Rachel Freundlich
Rotation #4 - Emergency Medicine

History
Identifying Data:

Chief Complaint: "My stomach is hurting so much" x2 hours

History of Present Illness:
Pt is a 43 y/o M with PMH of Afib not on anticoagulation presenting with right lower quadrant pain x2 hours. Pt reports that the pain started around 10pm around his umbilicus. He notes that the pain was sharp and rated it initially as 6/10. An hour after the pain began he admitted the pain moved to his right lower quadrant and now rates it 8/10. He denies associated nausea and vomiting. The pt denies taking any medications for pain relief and does not report any alleviating factors. Pt reports that he had appendicitis at age 16 in his home country but did not have his appendix removed due to unconfirmed reasons. The pt denies eating anything unusual for dinner. Pt denies history of GERD, fever, chills, chest pain, diarrhea, constipation, anorexia and inability to pass gas.

Past Medical History:
Present illnesses – Afib
Past medical illnesses – Appendicitis
Hospitalized – Appendicitis (2008)
Childhood illnesses – Denies any illnesses
Immunizations – received COVID booster 11/23/23; received Flu shot 10/31/23
Screening tests and results – Unknown

Past Surgical History:
Denies

At home Medications:
No reported medications

Allergies:
Denies any food, drug, or environmental allergies.

Family History:
Mother – age 74, alive and well
Father – deceased at age 68, MI
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons

Social History:

A.S. is a married male currently living with his wife and two children. He is currently working as a grocer at a supermarket.
Habits - Admits one cup of black coffee daily. Denies tobacco, alcohol, and drug use.
Travel - Pt denies recent travel.
Diet - Pt reports eating a well balanced diet.
Exercise - Pt reports he tries to go to the gym once a week but is often unsuccessful.
Safety measures - Admits to wearing a seat belt.
Sleep – Pt reports regular sleep patterns.
Sexual Hx - Pt is currently sexually active with his wife.

Review of Systems:
General – Denies recent weight loss, loss of appetite, generalized fatigue, fever or chills, or night sweats.

Skin, hair, nails – Denies changes in texture, excessive sweating or dryness, discolorations or pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head – Denies headaches, vertigo or head trauma.

Eyes – Pt wears glasses for farsightedness. Denies recent vision changes, photophobia, pruritus. Last eye exam unknown.

Ears – Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses – Pt denies nasal mucous discharge, epistaxis or obstruction.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcer or voice changes.

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion.

Pulmonary system – Denies cough, wheezing, hemoptysis, dyspnea, orthopnea, cyanosis, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – History of Afib. Denies chest pain, syncope, edema or known heart murmur.

Gastrointestinal system – Admits umbilical and right lower quadrant pain. Denies nausea, diarrhea, change in appetite, rectal bleeding, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructations, jaundice, hemorrhoids, constipation, hematemesis.

Genitourinary system – Denies urinary frequency, hesitancy, nocturia, urinary urgency, flank pain, oliguria, polyuria, or dysuria.

Nervous – Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status, weakness or recent onset memory loss.

Musculoskeletal system – Denies deformity or swelling, redness or arthritis.

Peripheral vascular system – Denies peripheral edema, discolorations, coldness or trophic changes.

Hematological system – Denies history of easy bruising, anemia, lymph node enlargement, or prior history of DVT/PE.

Endocrine system – Denies polydipsia, polyphagia, heat or cold intolerance, excessive sweating prior to admission, hirsutism, or goiter.

Psychiatric – Denies history.

Physical

General: 43 year old male appears well groomed, dressed appropriately for the weather, A&Ox3, looking about the stated age of 43. Pt appears mildly uncomfortable.

Vital Signs:
BP: Seated: 139/94
HR: 99 BPM
R: 18 min unlabored
T: 98.8F (forehead)
O2 Sat: 99% room air
Weight: 250 BMI: 39.16

Physical Exam:
Skin: Non diaphoretic. Warm and moist, with good turgor. Nonicteric, no erythema, pigmentation, lesions, unhealed scars, or tattoos.
Hair: Normal hair distribution. No lesions, lice, or seborrhea.
Nails: No clubbing, lesions or infection. Capillary refill <2 seconds in upper extremities.
Head: Normocephalic, atraumatic, non tender to palpation throughout. No swelling noted.
Eyes: Symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pale pink.
Visual acuity - not assessed.
Visual fields - full OU. PERRLA, EOMs intact with no nystagmus.
Ears: Symmetrical and appropriate in size. No lesions, scars, scabs, erythema or tenderness present. Ear canal nonerythematous, no masses, foreign bodies present. Cone of light, tympanic membrane noted.
Nose: Nasal mucosa pink with no discharge or bleeding noted. No bony deformities or tenderness present. Septum midline.
Sinuses: Sinuses nontender to palpation.
Lips: Pink, moist, and well hydrated.
Mucosa: Pink, no masses, well hydrated, nontender, no leukoplakia.
Palate: Pink, intact with no lesions, scars, erosion.
Teeth: Good dentition.

