1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Harold J. Benedetti

DOB
02/17/1960

AGE/SEX
66 / Male

MRN / PATIENT ID
HJB-2207641

DATE OF SERVICE
11/06/2026

PROVIDER
Meera Iyer

CREDENTIALS
MD (Rheumatology)

VISIT TYPE
Follow-Up — acute flare and urate-lowering therapy management

CARE SETTING
Outpatient — Rheumatology Clinic

PRIMARY CARE PROVIDER, IF APPLICABLE
Gloria Sandoval, MD

REFERRING PROVIDER, IF APPLICABLE
Gloria Sandoval, MD

INTERPRETER USED, IF APPLICABLE
Not required

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

"My left knee blew up two days ago — hot, swollen, can't bend it. It's my fourth attack since summer, and the lumps on my elbows keep growing."

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

3a PRESENTING SYMPTOMS

Reason for Rheumatology Evaluation:

Established gout follow-up: acute left knee flare, and urate-lowering therapy failure (serum urate above target on allopurinol 200 mg).

History of Present Illness:

Gout for 14 years: first big-toe attack 2012, now polyarticular with tophi. Left knee pain and swelling started 48 h ago after a family wedding (beer, red meat). Pain 8/10. Four flares in 5 months (R ankle, L 1st MTP, R wrist, now L knee). Allopurinol started 2024, increased only to 200 mg because of CKD; urate never below 7.

Joint Pain / Arthritis Symptoms:

L knee: hot, red, swollen, flexion limited to 40°. Chronic aching in both 1st MTPs and R wrist between flares. Morning stiffness 20 min. Inflammatory pattern during flares.

Inflammatory Arthritis Features:

Episodic, asymmetric, crystal-pattern attacks. No psoriasis, dactylitis, inflammatory back pain, uveitis, or bowel symptoms.

Flare History:

About 10 flares a year, each lasting 7–10 days. Triggers: alcohol, purine-rich meals, dehydration. NSAIDs avoided (CKD). Colchicine 0.6 mg twice daily causes diarrhea. Prednisone bursts work but raise his glucose. Active flare now.

Functional Status:

Walking with a cane today. Cannot do stairs. Between flares: independent, golfs 9 holes. Retired electrician. Elbow tophi make leaning on his arms painful.

Constitutional Symptoms:

Low-grade warmth with the flare; measured 99.6 °F at home. No chills, rigors, or weight loss.

3b SYSTEMIC REVIEW

Skin / Mucosal Symptoms:

Firm chalky nodules over both elbows and the R 2nd finger; one drained white material in 2025. No rash or ulcers.

Eye Symptoms:

None.

Oral / Sicca Symptoms:

None.

Cardiopulmonary Symptoms:

Coronary disease with stent 2021; no angina since. Mild ankle edema. Echo 2024: LVEF 50%.

Gastrointestinal Symptoms:

Diarrhea with colchicine at more than 0.6 mg/day. Mild fatty liver. NSAIDs stopped 2023 for CKD.

Renal / Urinary Symptoms:

CKD stage 3b (eGFR 38), hypertensive and diabetic. One uric acid kidney stone (2019). Sees nephrology yearly.

Neurologic Symptoms:

Mild numbness of both feet (diabetic neuropathy).

Muscle Symptoms:

None. On atorvastatin without myalgia.

Gout / Crystal Arthritis Symptoms, if applicable:

Polyarticular tophaceous gout. Urate: 9.8 (2024, before treatment) → 8.1 (08/2026 on allopurinol 200 mg). Tophi at both elbows and R index finger. 4–6 beers on weekends; drinks soda daily. Hydrochlorothiazide stopped 2025. Allopurinol taken daily; colchicine prophylaxis stopped because of diarrhea.

Vasculitis Symptoms, if applicable:

Not applicable.

3c TREATMENT & BACKGROUND

Medication History and Response:

Allopurinol 200 mg daily (HLA-B*58:01 negative, 2024) — tolerated, not at target. Colchicine 0.6 mg daily — diarrhea at higher doses. Prednisone 30 mg bursts ×3 in 2026 (glucose above 300). Also: losartan 100 mg, amlodipine 10 mg, metformin 500 mg BID, empagliflozin 10 mg, atorvastatin 40 mg, clopidogrel 75 mg.

Immunosuppression / Infection Risk:

No recent infections. No skin breaks over the knee. Influenza and COVID-19 vaccines 10/2026; Shingrix complete.

Past Medical and Surgical History:

Type 2 diabetes (A1c 7.4%), hypertension, CKD 3b, CAD with PCI (2021), obesity, fatty liver, knee osteoarthritis. Surgery: R knee arthroscopy (2015).

Family History:

Father and brother — gout.

