration.
RISK STRATIFICATION: High risk for DKA if insulin not initiated promptly; long-term risks include retinopathy, nephropathy, neuropathy, and cardiovascular disease with chronic hyperglycemia.

P Plan

9a DIAGNOSTICS & THERAPEUTICS

LABS ORDERED TODAY:
- Anti-tTG IgA + total IgA — celiac autoimmune screening (T1DM-associated autoimmune condition)
- Anti-TPO antibody — autoimmune thyroid disease (pending from PCP; confirming order today)
- Urine microalbumin/creatinine ratio (UACR) — diabetic nephropathy baseline
- Complete metabolic panel — renal and hepatic baseline
- Fasting lipid panel — hyperglycemia-related dyslipidemia; LDL 142 mg/dL at diagnosis
- Zinc transporter 8 antibody (ZnT8) — additional T1DM autoantibody confirmation if clinically warranted
- Repeat C-peptide (stimulated, post-mixed-meal) — to be performed at 3-month follow-up to track beta-cell reserve trajectory
IMAGING:
- Ophthalmology referral (non-urgent) — diabetic retinopathy and macular edema baseline screening (within 4 weeks)
DEVICES/MONITORING:
- Continuous glucose monitor (CGM) — Dexterity G7 prescribed today; insurance prior authorization submitted; education provided
- Insulin pump vs. multiple daily injections (MDI) — patient preference and insurance discussed; MDI initiated today; pump referral placed

9b PATIENT INSTRUCTIONS & EDUCATION

MEDICATIONS INITIATED TODAY:
1. Insulin glargine (Lantus) 10 units SQ at bedtime — basal insulin; titrate by 2 units every 3 days if fasting glucose >130 mg/dL (algorithm provided in writing).
2. Insulin aspart (NovoLog) 4 units SQ with each meal (breakfast, lunch, dinner) — rapid-acting bolus insulin; correction dose per sliding scale provided.
3. Metformin 1000 mg BID — DISCONTINUE (appropriate for T2DM, not T1DM; may resume for adjunctive benefit after glucose stabilization if desired, but not indicated as monotherapy).
PATIENT EDUCATION: Insulin injection technique demonstrated and return-demonstrated in office (RN diabetes educator present for 30-minute teaching session). CGM application demonstrated. Carbohydrate counting basics reviewed — dietitian referral placed. Hypoglycemia recognition and treatment (15-15 rule) reviewed. Medical alert bracelet strongly recommended. When to call/go to ER: blood glucose <70 mg/dL unresponsive to treatment, glucose >300 mg/dL with nausea/vomiting/confusion (DKA precaution). No driving if blood glucose <90 mg/dL until glucose patterns stabilize. Activity: light exercise encouraged; check glucose before/after until patterns established.

F Follow-Up

10 FOLLOW-UP PLAN

Follow-up in:	4 weeks (May 20, 2026)
Earlier if:	Blood glucose consistently >300 mg/dL, nausea/vomiting/confusion with high glucose (DKA), blood glucose <70 mg/dL unresponsive to treatment, severe hypoglycemia, difficulty using insulin — call office same day or go to ER
Reassess:	HbA1c (goal <7.0% at 3 months), fasting glucose trends via CGM download, insulin dose titration, celiac/thyroid autoimmune results, renal function (UACR), ophthalmology confirmation, CGM data review, DKA risk, patient adaptation to insulin therapy

Provider name & credentials:	Dr. Rachel A. Goldstein, MD, FACE — Endocrinology & Diabetes	**Date / Time:**	04/22/2026, 1:45 PM
Signature:	Rachel A. Goldstein, MD, FACE	**Facility:**	Boston Medical Endocrinology & Diabetes Center, 830 Harrison Avenue, Boston, MA 02118
NPI:	NPI: 1839201047 / Massachusetts Medical License #MA-MD-073821	**Visit type:**	New patient consultation — outpatient endocrinology