Alena Rakhman
H&P #2
Rotation 4 – Surgery

Location: Queens Hospital Center
Date: 5/10/19
Time: 2:00 PM

CC: "abdominal pain" x12 hrs

HPI
57 y/o M w/ no significant PMHx/PSHx, brought in to ED by EMS c/o abdominal pain x12 hrs. Surgical consult was requested. Pt states that pain is sharp, constant, localized in the RLQ, 7/10, worse w/ movement and started in the middle of the night. Pain was first colicky diffusely but has been gradually getting worse. Pt took OTC ibuprofen, last dose 600 mg 5 hrs prior to arrival w/ no relief. Additionally, pt also reports nausea, which began after the pain onset and loss of appetite due to nausea and abdominal pain. Pt did not eat anything after pain onset but is able to keep liquids down. Pt denies fever, chills, SBO, CP, palpitations, LOC, vomiting, diarrhea, constipation, hematochezia, dysuria, hematuria, urinary urgency, urinary frequency, recent travel, recent sick contacts, prior hx of intubation or prior hx of similar sxs.

Differential Diagnosis
- Acute appendicitis
- Gastroenteritis
- Crohn's disease
- Diverticulitis
- AAA
- SBO
- Nephrolithiasis
- Pyelonephritis

PMH
No significant past medical history

Immunizations
Up to date, including Influenza vaccine

Past surgical hx
No pertinent surgical history

Past hospitalizations
No pertinent hospitalization history

Medication
None

Allergies
Shrimp allergy – swelling
No known medication or environmental allergies

Family history
Mother → alive and well, 85
Father → deceased at 92, natural causes
Grandfather (maternal) → pt doesn't know
Grandmother (maternal) → pt doesn't know
Grandfather (paternal) → pt doesn't know
Grandmother (paternal) → pt doesn't know

Social History

- Pt has never been married and lives alone in a house in Queens.
- Occupation – works in constriction.
- Habits – denies hx of smoking cigarettes, drinking alcohol or illicit drug use.
- Education – high school.
- Diet – regular diet.
- Exercise – goes to the gym 2x/week, mostly weight training.
- Safety measures – admits to wearing a seatbelt.
- Sexual hx – is currently sexually active with 1 female partner. States that he uses condoms and denies hx of STIs.

ROS

General

- **reports loss of appetite**, denies generalized weakness/fatigue, recent weight loss or gain, fever, chills or night sweats

Skin, hair and nails

- denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution

Head

- denies HA, vertigo or head trauma

Eyes

- denies visual disturbance, lacrimation, photophobia or pruritus; does not remember date of last eye exam

Ears

- denies deafness, pain, discharge, tinnitus or use of hearing aids

Nose/Sinuses

- denies congestion, rhinorrhea, epistaxis or obstruction

Mouth and throat

- denies sore tongue, sore throat, mouth ulcers, voice changes, bleeding gums or use of dentures; does not remember date of last dental exam

Neck

- denies localized swelling/lumps or stiffness/decreased range of motion

Breast

- denies lumps or pain

Pulmonary System

- denies SOB, DOE, orthopnea, cough, wheezing, hemoptysis, cyanosis or PND

Cardiovascular System

- denies CP, palpitations, HTN, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur

Gastrointestinal System

- **has abdominal pain and nausea;** denies change in appetite, intolerance to specific foods, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal distention, constipation, diarrhea, change in bowel habit, hemorrhoids or melena

Genitourinary System

- denies urinary urgency, urinary frequency, flank pain, nocturia, oliguria, polyuria, dysuria, incontinence or awakening at night to urinate

Nervous System

- denies HA, seizures, loss of consciousness, sensory disturbances, ataxia, weakness, loss of strength or change in cognition/mental status/memory

Musculoskeletal System

- denies muscle/joint pain, deformity/swelling, redness or arthritis

Peripheral Vascular System

- denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color change

Hematologic System

- denies easy bruising or bleeding, hx of blood transfusions, lymph node enlargement or history of DVT/PE

Endocrine System

- denies polyuria/polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating or hirsutism

Psychiatric

- denies anxiety, depression/sadness, obsessive/compulsive disorder or seeing a mental health professional

Physical Exam (unperformed physical exam underlined)

Pt is AOx3, looks stated age, appears well-developed and well-nourished w/ appropriate hygiene. He appears to be in moderate distress.

