Rachel Freundlich
Rotation #3 - Internal Medicine

History

Identifying Data:

Chief Complaint: "I've been having rectal bleeding" x2 days

History of Present Illness:
Pt is an 80y/o M with HTN, HLD, GERD, prostate cancer s/p prostatectomy (2010), Afib (no AC) and recurrent rectal prolapse with proctectomy (April 2023 with revision in Feb 2024) presents with rectal bleeding x2 days. Pt reports that he has been having intermittent rectal bleeding since his proctectomy in February. Pt initially spoke with his surgeon due to concerns of bleeding and was reassured that this is part of the normal healing process. He was advised to go to the ER if bleeding increases. Pt reports that for the last two days he has noticed bright red blood on toilet paper and the bleeding soaked his undergarment which prompted his ER visit. Pt admits the bleeding is associated with straining. Pt notes that he is fecal incontinent and had a large bowel movement last night which occurs about every 3 days which is normal for him. He noted blood in the stool without clots. Pt is on aggressive bowel regimen and it is unknown if this is chronic or due to recent rectal surgery.
Pt denies rectal pain, abdominal pain, changes in appetite, N/V/D, fever, chills, lightheadedness, dizziness, chest pain, palpitations, or bleeding from any other area.

Pt was seen for admission to medicine for further workup.

Past Medical History:
Present illnesses – HTN, HLD, Afib, GERD
Past medical illnesses – Prostate cancer, rectal prolapse
Hospitalized – Prostatectomy 2010, Proctectomy April 2023, February 2024
Childhood illnesses – Denies any illnesses
Immunizations – received Prevnar 20 11/22/2023; TDAP 11/16/2014; received flu vaccine 11/27/2023; received COVID vaccine 10/18/2021
Screening tests and results – Colonoscopy 2017 - reportedly normal

Past Surgical History:
Prostatectomy - 2010
Proctectomy - April 2023; revision in February 2024

At home Medications:

Simethicone chewable tablet - 80mg PO PRN up to 4 times a day (proctectomy)
Metoprolol succinate - 25mg PO QD (HTN)
Polyethylene glycol 17g oral packet 1 packet QD (proctectomy)
Pantoprazole - 40 mg PO QD (GERD)
Acetaminophen - 650mg PO q6h PRN (prostatectomy)
Diazepam - 5mg PO q6h PRN (unknown)
Nubiqa - 300mg PO BID (s/p prostate cancer)
Tramadol - 50mg PO q6h PRN (unknown)

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

Family History:
Mother – deceased at unknown age, hx of CAD
Father – deceased at unknown age, hx of CAD
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons

Social History:
L.W. is a single male living alone. He reports he has a companion that he speaks to daily. He is independent in ADLs and IADLs.
Habits - Pt has a history of cigarette use which he quit in 1987. Denies caffeine, alcohol, tobacco and drug use
Travel - Pt denies recent travel.
Diet - Pt reports eating a well balanced vegetarian diet.
Exercise - Pt denies exercise.
Safety measures - Admits to wearing a seat belt.
Sleep – Pt reports regular sleep patterns.
Sexual Hx - Pt is not currently sexually active.

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

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

Head – Denies headaches, vertigo or head trauma.

Eyes – Pt wears glasses for nearsightedness. 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 discharge, obstruction or epistaxis.

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 dyspnea, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – History of HTN, HLD. Denies chest pain, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

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

Genitourinary system – Admits mild nocturia. Denies flank pain, frequency, urgency, 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 back pain, deformity or swelling, redness or arthritis.

Peripheral vascular system – Denies coldness or trophic changes, varicose veins, peripheral edema or color changes.

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

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

Psychiatric – Denies history.

Physical

General: 80 year old male appears well groomed, dressed appropriately for the weather, A&O x3, looking about his stated age of 80. Pt in no acute distress. Ambulates independently.

Vital Signs:
BP: Seated: 179/83
HR: 66 BPM
R: 16 min unlabored
T: 97.3F (forehead)
O2 Sat: 99% Room air
Weight: 123 BMI: 19.26

Labs:
Sodium - 136
Potassium - 4
Chloride - 101
Calcium total level - 9.2
BUN - 25.9
Creatinine - 0.54
BUN/Cr - 48
Glucose - 83
Anion gap - 10
GFR >90

WBC - 5.7
RBC - 3.73
Hgb - 11.1 (11-17.3)
Hct - 33.7 (35.4-56.5)
MCV - 90.3 (90.4-128)
MCH - 29.8
MCHC - 32.9
RDW - 14.0
Plt - 152
Mean platelet volume - 9.9

All other labs within normal limits.

Physical Exam:
Skin: Non diaphoretic. Warm and moist, with good turgor. Nonicteric, no erythema, pigmentation, lesions, unhealed scars, or tattoos.

