Alena Rakhman
H&P #3
Rotation 4 – Surgery

Location: Queens Hospital Center
Date: 5/11/19
Time: 2:30 PM

CC: "abdominal pain" x1 day

HPI
42 y/o M w/ PMHx of venous insufficiency presents to the ED c/o abdominal pain x1 day. Surgical consult was requested. Pt states that the pain started yesterday around 5PM, which became so severe that he was unable to sleep, so he decided to come to the ED to be evaluated. Pain is cramping, constant, 8/10, localized to the LLQ w/o radiation. Straining exacerbates the pain, and nothing makes it better. Nothing OTC. Pt states that he has never had this type of pain before. Pt also c/o dysuria, urinary frequency and flank pain which all started around the same time as abdominal pain. He has been having normal bowel movements daily. He also states that he never had a colonoscopy. Denies fever, chills, nausea, vomiting, diarrhea, constipation, hematuria, recent weight loss, SOB, CP, palpitations, LOC, urinary urgency, family hx of colorectal cancer, recent sick contacts, or recent travel.

Differential Diagnosis
- Diverticulitis
- Nephrolithiasis
- SBO
- Hernia
- Ischemic colitis
- IBD
- Appendicitis
- Colorectal CA
- Infectious colitis

PMH
- Venous (peripheral) insufficiency
- Varicose veins of both lower extremities
- Venous ulcer

Immunizations
Up to date

Past surgical hx
Phlebectomy of left lower extremity (high ligation and venous stripping of greater saphenous vein)

Past hospitalizations
No pertinent hospitalization history

Medication
Medical compression socks 20-30 mmHg, knee high, 2 pairs for b/l use

Allergies
No known medication, food or environmental allergies

Family history
Mother → alive and well, 67
Father → alive and well, 68
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 with his girlfriend in a 5th floor apartment in Queens.
- Occupation – works as a cook in a restaurant.
- Habits – denies hx of smoking cigarettes, drinking alcohol or illicit drug use.
- Education – high school.
- Diet – regular diet.
- Exercise – other than walking to work, does not exercise.
- Safety measures – admits to wearing a seatbelt.
- Sexual hx – is currently sexually active with 1 female partner, his girlfriend. States that he uses condoms and denies hx of STIs.

ROS

General

- denies generalized weakness/fatigue, recent weight loss or gain, loss of appetite, 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

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

Genitourinary System

- **reports dysuria, flank pain, and urinary frequency;** denies urinary urgency, nocturia, oliguria, polyuria, 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

- **has varicose veins;** denies intermittent claudication, coldness or trophic changes, 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 → 111/73 R hand, supine
HR → 77 beats/min, regular rate and rhythm
RR → 18 breaths/min, unlabored
Temp → 98.9 F oral
SpO2 → 97% room air
BMI → 26.3

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, **tenderness to the LLQ w/ guarding, nondistended, no rebound/rigidity, left CVA tenderness present**

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, **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

UA w/Rflx Micro

	Ref Range & Units	**5/11/19**
PH Urine	5.0 – 7.5	7.5
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	1.018
Blood Urine	Negative	Negative
Protein Urine	Negative mg/dL	Negative

Urobilinogen Urine	0.2 – 1.0 mg/dL	0.2
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

Urine Culture – 5/11/19 → <100 CFU/mL

Manual Differential

	Ref Range & Units	**5/11/19**
PLT Morphology	Normal	Normal
PLT Estimate	Adequate (130-400)	Adequate (130-400)
RBC Morphology	Normal	Normal
Segmented Neutrophil Manual	40 – 70 %	**87** ↑
Lymph Manual	22 – 43 %	**4** ↓
Monocyte Manual	0 – 9 %	2
Bands Manual	0 – 2 %	**7** ↑

BMP

	Ref Range & Units	**5/11/19**
Sodium	136 – 145 mmol/L	141
Potassium	3.5 – 5.1 mmol/L	4.6
Chloride	98 – 108 mmol/L	102
CO2	22 – 29 mmol/L	25
Glucose	74 – 110 mg/dL	100
BUN	6 – 23 mg/dL	11
Creatinine	0.70 – 1.20 mg/dL	0.89
Calcium	8.6 – 10.0 mg/dL	9.2
Anion Gap	8 – 16 mEq/L	14
eGFR, Non-African-American	>=60 ml/min/1.73m2	>60