Vitals

BP → 131/77 R hand, supine
HR → 66 beats/min, regular rate and rhythm
RR → 18 breaths/min, unlabored
Temp → 97.9 F oral
SpO2 → 99% room air
BMI → 24.9

HEENT

Skin
warm and moist, good turgor, nonicteric, no lesions/scars/tattoos noted

Hair
average quantity and distribution

Nails
no clubbing, capillary refill <2 sec throughout

Head
normocephalic, atraumatic, non-tender to palpation throughout

Eyes
symmetrical OU, no evidence of strabismus/exophthalmos/ptosis, sclera white, conjunctiva & cornea clear, visual fields full OU, PERRLA, EOMs full with no nystagmus

Ears
symmetrical and normal size, no evidence of lesions/masses/trauma on external ears, no discharge/foreign bodies in external auditory canals AU, TM's pearly white/intact with light reflex in normal position AU

Nose
symmetrical, no obvious masses/lesions/deformities/trauma/discharge, nares patent bilaterally/nasal mucosa pink & well hydrated, no discharge noted on anterior rhinoscopy, septum midline without lesions/deformities/injection/perforation, no evidence of foreign bodies

Sinuses
non-tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses

Lips
pink, moist, no evidence of cyanosis/lesions, non-tender to palpation

Mucosa
pink, well hydrated, no masses/lesions noted, non-tender to palpation, no evidence of leukoplakia

Palate
pink, well hydrated, palate intact with no lesions/masses/scars, non-tender to palpation

Teeth
good dentition, no obvious dental caries noted

Gingivae
pink, moist, no evidence of hyperplasia/masses/lesions/erythema or discharge, non-tender to palpation

Tongue
pink, well papillated, no masses/lesions/deviation noted, non-tender to palpation

Oropharynx
well hydrated, no evidence of exudate/masses/lesions/foreign bodies, tonsils present with no evidence of injection or exudate, uvula pink, no edema/lesions

Neck
trachea midline, no masses/lesions/scars/pulsations noted, supple, non-tender to palpation, full ROM, no stridor noted, 2+ carotid pulses, no thrills/bruits noted bilaterally, no palpable adenopathy noted

Thyroid
non-tender, no palpable masses, no thyromegaly

Chest
symmetrical, no deformities/evidence of trauma, respirations unlabored/no paradoxic respirations or use of accessory muscles noted, Lat to AP diameter 2:1, non-tender to palpation

Lungs
clear to auscultation and percussion bilaterally, chest expansion and diaphragmatic excursion symmetrical, tactile fremitus intact throughout, no adventitious sounds

Heart

JVP is <3cm above the sternal angle with the head of the bed at 30°, PMI in 5th ICS in mid-clavicular line, carotid pulses are 2+ bilaterally without bruits, S1/S2 are normal, no murmurs/extra heart sounds

Abdomen

flat, symmetrical, no evidence of striae/caput medusae/abnormal pulsations/masses/scars/striae or abnormal pulsations, BS present in all 4 quadrants, no bruits noted over aortic/renal/iliac/femoral arteries, no evidence of organomegaly, **rigidity and rebound tenderness of the RLQ, positive Psoas and Obturator signs, Rovsing's negative,** no CVA tenderness

Rectal (not performed, pt refused)

Peripheral Vascular

skin normal in color and warm to touch in upper and lower extremities b/l, no calf tenderness b/l, equal in circumference, no palpable cords/varicose veins b/l, no palpable inguinal or epitrochlear adenopathy, no cyanosis, clubbing or edema noted b/l

Mental Status

alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted.