Social / Occupational History:

Retired electrician. Former smoker (quit 2021). Alcohol as above. Lives with wife. Medicare Part D — febuxostat has a tier 3 copay; pegloticase would need infusion center prior authorization.

Pertinent Negatives:

No rigors, high fever, chest pain, hematuria, or skin wound near the knee. No prior knee injection in the last 3 months.

ROS RHEUMATOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Joint pain, swelling, warmth, stiffness, deformity, morning stiffness, or functional limitation
Positive — L knee flare; chronic MTP and wrist aching.

Back pain, inflammatory back symptoms, enthesitis, dactylitis, or tendon pain
Negative.

Rash, photosensitivity, oral/nasal ulcers, alopecia, Raynaud symptoms, nodules, or skin thickening
Positive — tophaceous nodules.

Dry eyes, dry mouth, eye pain, redness, photophobia, or vision changes
Negative.

Fatigue, fever, weight loss, night sweats, or constitutional symptoms
Low-grade temperature with flare.

Chest pain, dyspnea, cough, pleuritic pain, palpitations, or edema
Mild ankle edema only.

Abdominal pain, diarrhea, blood in stool, reflux, dysphagia, or liver symptoms
Colchicine-related diarrhea.

Hematuria, foamy urine, edema, hypertension, or renal concerns
Positive — CKD 3b, hypertension.

Numbness, tingling, weakness, headache, seizures, or neurologic symptoms
Positive — diabetic foot numbness.

Medication side effects, infection symptoms, immunosuppression concerns, or adherence barriers
Positive — steroid hyperglycemia, colchicine GI intolerance, febuxostat cost.

O OBJECTIVE

5 EXAMINATION

5a VITALS

TEMPERATURE	BLOOD PRESSURE	HEART RATE
99.4 °F	142/84 mmHg	88 bpm
RESPIRATORY RATE	**OXYGEN SATURATION**	**HEIGHT**
16 /min	97% RA	178 cm
WEIGHT	**BMI**	**PAIN SCORE, IF APPLICABLE**
104 kg	32.8	8/10 (L knee)

5b EXAMINATION

General Appearance:

Alert, uncomfortable, antalgic gait with a cane. Obese.

Head / Eyes / Ears / Nose / Throat:

Small tophus on the R helix. Otherwise normal.

Neck:

Normal.

Cardiovascular:

Regular, no murmur. Trace ankle edema. Pulses intact.

Pulmonary:

Clear.

Abdomen:

Obese, soft, non-tender.

Musculoskeletal:

L knee: large tense effusion, warm, overlying erythema, diffuse tenderness, flexion 10–40°. Bony changes of both 1st MTPs with mild swelling. R wrist: mild synovial thickening, no warmth. Strength 5/5 elsewhere.

Joint Examination:

Hands: tophus over R 2nd PIP; no synovitis elsewhere. Wrists: R thickened, non-tender. Elbows: olecranon tophi (L 3 cm, R 2 cm), non-inflamed. Shoulders and hips: full ROM. Knees: L as above; R crepitus, no effusion. Ankles: normal. Feet: 1st MTP bony enlargement on both sides, R tophus. Spine and SI: non-tender.

Skin:

Tophi as above with intact skin. L knee erythema without a break in the skin or cellulitis. No psoriasis.

Neurologic:

Reduced monofilament sensation at both forefeet. Otherwise normal.

Psychiatric:

Frustrated by repeated flares; engaged and motivated to treat.

DA JOINT / DISEASE ACTIVITY ASSESSMENT

6 ACTIVITY & FINDINGS

TENDER JOINT COUNT	SWOLLEN JOINT COUNT
4 (L knee, both 1st MTPs, R wrist)	3 (L knee, both 1st MTPs)

MORNING STIFFNESS DURATION

20 minutes

FUNCTIONAL LIMITATIONS

Cane, no stairs during flare

PATIENT GLOBAL ASSESSMENT WHEN AVAILABLE

8/10

PROVIDER GLOBAL ASSESSMENT WHEN AVAILABLE

7/10

DISEASE ACTIVITY SCORE WHEN USED

Not applicable (gout)

FLARE STATUS

Active L knee flare

EXTRA-ARTICULAR MANIFESTATIONS

Tophi (elbows, finger, R ear, R foot); uric acid stone history

DAMAGE OR DEFORMITY

Erosive 1st MTP changes; tophaceous burden

COMPARISON TO PRIOR EXAMINATION

L elbow tophus 2 → 3 cm since 02/2026

RESPONSE TO CURRENT THERAPY

Inadequate — not at urate target, frequent flares

MM MEDICATION / IMMUNOSUPPRESSION MONITORING

7 SAFETY REVIEW

CURRENT DMARDS, BIOLOGICS, JAK INHIBITORS, STEROIDS, NSAIDS, URATE-LOWERING THERAPY, OR OTHER RHEUMATOLOGIC MEDICATIONS

Allopurinol 200 mg; colchicine 0.6 mg daily (as tolerated)

