

1 Patient Information**1 PATIENT DETAILS**

Name Delores M. Hutchinson	Date of Service 05/06/2026
DOB 09/02/1958	Provider Dr. Anthony J. Morrow, DPM — Podiatric Medicine & Surgery
Age / Sex 67 / Female	MRN POD-2026-0831
Visit Type Wound Care / Diabetic Foot Follow-up — Visit 6	Affected Foot / Laterality Right foot — plantar forefoot (first metatarsal head)

CC Chief Complaint**2 PRIMARY CONCERN**

Ms. Hutchinson presents for wound care visit #6 of her right plantar diabetic foot ulcer. She reports the wound is not healing as expected and has developed new peri-wound erythema and increased drainage over the past 10 days. She states: 'My foot looks worse than last time — it's red around the sore and there's more drainage. I've been trying to stay off it.' Husband reports fever x2 days (100.6–101.2°F at home). Also reports new warmth and swelling of the right midfoot/ankle beginning ~3 weeks ago — initially attributed to dependent edema.

S Subjective**3 PATIENT-REPORTED SYMPTOMS & PODIATRIC HISTORY****3a ONSET & CONTEXT**

Diabetic foot ulcer (DFU) right plantar first MTP — first identified by endocrinologist 8 weeks ago (03/09/2026) during routine diabetic foot exam. Classified Wagner Grade 1 at that time; referred to this practice for wound care. Developed insidiously — patient unaware until endocrinologist noticed it, consistent with protective sensation loss from neuropathy. Progressed to Wagner Grade 2 by visit 3 (04/08/2026). New concern: progressive right midfoot warmth, erythema, and swelling beginning ~3 weeks ago (distribution not localized to ulcer) — raising concern for Charcot neuroarthropathy.

3b LOCATION & LATERALITY

Right foot: (1) Primary ulcer — plantar surface, right first MTP, plantar aspect. (2) New concern — right midfoot diffuse warmth and swelling: dorsal and plantar, Lisfranc/midtarsal region, extending toward ankle. No left foot ulcers.

3c PAIN CHARACTERISTICS

Paradoxically minimal pain at ulcer site (2/10) — consistent with severe peripheral neuropathy and protective sensation loss. Right midfoot swelling/warmth: 4/10 deep aching. Mild bilateral burning feet at night — longstanding neuropathic symptom.

3d FUNCTIONAL IMPACT

Retired, lives at home with husband. Non-weight-bearing right foot using knee-walker scooter x4 weeks. Uses rollator for short indoor distances. Unable to drive. Mostly homebound. Significant anxiety — sister had right BKA secondary to diabetic foot complications in 2019.

3e ASSOCIATED SYMPTOMS

Fever x2 days (home temp 100.6–101.2°F). Increased wound drainage — purulent, yellowish-green, malodorous (worsened x10 days). Peri-wound erythema spreading ~2.5 cm beyond wound margins. Right foot/ankle swelling. Bilateral burning feet nightly (chronic). No lymphangitic streaking noted by patient.

3f RELEVANT MEDICAL HISTORY

Diabetes / Peripheral Neuropathy

Type 2 DM x19 years (diagnosed 2007), poorly controlled HbA1c 9.8% (02/2026). Severe bilateral sensorimotor polyneuropathy confirmed on NCS (2023).

Prior Ulcers / Amputations

1 prior right foot ulcer (plantar 2nd toe, 2021) — healed with 6 weeks wound care. No prior amputations. Sister: right BKA 2019.

Peripheral Arterial Disease

PAD — ABI right 0.68 (moderate), left 0.74 (moderate), measured 09/2025. No prior revascularization.

Other

HTN (lisinopril 10 mg). CKD stage 3b (eGFR 38). Obesity (BMI 38.4). Hypothyroidism (levothyroxine 100 mcg). History of left foot Charcot resolved 2018 (12 weeks TCC).

3g PRIOR TREATMENT

Visits 1-2: wound debridement, saline wet-to-dry dressings, custom diabetic footwear. Visit 3: upgraded to TCC; foam wound dressing. Visit 4: wound culture obtained. Visit 5 (04/29/2026): MRSA-positive culture result received — initiated doxycycline 100 mg BID (day 7 today). TCC changed at each visit. Home dressing changes by husband between visits.