Cranial Nerves

I - Intact no anosmia.
II- VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopic + red light reflex OS/OD, discs yellow with sharp margins. No AV nicking, hemorrhages or papilledema noted.
III-IV-VI- PERRL, EOM intact without nystagmus.
V- Facial sensation intact, strength good. Corneal reflex intact bilaterally.
VII- Facial movements symmetrical and without weakness.
VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.
IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.
XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar

full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No Pronator Drift. Gait normal with no ataxia. Tandem walking and hopping show balance intact. Coordination by RAM and point to point intact bilaterally. Romberg negative.

Sensory

Intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally.

Reflexes	R	L		R	L
Brachioradialis	2+	2+	Patellar	2+	2+
Triceps	2+	2+	Achilles	2+	2+
Biceps	2+	2+	Babinskineg	neg	
Abdominal	2+/2+	2+/2+	Clonus	negative	

Meningeal Signs

No nuchal rigidity noted. Brudzinski's and Kernig's signs negative.

Labs/Imaging

CBC and differential		
	Ref Range & Units	**5/10/19**
WBC	4.5 – 11.0 K/mcL	**12.2** ↑
RBC	4.00 – 5.20 M/mcL	4.99
HGB	12.0 – 16.0 gm/dL	13.8
HCT	36.0 – 46.0 %	42.8
MCV	80.0 – 100.0 fL	85.7
MCH	26.0 – 34.0 pg	27.7
MCHC	31.0 – 37.0 g/dL	32.3
MPV	7.4 – 10.4 fL	7.8
RDW	11.5 – 14.5 %	13.1
PLT	130 – 400 K/mcL	221
Neutrophil %	40.0 – 70.0 %	**80.1** ↑
Lymphocyte %	22.2 – 43.6 %	**9.7** ↓

Monocyte %	2.0 – 11.0 %	9.5
Eosinophil %	0.0 – 8.0 %	0.4
Basophil %	0.0 – 2.0 %	0.3
Neutrophil Abs	1.8 – 7.7 K/mcL	**9.8** ↑
Lymphocyte Abs	1.0 – 4.8 K/mcL	1.2
Monocyte Abs	0.3 – 1.1 K/mcL	**1.2** ↑
Eosinophil Abs	0.0 – 0.7 K/mcL	0.1
Basophil Abs	0.0 – 0.2 K/uL	0.0
NRBC Abs	<=0.00 K/mcL	0.00
NRBC %	<=0.0 %	0.0

BMP

	Ref Range & Units	**5/10/19**
Sodium	136 – 145 mmol/L	136
Potassium	3.5 – 5.1 mmol/L	4.3
Chloride	98 – 108 mmol/L	99
CO2	22 – 29 mmol/L	28
Glucose	74 – 110 mg/dL	**143** ↑
BUN	6 – 23 mg/dL	19
Creatinine	0.70 – 1.20 mg/dL	1.05
Calcium	8.6 – 10.0 mg/dL	9.3
Anion Gap	8 – 16 mEq/L	9
Indices		Slight Hemolysis
eGFR, Non-African-American	>=60 ml/min/1.73m2	>60

CT Abdomen and Pelvis w/ Contrast

Impression: The appendix is dilated and fluid-filled measuring up to 1.3 cm in diameter with small intraluminal appendicolith and adjacent inflammatory changes. **Findings are compatible with acute appendicitis.**

aPTT

	Ref Range & Units	**5/10/19**
aPTT	27.0 – 36.0 second(s)	37.8

Type and Screen (3/13/19)

ABO Grouping	O
Rh Factor	Negative
Antibody Screen	Negative

UA w/Rflx Micro

	Ref Range & Units	**5/10/19**
PH Urine	5.0 – 7.5	**8.5** ↑
Color Urine	Yellow	Yellow
Appearance Urine	Clear	Clear
Glucose Qualitative Urine	Negative mg/dL	Negative
Bilirubin Urine	Negative	Negative
Ketones Urine	Negative mg/dL	Negative
Specific Gravity Urine	1.005 – 1.030	1.024
Blood Urine	Negative	Negative
Protein Urine	Negative mg/dL	Negative
Urobilinogen Urine	0.2 – 1.0 mg/dL	1.0
Nitrite Urine	Negative	Negative
Leukocyte Esterase Urine	Negative	Negative
White Blood Cells Urine	0 – 4 HPF	0 - 4
Red Blood Cells Urine	0 – 3 HPF	0 - 3
Bacteria Urine	Negative	Negative