DOSE, ROUTE, FREQUENCY, AND ADHERENCE

Oral daily; adherent per refill history

RESPONSE AND RESIDUAL SYMPTOMS

Urate 8.1; frequent flares

SIDE EFFECTS AND TOXICITY SYMPTOMS

Colchicine diarrhea; steroid hyperglycemia

INFECTION HISTORY AND MEDICATION HOLDS

None

LAB MONITORING STATUS

CMP, CBC, urate 08/2026

TB, HEPATITIS, HIV, OR OTHER SCREENING WHEN RELEVANT

Not required for current therapy

VACCINE STATUS AND COUNSELING

Up to date

PREGNANCY INTENTIONS OR CONTRACEPTION COUNSELING WHEN RELEVANT

Not applicable

PERIOPERATIVE MEDICATION GUIDANCE WHEN APPLICABLE

Not applicable

REFILL NEEDS AND INSURANCE/ACCESS BARRIERS

Allopurinol refill sent; no barrier at higher doses

PR PROCEDURES PERFORMED, IF APPLICABLE

8 RHEUMATOLOGY PROCEDURES

1) Diagnostic musculoskeletal ultrasound, L knee: large complex effusion with floating echogenic foci and a “double contour” sign on the femoral cartilage. 2) Ultrasound-guided L knee aspiration and injection, superolateral approach. Indication: acute monoarthritis — exclude septic arthritis and treat the flare. Verbal and written consent; site marked; timeout done. Chlorhexidine prep, sterile technique. 1% lidocaine 3 mL. Aspirated 62 mL of cloudy yellow fluid, sent for cell count, crystals, Gram stain, and culture. Bedside polarized microscopy: many needle-shaped, negatively birefringent crystals, some inside white cells. After fluid review and with no skin infection, injected triamcinolone acetonide 40 mg (lot TA26-0915, exp 06/2028). Tolerated well; no complications. Aftercare: rest 24–48 h, ice, call for fever or worse pain.

ST SCREENING / ASSESSMENT TOOLS

9 SCORES & INTERPRETATION

Gout flare frequency: 4 in 5 months (about 10/year). Serum urate 8.1 mg/dL — target below 5 because of tophi; not met. Pain 8/10. Patient global 8/10. HAQ-DI 1.25 during flare (0.25 between flares). RAPID3 18.0 today (flare-weighted). Adherence: refill history 95%. DAS28, CDAI, BASDAI, and SLEDAI not applicable.

L LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

Inflammatory Markers:

CRP 64 mg/L today (flare). ESR 58.

Autoimmune Serologies:

RF and anti-CCP negative (2024). HLA-B*58:01 negative (2024).

Medication Monitoring Labs:

08/2026: Cr 1.9, eGFR 38, K 4.8, AST 34, ALT 41, WBC 7.2, Hb 13.1, platelets 240. Glucose 162. A1c 7.4%.

Crystal Arthritis Testing:

Serum urate 8.1 (08/2026). Synovial fluid today: monosodium urate crystals seen at bedside; lab cell count, Gram stain, and culture pending.

Infectious Screening:

Not indicated today. Hepatitis B and G6PD testing ordered in case pegloticase is needed later.

Imaging:

Foot X-rays 2025: punched-out erosions with overhanging edges at both 1st MTPs. Knee ultrasound today as above. Dual-energy CT not needed — diagnosis confirmed.

Cardiopulmonary Testing:

Echo 2024: LVEF 50%. EKG 2026: sinus rhythm, old inferior Q waves.

Pathology / Biopsy:

Not applicable.

Prior Records Reviewed:

PCP and nephrology notes, cardiology note (2026), urate and eGFR trends 2024–2026, medication list.

A ASSESSMENT

11 RHEUMATOLOGIC INTERPRETATION

1) Acute gout flare of the L knee, crystal-proven today, on a background of chronic polyarticular tophaceous gout with erosions. Disease is uncontrolled: about 10 flares a year, growing tophi, urate 8.1 against a target below 5. 2) Septic arthritis judged unlikely (crystals inside cells, no skin break, mild temperature only) but not excluded until Gram stain and culture result. 3) Cause of treatment failure: allopurinol was under-dosed out of CKD caution. Current guidance supports careful titration above the creatinine-based dose with monitoring. HLA-B*58:01 negative lowers hypersensitivity risk. 4) Flare treatment is limited by comorbidities: NSAIDs are unsafe (CKD, CAD, clopidogrel); systemic steroids worsen his diabetes; colchicine causes GI side effects at full dose. An intra-articular steroid is the best fit today. 5) Contributors: alcohol, sugary soda, obesity, CKD. Prior thiazide already stopped. Losartan and empagliflozin modestly lower urate — continue both. 6) If titration fails or is not tolerated, consider febuxostat (caution with his CAD) or pegloticase.