Hair: Normal balding pattern on Pt's head. 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: No discharge noted. Symmetrical, no bony deformities, tenderness. Nasal mucosa pink and well hydrated. Septum midline with no perforation or inflammation. No foreign bodies.
Sinuses: Nontender to palpation and percussion over bilateral frontal and maxillary sinuses.
Lips: Pink, moist, and mildly dehydrated.
Mucosa: Pink, no masses, mildly dehydrated, nontender, no leukoplakia.
Palate: Pink, intact with no lesions, scars, erosion.
Teeth: Mild erosion of teeth noted.
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 noted.
Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.
Chest: Symmetrical, no deformities, no trauma. Respirations unlabored.
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.
Heart: No JVP preset. Normal rate, normal rhythm. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Abdomen: Nontender, nondistended abdomen. No CVA tenderness appreciated. No striae or pulsations noted. Well healed scars noted around the umbilicus. Normoactive bowel sounds present with no aortic/renal/iliac or femoral bruits. Tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation.
Rectal: ER performed a rectal exam prior to my arrival and pt did not want to repeat exam. As per ER note - no masses, lesions or tenderness, rectal prolapse, hemorrhoids noted. Blood clot noted on undergarment with BRBPR. No evidence of active bleeding.
Neuro Exam: Mental status normal. Gait was not assessed due to patient lying in bed and not desiring to stand up.
PVS: Extremities are warm and without edema. Calves are nontender with no stasis changes. Pulses are 2+ and symmetric.
MSK: No erythema, warmth or crepitus noted. FROM bilaterally in upper and lower extremities.

Problem list:

- HTN
- HLD
- Afib
- GERD
- Dehydration
- Prostate cancer s/p prostatectomy
- Rectal prolapse hx s/p proctectomy

Differentials:

LGIB

- Hemorrhoids
- Fissure
- Polyps

Suture line from recent surgery

The initial workup for all of these concerns is a colonoscopy.

Assessment:

80y/o M with HTN, HLD, GERD, prostate cancer s/p prostatectomy (2010), Afib (no AC) and recurrent rectal prolapse with proctectomy (2023 with revision in Feb 2024) with rectal bleeding for 2 days. VSS with lab values indicating mild dehydration and chronic anemia. All other lab values unremarkable. Pt denies rectal pain, abdominal pain, N/V/D, fever, chills, lightheadedness, dizziness, chest pain, palpitations, or bleeding from any other area.

Plan:

- **Admit to medicine for workup of lower GI bleed vs internal hemorrhoids vs surgical incision leak**
- **GI Consult (see below)**
- **NPO until GI Consult recommendations**
- Active T&S
- Monitor CBC
- Transfuse if hgb <7
- Telemetry
- GI PPX - Pantoprazole IV q12 hours
- DVT PPX - SCDs
- Administer Normal saline 0.9% 500ml bolus IV

As per GI consult

- CBC BID
- Active T&S
- Colonoscopy tomorrow
    - Prep
        - Polytethylrene glycol - 236g oral solution 4,000ml – mix in 64oz clear liquid, drink 8oz every 15 minutes until complete. Begin at 8pm.
        - Simethicone chewable tablet 80mg (after prep is complete)
        - Bisacodyl enteric coated tablet 10mg 2 tabs (after prep is complete)
        - NPO after completion
        - Ensure electrolytes are within normal limits
    - CLD until colonoscopy prep begins
    - Consider changing Metoprolol to another form

#Afib/HTN
- Update Metoprolol to Metoprolol tartrate - 12.5mg PO BID
    - Continue home metoprolol succinate - 25mg PO QD after colonoscopy
- Hold AC white treating acute bleed
- Monitor on telemetry

#HLD
- No management indicated currently

#GERD
- Pantoprazole - 40 mg IV BID

#Dehydration
- Normal saline 0.9% 500ml bolus IV

Updated Medication List:

Bowel Prep:
- Polyethylene glycol - 236g oral solution 4,000ml – mix in 64oz clear liquid, drink 8ox every 15 minutes until complete
- Simethicone chewable tablet 80mg (after prep is complete)
- Bisacodyl enteric coated tablet 10mg 2 tabs (after prep is complete)

Metoprolol tartrate - 12.5mg PO BID (HTN)
Polyethylene glycol 17g oral packet 1 packet per day - continue once colonoscopy is complete (proctectomy)
Simethicone chewable tablet - 80mg PO PRN up to 4 times a day (continue after endoscopy)
Bisacodyl enteric coated tablet - 10mg PO 2 tablets QD (continue after endoscopy)
Pantoprazole - 40 mg IV BID (GI PPX)
Acetaminophen - 650mg q6 hours PRN (prostatectomy)
Diazepam - 5mg PO q6 hours PRN (unknown)

Nubiqa - 300mg PO BID (s/p prostate cancer)
Tramadol - 50mg PO q6 hours PRN (unknown)

Patient Education:
The patient expressed his concerns that the rectal bleeding may be related to cancer recurrence and this was addressed in patient education.

The patient was informed that the rectal bleeding may be caused by a few different possibilities and we are going to admit him to the hospital in order to better understand what is happening. It was explained to the patient that the gastroenterology team would be involved as they are the team that completes the colonoscopy. The patient has had colonoscopies before and was familiar with the concept and the prep. The patient was told that the colonoscopy would allow the doctors to see if there were any polyps which may be bleeding, internal hemorrhoids which were not visualized on the rectal exam, or if the bleeding was related to the surgery that he had. The patient was reassured that the concern for cancer recurrence would be addressed if there was no other identifiable source of bleeding that could be found. The patient was assured that there were multiple benign causes of rectal bleeding that were likely the causative factors and it was not necessary to fear the worst at the current time.