Squamous Epithelial Cells Urine	0 – 4 HPF	0 - 4
Hyaline Cast Urine	0 – 4 /lpf	0 - 4

Protime-INR

	Ref Range & Units	**5/10/19**
PT	10.0 – 13.0 second(s)	12.8
INR	ratio	1.1

Hepatic Function Panel

	Ref Range & Units	**5/10/19**
Albumin	3.5 – 5.2 g/dL	4.3
Total Protein	6.6 – 8.7 g/dL	7.0
Total Bilirubin	0.0 – 1.2 mg/dL	0.6
Direct Bilirubin	0.0 – 0.3 mg/dL	<0.2
Alk Phos	40 – 129 U/L	126
ALT (SGPT)	0 – 41 U/L	20
AST (SGOT)	5 – 40 U/L	22
Indices		Slight Hemolysis

Manual Differential

	Ref Range & Units	**5/10/19**
PLT Estimate	Adequate (130-400)	Adequate (130-400)
RBC Morphology	Normal	Normal
Segmented Neutrophil Manual	40 – 70 %	**79** ↑
Lymph Manual	22 – 43%	**11** ↓
Monocyte Manual	0 – 9 %	7
Bands Manual	0 – 2 %	2
Lymph Reactive Manual	0 – 8 %	1

Lipase

	Ref Range & Units	**5/10/19**
Lipase	13 – 60 U/L	36

Assessment

57 y/o M w/ no significant PMHx/PSHx, brought in to ED by EMS c/o sharp, constant abdominal pain localized in the RLQ, 7/10, worse w/ movement and started in the middle of the night x12 hours as well as nausea and loss of appetite. Presenting symptoms, PE, labs and imaging studies are most consistent w/ acute appendicitis.

Plan

- NPO
- IVF
- Pain control (Morphine 0.05-0.1 mg/kg)
- Nausea management (Zofran 4 mg IV)
- Labs
- CT abdomen and pelvis w/ contrast
- Abx within 1 hr of surgery (cefoxitin 2g IV QID)
- Anesthesia evaluation
- OR for laparoscopic appendectomy, possibly open
- d/c home if stable post-op
- DVT ppx – encourage early ambulation
- Pain management post-op
- Constipation prevention post-op

Patient Education/Follow-up care

- You were diagnosed with acute appendicitis, an inflammation of appendix which can cause pain, fever, loss of appetite, and an upset stomach.

- You also underwent a laparoscopic appendectomy surgery to remove the appendix, after which you should follow certain instructions:
    - You may shower daily, no baths and do not submerge the wound/incision in warm water
    - Activity as tolerated, ambulate out of bed to chair as tolerated
    - No heavy lifting, pushing or pulling greater than 10-15 pounds for 4-6 weeks
    - Do not drive for 1 week or while on narcotic pain medication
    - Return to general surgery clinic on 5/17/19 at 10AM for a follow-up
- We are also prescribing you some new medications to help manage your symptoms after the surgery
    - Acetaminophen-codeine (Tylenol #3) 300mg/30mg, 2 tabs by mouth every 4 hours as needed to help manage your pain
    - Amoxicillin-clavulanate (Augmentin) 875 mg/125 mg, 1 tab by mouth twice a day for 4 days to make sure you do not develop an infection
    - Docusate sodium (Colace) 100 mg capsule, 1 pill twice a day, to prevent constipation
- Return or call 911 if:
    - Pain persists or gets worse
    - You develop high fevers
    - You have persistent nausea, vomiting or any new or concerning symptoms