5/4/2019

Mariyanthire Linans

Third Hospital Visit - Emergency Department

History

-Identifying Data
-Full name - JG
-Address - Queens, NY
-Date of Birth - 7/24/1942
-Date and Time - 4/30/2019, 8:00 AM
-Location - New York Presbyterian / Queens, Flushing, NY
-Religion - Catholic
-Source of information - self
-Source of referral - none
-Mode of transportation - Taxi

-Chief Complaint ML 5/4/2019
"My stomach hurts" x 1 day

-History of Present Illness
JG is a 76 year old reliable, widowed, Latino man with a significant past medical history of gastritis who presents to the ED complaining of lower left abdominal pain for one day. The pain is constant, but worsens 1-2 hours after eating the rates his pain as an 8/10. JG took acetaminophen 500mg / Milanta, and famotidine 40mg for little relief, but reports feeling mild relief when lying down compared to standing. He also complains of mild nausea, headache, and constipation (last bowel movement 2 days ago). He denies any vomiting, diarrhea, bloody stools, eructations, flatulence, intolerance to foods, recent travel or pyrosis. JG reports having felt similar pain in the past, but not as intensely as this most recent episode.

does it happen after eating specific foods? < same for fatty etc

Chest pain? always consider AAA starting in that region and moving to back. dyspnea? SOB?

-Past Medical History

-Present illnesses:

1) Gastritis x 18 months

-Reports having been hospitalized for gastritis 7 times at New York Presbyterian/Queens

-Treated with famotidine and myfanta (see Medications)

2) Benign prostatic hyperplasia x "a few years" (could not give more specific time frame

-Scheduled for surgery 5/1/2019 at New York Presbyterian/Queens

- Urologist's name unavailable

-Past medical illnesses

1) Tumor in right lower abdomen → patient not sure exactly what it was → 45 years ago

-Surgically removed (Hospital and surgeon's name)

-Denies any childhood illnesses

-Immunizations:

-Up to date

-Receives flu shot annually → November 2018

-Pneumonia vaccine November 2018

-Screening tests and results:

1) Colonoscopy 2017 → normal

2) Prostate exam 2-3 months ago → enlarged

-Past Surgical history

1) Tumor removed from lower right abdomen → 45 years ago

-Does not recall which hospital or the surgeon's name

-Denies any complications

2) Scheduled for BPH surgery on 5/1/2019 at New York Presbyterian/Queens

-Denies any other surgeries or injuries

-Denies any blood transfusions

→ -last dose last night ~10:30 PM

-Medications
1) Famotidine (Pepcid) 40 mg → For gastritis
-PO, 30-60 minutes before meals
-last dose this morning before breakfast
2) Mylanta 500 mg/5 mL oral suspension → for gastritis
-PO, as needed for stomach discomfort
3) Acetaminophen (Tylenol) 500 mg → for pain
-PO, as needed
-last dose this morning for headache

-Allergies
-JG denies any known allergies to medications, foods, or environmental factors

-Family history
-Mother - Deceased at 101 from natural causes
-Denies any hypertension, hyperlipidemia, diabetes, cancer, or any other medical conditions
-Father - Deceased at age 68, cause unknown
-Denies any hypertension, hyperlipidemia, diabetes, cancer, or any other medical conditions
-JG denies any knowledge of his maternal and paternal grandparents' health

-Social history
-JG is a widowed male living with his sister and 2 brothers. He does not currently work
-Habits:
-JG denies ever drinking alcohol
-Denies current or past smoking or tobacco use
-Denies any illicit drug use past and present
-JG denies any recent travel
-Diet - JG eats a balanced diet. He does not drink

caffeinated beverages
- Exercise - JG walks with a cane, so he does not exercise too much. He takes walks when the weather is nice
- Admits to wearing a seatbelt
- Sexual history - JG is not currently sexually active, and has not been since his wife died several years ago
- In the past he has only been sexually active with 1 woman
- ~~He is not currently taking any bir~~ ML 5/14/2019
- Denies history of STIs

-Review of Systems
- General
  - Denies any recent weight loss or gain, loss of appetite, generalized weakness/fatigue, night sweats, fever, or chills
- Skin, Hair, and Nails
  - Reports having a scar on his lower right abdomen from previous surgery to remove a tumor
  - Denies any changes in texture, excessive dryness, sweating, discolorations, pigmentations, moles/rashes, pruritis, or changes in hair distribution
- Head
  - Reports having a mild headache that started last night (at the same time as the abdominal pain); he rates the pain as 5/10 and describes as a mild throbbing in the right temporal area. Nothing makes the pain worse, but he reports pain relief after taking acetaminophen. The pain does not radiate. The pain comes and goes
  - Denies vertigo or head trauma