3h PERTINENT NEGATIVES

Denies rapid spreading lymphangitic streaking, acute ischemic symptoms, new complete sensory loss, new motor weakness, recent trauma. No rigors or productive cough.

Objective

4 MEASURABLE & OBSERVED FINDINGS

V VITAL SIGNS

Temperature

100.8°F (low-grade fever — concerning in diabetic foot context)

Heart Rate

94 bpm

Oxygen Saturation

97% on room air

Pain Score

2/10 at ulcer site; 4/10 right midfoot — reduced pain consistent with neuropathy

Blood Pressure

148/88 mmHg

Respiratory Rate

16 breaths/min

Weight / BMI

224 lbs (101.8 kg) / BMI 38.4

4a INSPECTION

Right foot (TCC removed for assessment): ULCER — full-thickness wound right plantar 1st MTP, 2.4 x 1.8 x 0.8 cm depth; wound bed 60% slough/fibrin, 40% granulation; edges indurated, callused, undermined 0.5 cm posterior. Drainage: moderate-heavy, purulent yellow-green, malodorous. Peri-wound erythema 2.5-3.0 cm circumferentially — non-demarcated. No frank fluctuance on inspection. RIGHT MIDFOOT: Significant diffuse swelling and erythema of Lisfranc/mid tarsal region extending toward medial ankle. Skin warm, erythematous, intact. Distribution of warmth/swelling disproportionate to ulcer site — strong concern for Charcot neuroarthropathy. Rocker-bottom plantar midfoot deformity visible.

4b PALPATION

Right plantar ulcer: Periwound induration ~2 cm rim. Mild fluctuance at posterior wound margin (small abscess component suspected). No crepitus. Right midfoot: Significantly warmer than left midfoot. Diffuse tenderness (limited — neuropathy). Tarsometatarsal joints: irregular bony prominences (deformity vs. left). No distinct midfoot abscess fluctuance.

4c RANGE OF MOTION

Ankle ROM (Right)

Dorsiflexion 8° (limited, normal 20°); Plantarflexion 35°

Midfoot ROM (Right)

Significantly restricted all planes — stiffness consistent with midfoot arthropathy/Charcot

Subtalar ROM (Right)

Inversion 10°, Eversion 5° — restricted, pain with end range

Toe ROM (Right)

1st MTP restricted; 2nd-5th MTP mild restriction

4d STRENGTH

Ankle DF / PF

Right: 3+/5 DF, 4/5 PF (neuropathic atrophy). Left: 4/5 DF, 4+/5 PF

Inversion / Eversion

Right: 3/5 both (intrinsic wasting). Left: 4/5

4e VASCULAR STATUS

Dorsalis Pedis (R/L)

Right: 1+ (diminished, known PAD). Left: 1+ (diminished)

Capillary Refill

Right: 3.5 sec (delayed). Left: 3 sec (borderline)

Posterior Tibial (R/L)

Right: 1+ (diminished). Left: 1+ (diminished)

Skin Temp / Color / Edema

Right: Warm overall (Charcot concern), erythematous, 3+ pitting edema to mid-calf. Left: Mildly cool distally, 1+ ankle edema

4f NEUROLOGIC STATUS

10g Monofilament

RIGHT: ABSENT all 10 plantar sites (0/10 — complete loss of protective sensation). LEFT: Absent 8/10 sites. Consistent with severe bilateral sensorimotor neuropathy.

Light Touch / Proprioception

Severely diminished bilaterally to ankle level. Proprioception absent at bilateral great toes.

Vibration Sense

Right: Absent at 1st MTP and medial malleolus. Left: Absent at 1st MTP, present at medial malleolus.

Neuropathic Symptoms

Bilateral burning, tingling feet — worse at night. No acute change in pattern.

4g DERMATOLOGIC / NAIL FINDINGS

Bilateral nails: Thickened, dystrophic — onychomycosis (not current priority). Bilateral plantar skin: Dry, fissured heels bilaterally. No maceration between toes. Right foot: Hyperkeratosis surrounding ulcer site. Left foot: Small calluses at 2nd and 3rd MTPs — noted for monitoring.