CBC and differential

	Ref Range & Units	**5/11/19**
WBC	4.5 – 11.0 K/mcL	**16.3** ↑
RBC	4.00 – 5.20 M/mcL	4.95
HGB	12.0 – 16.0 gm/dL	14.7
HCT	36.0 – 46.0 %	44.5
MCV	80.0 – 100.0 fL	89.9
MCH	26.0 – 34.0 pg	29.8
MCHC	31.0 – 37.0 g/dL	33.1
MPV	7.4 – 10.4 fL	8.5
RDW	11.5 – 14.5 %	13.7
PLT	130 – 400 K/mcL	213
Neutrophil %	40.0 – 70.0 %	**85.8** ↑
Lymphocyte %	22.2 – 43.6 %	**7.5** ↓
Monocyte %	2.0 – 11.0 %	5.5
Eosinophil %	0.0 – 8.0 %	0.4
Basophil %	0.0 – 2.0 %	0.8
Neutrophil Abs	1.8 – 7.7 K/mcL	**13.9** ↑
Lymphocyte Abs	1.0 – 4.8 K/mcL	1.2
Monocyte Abs	0.3 – 1.1 K/mcL	0.9
Eosinophil Abs	0.0 – 0.7 K/mcL	0.1

Basophil Abs	0.0 – 0.2 K/uL	0.1
NRBC Abs	<=0.00 K/mcL	0.00
NRBC %	<=0.0 %	0.0

Hepatic Function Panel

	Ref Range & Units	**5/11/19**
Albumin	3.5 – 5.2 g/dL	4.4
Total Protein	6.6 – 8.7 g/dL	6.8
Total Bilirubin	0.0 – 1.2 mg/dL	0.3
Direct Bilirubin	0.0 – 0.3 mg/dL	<0.2
Alk Phos	40 – 129 U/L	48
ALT (SGPT)	0 – 41 U/L	24
AST (SGOT)	5 – 40 U/L	23

Lipase

	Ref Range & Units	**5/11/19**
Lipase	13 – 60 U/L	32

CT Abdomen Pelvis without contrast (5/11/19)
Impression:
Acute diverticulitis of the descending/sigmoid colon.

Assessment
42 y/o M w/ PMHx of venous insufficiency presents to the ED c/o cramping, constant, 8/10, abdominal pain localized to the LLQ w/o radiation, dysuria, urinary frequency and left flank pain x1 day. Presenting symptoms, PE, labs and imaging studies are most consistent w/ acute diverticulitis of the descending/sigmoid colon without perforation or abscess without bleeding.

Plan
- admit to surgery service
- NPO
- IVF
- Zosyn IV q6h
- Pain control
- Serial abdominal exams
- DVT ppx w/ enoxaparin
- Encourage ambulation
- f/u repeat labs
- Colonoscopy as outpatient
- Augmentin x2 weeks prescription w/ d/c
- f/u in clinic

Patient Education/Follow-up care
- You have been diagnosed with diverticulitis, when small pouches form in your colon aka large intestine and become inflamed or infected.
- When you are discharged and go home, eat a low-fiber diet, monitor your temperature and report any rising temperature to your healthcare provider, drink 6-8 glasses of water every day, and you may also use a heating pad or hot water bottle to reduce abdominal cramping or pain.
- We are prescribing you new medication:
    - Antibiotic Augmentin, 875 mg/125 mg, take 1 tablet by mouth twice a day for 14 days
    - You are also scheduled to follow-up with our clinic, where we will also schedule you for a colonoscopy
- In order to prevent diverticulitis in the future:
    - Eat a high-fiber diet
    - Keep drinking 6-8 glasses of water every day
    - Begin an exercise program
    - Treat diarrhea with a bland diet
    - Watch for changes in your bowel movements such as constipation to diarrhea

    - Avoid constipation with fiber and add a stool softener if needed
    - Get plenty of rest and sleep
- Seek medical help immediately if you are experiencing any of these:
    - Fever of 100.4 F or higher
    - Chills
    - Severe cramps or tenderness in the abdomen
    - Nausea and vomiting
    - Bleeding from your rectum