-Eyes
-Reports having cataract in left eye
-Wears reading glasses
-Denies visual disturbances, lacrimation, photophobia, or pruritis
-Ears
-Denies any deafness, pain, discharge, tinnitus, or use of hearing aids
-Nose / Sinuses
-Denies discharge, epistaxis, or obstruction
-Mouth and Sinuses
-Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures
-Practices good oral hygiene
-Last dental exam 6 months ago
-Neck
-Denies any localized swelling/lumps, stiffness, or decreased range of motion
-Breast
-Denies any lumps, nipple discharge, or pain
-Pulmonary System
-Denies any dyspnea, dysphea on exertion, cough, wheezing hemophysis, cyanosis, othophnea, and paroxysmal nocturnal dyspn
-Cardiovascular System
-Denies chest pain, history of hypertension, heart palpatations, irregular heartbeat, syncope, or a known heart murmur
-Gastrointestinal System
-Complains of lower left abdominal pain, nausea, and constipation (last BM 2 days ago) for 1 day
-History of gastritis (x 18 months) and abdominal surgery (45 years ago)
-Denies changes in appetite, vomiting, dysphagia, pyrosis,

flatulence, eructations, diarrhea, jaundice, hemorrhoids, or blood in stool

- Genitourinary System
  - History of BPH → scheduled for surgery
  - Complains of urinary hesitancy → urinates every 1-2 hours
  - Denies incontinence, dysuria, nocturia, urgency, oliguria, or polyuria
  - Last prostate exam 2-3 months ago → enlarged
- Sexual History
  - See Social History
- Musculoskeletal System
  - Denies muscle/joint pain, deformity or swelling, redness, or arthritis
- Nervous System
  - Denies seizures, headaches, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in mental status/cognition/memory, or weakness
- Peripheral Vascular System
  - Denies intermittent claudication, coldness, trophic changes, varicose veins, peripheral edema, or color change
- Hematologic System
  - Denies anemia, easy bruising or bleeding, lymph node enlargement or history of DVT/PE
- Endocrine System
  - Denies polyuria/polydipsia/polyphagia, heat or cold intolerance goiter, excessive sweating, and hirsutism
- Psychiatric
  - Denies depression/sadness, anxiety, OCD, having seen a mental health professional, or taking ~~and~~ medications

Physical

-General

-Thin, well nourished male, neatly groomed, alert and oriented x 3, looks his age; in no acute distress

-Vital Signs

-BP (supine) - 138/74 (right arm), 136/72 (left arm)

-Respiration rate - 15 breaths/min, unlabored

-Temperature - 36.4 °C, oral

-O_2 % - 100%, room air

-Pulse - 55 bpm, regular

-Height - 5'6"

-Weight - 137 lbs

-BMI - 22.11 (normal)

-Skin, Hair, Nails, and Head

-Skin - horizontal scar from previous surgery (4 inches)

- Skin warm and moist, good turgor, nonicteric, no tattoos

-Hair - thinning on frontal and parietal regions

- Normal texture

-Nails - no clubbing, paronychia, or lesions; capillary refill <2 seconds throughout

-Head - normocephalic, atraumatic, nontender to palpation throughout

-Eyes

-Symmetrical OU, no evidence of strabismus, exophthalmus, ptosis

-Sclera white, conjuctiva pink OU, cornea clear OD

-Cataract in left eye (OS)

-Visual acuity (uncorrected) - 20/25 OU, 20/20 OD, — OS

-Visual fields full OU, EOM intact, PERRL

-No nystagmus visualized
-Fundoscopy:
  -Red reflex intact ~~bilateraltly~~, cup: disc <0.5 ~~OU~~ OD; not visualized OS (ML 5/4/2019 OD) (ML 5/4/2019)
  -No evidence of AV nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OD

-Ears
  -Symmetrical and normal size. No evidence of lesions/masses/trauma on external ears
  -No discharge/foreign bodies in external auditory canals AU
  -TMs intact and pearly gray with light reflex in normal position AU
  -Auditory acuity intact to whispered voice AU
  -Weber midline, Rinne test reveals AC >BC AU

-~~Nose and Sinuses~~
  -Nose symmetrical; no obvious masses/lesions/deformities/discharge
  -Nares patent bilaterally
  -Nasal mucosa pink and moist; no discharge or foreign bodies
  -Septum midline without lesions/deformities/injection/perforation
  -Sinuses nontender to palpation and percussion over frontal and maxillary sinuses