4h BIOMECHANICS / GAIT

Non-weight-bearing right foot per offloading protocol (knee-walker). Left foot gait: antalgic, reduced push-off at left great toe. Flat arch bilaterally. Right foot: rocker-bottom deformity plantar midfoot — consistent with Charcot midfoot deformity.

4i WOUND ASSESSMENT

Location

Right plantar 1st MTP — plantar aspect, central forefoot

Size (L x W x D cm)

2.4 cm x 1.8 cm x 0.8 cm depth (increased from 2.0 x 1.5 x 0.6 cm at visit 5)

Wound Bed / Drainage / Odor

60% slough/fibrin, 40% granulation. Moderate-heavy purulent yellow-green drainage. Malodorous.

Periwound Skin

Erythema 2.5–3.0 cm circumferentially. Induration. Callus at wound margins.

Tunneling / Undermining

Undermining 0.5 cm at posterior margin. No tunneling on probing.

Signs of Infection

PRESENT: Purulent drainage, periwound erythema >2 cm, fever 100.8°F, MRSA-positive culture. IDSA: MODERATE infection.

L Lab & Imaging Results

5 REVIEWED DATA

5a IMAGING STUDIES

RIGHT FOOT X-RAY (AP, lateral, oblique — today): (1) CHARCOT SIGNS: Fragmentation and subluxation of right Lisfranc joint complex — 2nd–3rd TMT joints with bony fragmentation and lateral column subluxation. Bony debris at midfoot. 'Debris, destruction, dislocation' pattern — consistent with acute/subacute Charcot (Eichenholtz Stage I–II). (2) Plantar ulcer site: Subtle periosteal reaction at distal right 1st metatarsal shaft — OSTEOMYELITIS CANNOT BE EXCLUDED on plain film; MRI indicated urgently. (3) No acute fracture of ankle or calcaneus. Vascular studies: ABI right 0.68, left 0.74 (09/2025). TBI right 0.42, left 0.48 (borderline for wound healing).

5b LABORATORY STUDIES

Stat labs ordered today (pending): CBC, CMP, ESR, CRP, HbA1c, blood cultures x2 sets, procalcitonin. Prior results: HbA1c 9.8% (02/2026). eGFR 38 (CKD 3b). Wound culture (04/22/2026, visit 4): MRSA-positive — sensitive to doxycycline, TMP-SMX, linezolid, vancomycin; resistant to oxacillin, erythromycin. CBC (02/2026): WBC 9.8 (no leukocytosis at that time — repeat today).

5c OTHER DIAGNOSTICS

NCS (2023): Severe bilateral sensorimotor polyneuropathy. ABI/TBI (09/2025) as above. MRI right foot with/without contrast — ORDERED TODAY URGENTLY (scheduled 05/07/2026): Evaluate for osteomyelitis and Charcot midfoot extent.

A Assessment

6 PODIATRY CLINICAL INTERPRETATION

Ms. Hutchinson is a 67-year-old female with T2DM (HbA1c 9.8%), severe bilateral diabetic peripheral neuropathy, and moderate bilateral PAD presenting with a complex worsening diabetic foot situation with multiple concurrent pathologies: (1) INFECTED DFU (Wagner Grade 2; IDSA Moderate) — MRSA-positive, increasing size despite TCC offloading, purulent drainage, peri-wound erythema >2 cm, fever. Oral doxycycline inadequate — antibiotic escalation required. (2) SUSPECTED OSTEOMYELITIS — right 1st metatarsal: periosteal reaction on X-ray at ulcer base; MRI ordered urgently. (3) ACUTE CHARCOT NEUROARTHROPATHY (Eichenholtz Stage I-II) — right foot: Lisfranc fragmentation and subluxation; disproportionate midfoot warmth/erythema/swelling in setting of severe neuropathy. Limb-threatening emergency if not protected. (4) MODERATE PAD (ABI 0.68, TBI 0.42) — borderline adequate perfusion; vascular surgery consultation indicated. (5) POOR GLYCEMIC CONTROL (HbA1c 9.8%) — significantly impairing wound healing and immune response.

