Markenzie Jean-baptiste

3/5/2020

Rotation # 2: General Surgery

H&P

**Identifying Data:**

Name: ZR

Age: 67

Nationality: Hispanic

Date & Time: 3/2/2020 @ 6:43pm

Location: Queens Hospital Emergency Department

Source of Referral: self

Source of Information: Self - Reliable

Mode of Transport: Ambulatory

**Chief Complaint:** “I keep having pain in my stomach right here x 1 day”

67 y/o F PMHx of morbid obesity, anxiety, asthma, CAD( s/p stent x 3), DM, endometrial cancer, HLD, HTN, hypothyroid and MR, presents to ED with RUQ abdominal pain x 1 day. Describes pain as sharp, constant, going across the upper abdomen around the RUQ w/o radiation of pain. First noticed the pain after eating white rice sand boiled chicken 6 hours ago. Reports that she has had recurring episodes of RUQ pain over the past 10 years usually occurring 1-2 hours after meals. Reports that frequency of pain has increased and occurring daily, lasting a full day. PT has not taken any medications for her symptoms. Denies fever, chills, headache, change in appetite, chest pain, SOB, nausea, vomiting, diarrhea, bloody stools, dysuria, urinary frequency.

Past Medical History

PMH: morbid obesity, anxiety, asthma, CAD( s/p stent x 3), DM, endometrial cancer, HLD, HTN, hypothyroid, non-alcoholic fatty liver disease and MR

Past surgical hx: None

Social hx:  Lives in Assisted care, former 25 pack year smoker ( 5 packs/day) , Denies any alcohol or illicit drug use.

Meds:

Albuterol 2.5 MG/3ML, alendronate 10 mg, atorvastatin 40 mg, Calcium D3, Certirizine 10 MG, chlorthalidone 25 mg, clopidogrel 75 mg, furosemide 40 mg, isosorbide mononitrate 30 MG 24 hr,  levothyroxine 125 MCG, losartan 100 MG, metoprolol 50 mg, montelukast 10 mg, naproxen, omeprazole 20 mg, Symbicort 160-4.5, theophylline 300 x 12 hr tab, Ventolin HFA 108( 90 base) MCG/ACT inhaler.

Allergies: No known food, drug or environmental allergies.

Family hx: unknown

**Review Of Symptoms:**

General: Denies fever, chills, night sweats, fatigue, weakness, loss of appetite, recent weight gain or loss

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

Head: Denies headache, vertigo, head trauma, unconsciousness, coma, fracture

Eyes Denies visual disturbances, fatigue, lacrimation, photophobia, pruritus,

Ears: Denies deafness, pain, discharge, tinnitus, hearing aids

Nose/Sinuses: Denies discharge, epistaxis, obstruction

Mouth and throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures, last dental exam

Neck: Denies localized swelling/lumps, stiffness/decreased range of motion

Pulmonary: Denies dyspnea, SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, PND

Cardiovascular: Denies chest pain, HTN, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, known heart murmur

Gastrointestinal: ***(+) abdominal pain,***

Denies vomiting, diarrhea, changes in appetite, dysphagia, pyrosis, flatulence, eructation, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool, pain in flank

Genitourinary: Denies urinary frequency/urgency, incontinence, dysuria, nocturia, oliguria, polyuria, impotence, anorgasmia, sexually transmitted infections, contraception

Musculoskeletal: Denies muscle/joint pain, deformity or swelling, redness, arthritis

Peripheral Vascular: Denies intermittent claudication, coldness, trophic changes, varicose veins, peripheral edema, color changes

Hematologic: Denies anemia, easy bruising or bleeding, lymph node enlargement, history of DVT/PE

Endocrine: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism

Nervous System: Denies seizures, loss consciousness, sensory disturbances (numbness, paresthesia, dysesthesias, hyperesthesia), ataxia, loss of strength, change in cognition/mental status/memory, weakness (asymmetric)

Psychiatric: Denies depression/sadness, suicidal ideation, anxiety, obsessive/compulsive disorder, history of seeing mental health professionals

Initial DDX

1.Cholecystitis

2.Cholelithiasis

3.Hepatitis

4.GERD/Peptic Ulcer Disease/Duodenal Ulcer

5.Pancreatitis

Physical Exam:

Vitals: T 97.9F, HR 79 bpm, RR 18, BP 139/83 bpm SP02: 98%

General: A/O x 3, pt is cooperative but in pain, morbidly obese

Skin: warm and moist, good turgor, non-icteric, no lesions or rashes

Nails: cap refill <2 secs throughout,

Head:  normocephalic, atraumatic w/o obvious abnormality

Eyes: PERRLA, conjunctiva and cornea clear. No scleral icterus

Nose: Nares normal, septum midline, mucosa normal.

Throat: lips, mucosa and tongue are normal; missing upper and lower teeth, front tooth is loose.

Lungs: Clear to auscultation bilaterally, respirations unlabored, no wheezes/ rales/rhonchi

Cardiovascular: Regular rate and rhythm, S1 and S2 normal, no murmur, rubs or gallop

Abdomen: Soft, non-distended, voluntary guarding w/ positive RUQ tenderness. (+) Murphy sign. No masses. No rigidity.

Extremities: Normal in color, size and temp. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted b/l.

Neuro: Pt alert and oriented to place and time. Receptive and expressive abilities intact. Full ROM of extremities. Strength 5/5  bilaterally throughout all extremities.CN 2-12 Intact. Reflexes: 2+ throughout.

Labs:

CBC

**WBC 11 H.   Ref 4-10**

RBC 4.55

HGB 13

HCT 41.1

PLT 308

Plt 307

BMP

GLU 149 H

Sodium 138

Potassium grossly hemolyzed

Chloride 104

CO2 22

BUN 13

Creatinine 0.90

**Calcium 8.5 L**

Albumin 3.6

Total Protein 7.5

Total Bilirubin <0.3

**ALK PHOS 122 (H)**

**ALT( SGPT) 35 (H)**

**AST( SGOT) 45(H)**

**IMAGING:**

US Gallbladder showed GBW 4.6 mm, CBD 4mm, partially distended GB with wall thickening, suggested hepatic steatosis and hepatomegaly, with no stones.

**Adjusted Differential Diagnosis after exam, labs, imaging**

1.Biliary Colic

2.Cholecystitis

3.Choledocholithiasis

4.Hepatitis

5.Pancreatitis

**Assessment:**

67 y/o F w complex PMH and recurring RUQ abdominal pain after meals, presents to ED with RUQ abdominal pain x 1 day. On exam, has voluntary guarding w/ positive RUQ tenderness and + Murphy sign. US Gallbladder showed GBW 4.6 mm, CBD 4mm, partially distended GB with wall thickening, suggested hepatic steatosis and hepatomegaly, with no stones. Labs showed mildly elevated WBC’s and LFT’s.

Plan:

PT to go for HIDA Scan w/ CCK scintigraphy and EF to r/o cholecystitis vs. biliary dyskinesia

PT will be NPO, Start IV fluids 1 L bolus

Repeat labs

Continue home meds as directed.

If surgery is required- pt to be transferred to another hospital with bariatric instruments.

Pt to follow up at her hospital for hx endometrial cancer

Follow up:

HIDA scan on 3/3/2020 showed no evidence of cholecystitis.

No plans for surgery due to pt other diagnosis.

PT discharged to follow up at her hospital.