Gingivae: Pink, moist, no hyperplasia, masses, lesions, discharge.
Tongue: Pink, well papillated, no masses, lesions, deviations. Frenulum intact.
Oropharynx: No exudates, masses, lesions, foreign bodies. Tonsils present with no exudate.
Uvula: pink, no edema.
Neck: Trachea midline. No masses, lesions, scars. FROM, no stridor, 2+ carotid pulse, no thrills, no bruits noted bilaterally, no cervical adenopathy, JVD noted.
Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.
Chest: Symmetrical, no deformities, no trauma. Respirations unlabored.
Lungs: Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. Normal breath sounds throughout.
Heart: No JVP present. Irregular rate, irregular rhythm. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Abdomen: Tenderness surrounding the umbilicus and right lower quadrant. Abdomen is nondistended with no striae or pulsations noted. No CVA tenderness appreciated. McBurney's Positive. Normoactive bowel sounds present with no aortic/renal/iliac or femoral bruits. Mild guarding with no rebound tenderness. No hepatosplenomegaly to palpation.
Rectal: not performed
Neuro Exam: Mental status normal with no focal deficits.
PVS: Extremities are warm and without edema. No varicosities or stasis changes. Calves are supple and nontender. Pulses are 2+ and symmetric.
MSK: No erythema, warmth or crepitus noted. FROM bilaterally in upper and lower extremities.

Differentials:
Appendicitis - is likely due to the patient's presentation. Abdominal pain that begins epigastric and migrates to the right lower quadrant is classic of appendicitis. Furthermore, the patient's history of appendicitis increases the likelihood that the patient is currently presenting with appendicitis.
Pancreatitis - although less likely than appendicitis, the pain that the patient is experiencing may be due pancreatitis. This can be excluded on CT
Diverticulitis - although diverticulitis is most commonly seen in the left lower quadrant, it may uncommonly present in the right lower quadrant. A CT will rule in/rule out this diagnosis.
Gastritis and Food poisoning - are diagnoses of exclusion and are treated symptomatically in the ER.

Labs: (right most column)
<u>BMP</u>

Anion Gap	9.0		10.0
Sodium	136		135 ▼
POC Na Venous			140
Potassium	4.0		4.2
POC K Venous			4.1
Chloride	102		101
CO2	25.0		24.0
BUN	14.0		15.0
Creatinine	0.8		0.8
Glucose	130 ▲		128 ▲
ALT (SGPT)			46 ▲
AST (SGOT)			25
ALK PHOS			58
Total Bilirubin			0.4
Calcium	8.1 ▼		9.3
Total Protein			8.0
Albumin			4.3

CBC W/WO DIFFERE...			
WBC	6.91		7.96
RBC	4.87		5.14
HGB	15.4		16.0
HCT	42.9		45.2
MCV	88.1		87.9
MCH	31.6		31.1
MCHC	35.9		35.4
RDW	12.5		12.4 ▼
PLT	277		313
MPV	10.0		10.5
Monocyte %	6.5		5.5
Monocyte Abs	0.45		0.44
Neutrophil Abs	3.98		4.90
Neutrophil %	57.7		61.5
Lymphocyte Abs	1.95		2.18
Lymphocyte %	28.2		27.4
Eosinophil %	6.2 ▲		4.0

COAGULATION			
aPTT			30.3
PT			11.2
INR			1.0

HEPATIC FUNCTION			
Albumin			4.3
Total Protein			8.0
Total Bilirubin			0.4
Direct Bilirubin			<0.2
Indirect Bilirubin			>0.2 ▼
ALK PHOS			58
ALT (SGPT)			46 ▲
AST (SGOT)			25

RENAL FUNCTION P...			
Sodium	136		135 ▼
Potassium	4.0		4.2
Chloride	102		101
CO2	25.0		24.0
BUN	14.0		15.0
Creatinine	0.8		0.8
Albumin			4.3
Total Protein			8.0

URINALYSIS (UA)				
Specific Gravity Urine				>1.030
Protein Urine				Negative
Glucose Qualitative Urine				Negative
Ketones Urine				Negative
Bilirubin Urine				Negative
Blood Urine				Negative
Urobilinogen Urine				0.2
Nitrite Urine				Negative
Leukocyte Esterase Urine				Negative
Squamous Epithelial Cells Urine				0-7
White Blood Cells Urine				0-5
Red Blood Cells Urine				0-4
Bacteria Urine				Negative
Hyaline Cast Urine				0-4
pH Urine				7.0
Appearance Urine				Clear
Color Urine				Yellow

T&S - A+

Imaging:
CT Abdomen and Pelvis: Umbilical hernia without obstruction or gangrene. Otherwise unremarkable.

Assessment:
A.S. is a 43 y/o M presenting with umbilical and right lower quadrant pain. Pt appears in mild discomfort, mildly elevated blood pressure and mildly tachycardic. After receiving Toradol 15mg IM pt remains in pain. CT scan negative for appendictis, pancreatitis, diverticulitis.

Plan:
- **Morphine 4mg IV push provided**
- **Patient provided with referral to PCP to continue abdominal pain workup**
- **Discharged patient with Pepcid 20mg tablet x10 days**
- **Pt provided with return instructions if symptoms worsen of fever, chills develop**