P Plan

7 PODIATRIC MANAGEMENT

7a FOOTWEAR, ORTHOTICS & OFFLOADING

STRICT NON-WEIGHT-BEARING right foot — reinforced today given Charcot diagnosis. Transition from TCC to removable CAM boot ONLY for wound care visits; TCC to be re-applied immediately after. Once MRI confirms Eichenholtz stage, TCC maintained until X-ray evidence of coalescence (Stage III) — typically 3–6 months. No right weight-bearing of any kind until further notice. Left foot: continue custom diabetic depth shoe with molded insole.

7b WOUND CARE & INFECTION MANAGEMENT

WOUND DEBRIDEMENT PERFORMED TODAY: Sharp debridement with #15 scalpel — removed periwound callus circumferentially, debrided slough and non-viable tissue from wound base (~0.4 cm tissue removed). Post-debridement wound size: 2.6 x 2.0 x 0.9 cm. ANTIBIOTIC CHANGE: Stop doxycycline — inadequate for moderate IDSA infection with fever. Start TMP-SMX DS 1 tab PO BID x14 days (MRSA-sensitive; renally dosed for CKD 3b eGFR 38 — standard dose appropriate per guidelines). If osteomyelitis confirmed on MRI or systemic sepsis develops → IV antibiotics and hospitalization required. Blood cultures x2 drawn today. DRESSING: Aquacel Ag EXTRA applied — antimicrobial + moisture management. Non-adherent primary + foam secondary. Husband instructed on daily dressing changes; kit provided.

7c NAIL / CALLUS CARE

Periwound callus debridement performed today (see wound care section). Onychomycosis treatment deferred — not priority during active infected ulcer management.

7d MEDICATIONS & INJECTIONS

Stop doxycycline 100 mg BID. Start TMP-SMX DS 1 tab PO BID x14 days. Hold empagliflozin temporarily — SGLT2 inhibitors relatively contraindicated during active foot infections (mycotic infection risk). Notify endocrinologist today. Continue all other medications.

7e DIAGNOSTICS & REFERRALS

1. MRI right foot with/without contrast — URGENT: 05/07/2026. 2. Vascular surgery — urgent consult (Dr. Kim Nguyen, MD) for revascularization assessment. 3. Infectious disease — Dr. Patricia Monroe, MD (antibiotic management if osteomyelitis confirmed). 4. Endocrinology — urgent message to Dr. Susan Park, MD re: HbA1c 9.8%, active infection, hold empagliflozin, insulin initiation discussion. 5. Stat labs drawn today. 6. Social work referral for home health aide.

7f PATIENT EDUCATION

Extensive education (30 min) to patient and husband: (1) Seriousness explained — infected DFU with possible bone involvement and Charcot are limb-threatening; (2) ABSOLUTE NWB reinforced — one step risks catastrophic Charcot collapse and amputation; (3) Signs requiring IMMEDIATE ER: fever >101.5°F, spreading redness up the leg, red streaks, confusion, rapid worsening pain; (4) Empagliflozin held — rationale explained; (5) Blood glucose monitoring target 120–180 mg/dL; (6) Wound dressing technique reviewed — husband demonstrated competency; (7) Patient tearfully reaffirmed commitment to compliance.

F Follow-Up

8 REASSESSMENT PLAN

Follow-Up Schedule

URGENT 3-day follow-up: 05/09/2026 — MRI results review, blood culture results, stat lab review, wound reassessment, antibiotic response. Vascular surgery urgent within 1 week. ID consult within 1 week. If fever worsens, spreading cellulitis, or systemic deterioration before 05/09 → ER immediately.

TIME DOCUMENTATION & BILLING

Total Time

48 minutes

Counseling / Coordination Time

20 minutes

Primary ICD-10 Code

L97.512 — Non-pressure chronic ulcer of other part of right foot with fat layer exposed

E/M Level

99214 — Established patient, moderate-high complexity

Basis for Billing

Medical Decision Making — High Complexity

Secondary ICD-10 Code(s)

E11.621 — T2DM with diabetic foot ulcer; B95.62 — MRSA; M14.671 — Charcot joint, right ankle/foot; I70.233 — Atherosclerosis with ulceration right leg

PROVIDER NAME

Anthony J. Morrow, DPM

CREDENTIALS

DPM — Podiatric Medicine & Surgery | ABPS Board Certified

DATE & TIME

05/06/2026, 9:45 AM

Questions? Visit us at www.marvix.ai