P PLAN

12 MANAGEMENT BY PROBLEM

Diagnostic plan,

Follow synovial fluid cell count, Gram stain, and culture (results in 24–72 h). Urate, CMP, and CBC in 4 weeks. G6PD and hepatitis B serology now.

Disease-specific treatment plan,

Treat-to-target, urate below 5. Increase allopurinol to 300 mg daily now, then by 50 mg every 4 weeks according to urate and eGFR (expected 400–500 mg). Continue during flares.

Flare management plan,

Intra-articular triamcinolone given today. Ice and rest. Colchicine 0.6 mg daily as tolerated. Written home flare plan: start colchicine 0.6 mg ×1 then 0.3 mg in 1 h (renal dose) within 12 h of onset; call clinic for a large-joint flare (injection preferred over oral steroids).

Medication monitoring plan,

Urate, CMP, and CBC every 4 weeks during titration, then every 6 months. Stop allopurinol and call at once for rash, fever, mouth sores, or yellow eyes. Watch glucose for 3 days after the injection.

Steroid-sparing plan,

Avoid systemic steroid bursts. Use joint injections and low-dose colchicine. Pegloticase infusion if not at target after 6 months of optimized oral therapy.

Joint-specific plan,

Cane until the knee settles. PT for knee strengthening once the flare resolves. No surgical removal of elbow tophi now — expect shrinkage with treat-to-target.

Systemic involvement plan,

Nephrology notified of the allopurinol titration plan. Cardiology notified that febuxostat is being avoided for now.

Bone health plan,

Not indicated now; avoiding repeated steroids lowers risk.

Lifestyle and risk reduction plan,

Limit beer and avoid sugar-sweetened soda. Moderate red meat and shellfish. Drink 2 L of water daily (within cardiac limits). Aim for 5–7% weight loss; dietitian referral.

Referral and care coordination plan

PCP (glucose after injection, weight), nephrology, dietitian, physical therapy.

Patient education

Explained that urate crystals dissolve over months once urate stays below 5, and that flares may rise briefly at the start. Seek urgent care for fever above 101 °F, chills, or a knee that worsens after the injection — possible infection.

F FOLLOW-UP

13 REASSESSMENT PLAN

Phone call in 48–72 h with culture results and knee check. Labs in 4 weeks for allopurinol titration. Clinic visit in 8 weeks for urate review, tophi measurement, and flare frequency. Urgent return precautions as above.

TB TIME DOCUMENTATION & BILLING

14 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
48 minutes (excluding procedure)

RHEUMATOLOGY COUNSELING TIME
15 minutes

MEDICATION / IMMUNOSUPPRESSION COUNSELING TIME
10 minutes

PROCEDURE TIME, IF APPLICABLE
20 minutes (ultrasound, aspiration, injection)

CARE COORDINATION TIME
6 minutes

RECORDS REVIEW TIME, IF APPLICABLE
7 minutes

LAB / IMAGING REVIEW TIME, IF APPLICABLE
5 minutes

14a BILLING CONSIDERATIONS — E/M / RHEUMATOLOGY CODING

E/M LEVEL
99214-25

JOINT INJECTION / ASPIRATION CODE(S), IF APPLICABLE
20611 — major joint arthrocentesis/injection with ultrasound guidance and permanent recording

MUSCULOSKELETAL ULTRASOUND CODE(S), IF APPLICABLE
Included in 20611

INFUSION MANAGEMENT CODE(S), IF APPLICABLE
Not applicable

MEDICATION MONITORING / HIGH-RISK DRUG THERAPY DOCUMENTATION, IF APPLICABLE
Allopurinol titration in CKD 3b with lab monitoring

BASIS FOR BILLING
Medical Decision Making (moderate) + Procedure-based

ICD-10 DIAGNOSIS CODES

M1A.0621 — Idiopathic chronic gout, left knee, with tophus

[SECONDARY AUTOIMMUNE / JOINT / MEDICATION MONITORING / SYMPTOM DIAGNOSIS CODE(S), IF APPLICABLE]

M10.062 — Idiopathic gout, left knee (acute flare); N18.32 — CKD stage 3b; E11.22 — Type 2 diabetes with diabetic CKD; Z79.899 — Other long-term drug therapy

SO SIGNATURE

15 PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY
Meera Iyer	MD	Rheumatology

DATE	TIME
11/06/2026	10:50