Hello everyone. My name is [redacted] and this is my Snaps oral presentation. This is a patient that I saw last week and his name was GH, is a 63 year old male, established patient who presents with a two day history of mild congestion, sore throat, and unproductive cough that progressed into severe nasal congestion, productive cough, fever, chills, sinus pressure, and headaches, and general malaise. Since yesterday he states he is spitting up green mucus sputum, had a T max of about 102 degrees Fahrenheit, and has been unable to perform any activities of daily living for the last two days because he has been in bed without energy to do anything. He reports fatigue and mild shortness of breath with activity, and overall muscular and joint pain. He denies any chest pain or dyspnia, and also denies loss of taste or smell, From what he can tell when his nose is uncongestion from the medications he's been taking at home. He reports taking Quil with acetaminophin during the day and Nyquil with acetaminophin during the night with mild to no symptom relief. He reports sick contact with his grandson two weeks ago. He is a non smoker with history of diabetes, hypertension, COPD, and obstructive sleep apnea. His surgical history consists of a cardiac catheter placement in 2018 and a tonsillectomy with a year Unknown. He reports his immunizations are up to date, including two doses of Covid vaccine plus the booster, but denies receiving the annual flu vaccine this year.

Upon physical examination, his oxygen saturation was 92% On um, he had a temperature of one oh 1.6 Fahrenheit. He had a heart rate of one oh six and a blood pressure of 137/86 He had swollen and tender cervical lymph nodes and epithemetous posterior pharynx. It was very red and swollen. Nasal discharge was clear, but otherwise no polyps or deviations were noted upon nostril inspection and no neutral rigidity was observed either. His lung sounds were diminished bilaterally, but breathing was regular and unlabored. S one and S two, hard sounds were oscultd and no murmurs were noted. The strength was five out of five on all four extremities. I performed an influenza PCR, a Covid 19 PCR, and a rapid strep antigen detection test

To narrow my differentials, I believe this he either could have influenza Covid 19 or strep throat infection. Analyze Covid 19 and influenza infections typically have nearly the same exact clinical presentations with symptoms such as fever, sore throat, body aches and fatigue, cough, headache, and nasal congestion. That is why performed both the influenza and the Covid 19 PCR swabs.

I think his diagnosis is likely influenza infections since he denies loss of smaller taste as