-Mouth and Pharynx
  -Lips - pink and moist; no evidence of cyanosis or lesions; nontender to palpation
  -Mucosa - pink, well-hydrated; no masses, lesions; no evidence of leukoplakia
  -Palate - pink and well-hydrated; intact with no lesions, masses, or scars
  -Teeth - good dentition; no obvious dental caries

-Gingivae - pink and moist; no evidence of hyperplasia, masses, lesions, erythema, or discharge
-Tongue - pink, well-papillated; no masses, lesions, or deviation
-Oropharynx - well-hydrated; no evidence of injection, exudate, masses, lesions, or foreign bodies
- Grade I tonsils present without evidence of injection or exudate
-Uvula pink without edema or lesions

-Neck, Trachea, and Thyroid
-Neck - trachea midline; no masses, lesions, scars, or pulsations
-Supple, nontender to palpation
- Full range of motion
- No stridor noted; 2+ carotid pulses; no thrills or bruits bilaterally
-No palpable adenopathy noted
-Thyroid - non-tender; no palpable masses, thyromegaly, or bruits

-Chest and Lungs
-Chest - symmetrical; no deformities or signs of trauma
-Respiration unlabored / no paradoxic respiration or use of accessory muscles noted
-Lateral AP diameter 2:1
-Nontender to palpation
-Lungs - clear to auscultation bilaterally; no rales / ronchi / wheezes
-No egophony, tactile fremitus, or abnormal percussion

-Cardiovascular
-JVP 2 cm above sternal angle with head at 30°, PMI in 5th intercostal space in left midclavicular line
-Carotid pulses 2+ bilaterally

- Regular rate and rhythm; S1 and S2 present
- No murmurs, S3 or S4, splitting of heart sounds, friction rubs, or other extra sounds on auscultation

- Abdomen
  - Abdomen is flat and symmetrical without striae, caput medusae, or abnormal pulsations
  - 4 inch horizontal scar on lower right abdomen from previous surgery
  - Bowel sounds present in all 4 quadrants; no bruits noted over aortic, renal, iliac, or femoral arteries
  - Tympani to percussion throughout
  - Mild tenderness to percussion and light / deep percussion over lower left quadrant
  - No evidence of organomegaly; no masses noted
  - No evidence of guarding, rebound tenderness, or CVA tenderness

- Breast
  - Symmetric; no dimpling or masses; nipples without discharge
  - No axillary nodes palpable

- Genitourinary Male
  - Uncircumcised male; prepuce easily retractable
  - No penile discharge or lesions.
  - No scrotal swelling or discoloration; testes descended bilaterally, smooth, and without masses
  - Epididymis nontender
  - No inguinal or femoral hernias noted

Rectal Male
- No perirectal lesions or fissures

-External sphincter tone intact; rectal vault without masses
-Prostate enlarged, but smooth and nontender with palpable median sulcus
-Stool brown and hemoccult negative

-Peripheral Vascular
-Extremities normal in color, size, and temperature
-Pulses 2+ bilaterally in upper and lower extremities
-No bruits, clubbing, cyanosis, or edema noted
-No stasis changes or ulcerations noted

-Musculoskeletal ~~Upper~~ ML 5/4/2019
-No soft tissue swelling/erythema/ecchymosis/atrophy/deformities in bilateral upper and lower extremities
-Nontender to palpation and no crepitus noted throughout
-Full range of motion of all upper and lower extremities bilaterally
-No evidence of spinal deformities
-Drop-arm test, SITS tests, Phalen's test, Tinel's sign, Finkelstein's test, straight leg raise test, Lachman's test, anterior/posterior draw signs, valgus/varus tests, McMurray's test, Apley's compression test, patellar apprehension test, patellofemoral grinding test, and ballotment test negative

-Neurological
-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 - see eye exam fundoscopy

- III, IV, VI - PERRL; EOM intact; no nystagmus
- V - Facial sensation intact; strength good
  - Corneal reflex intact bilaterally
- VII - Facial movements symmetrical and without weakness
- VIII - See ear exam
- 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 range of motion of all extremities without rigidity or spasticity
  - Normal muscle bulk and tone; no atrophy, tics, tremors, or fasciculations
  - Strength equal and 5/5 throughout
  - Negative Romberg sign and pronator drift
  - Gait normal without ataxia
  - Tandem walking and hopping show balance intact
  - Coordination by RAM and part to point intact bilaterally
- Sensory - intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosia, graphesthesia testing bilaterally
- Reflexes -

	R	L		R	L
Brachioradialis	2+	2+	Patellar	2+	2+
Triceps	2+	2+	Achilles	2+	2+
Biceps	2+	2+	Babinski	neg	neg
Abdominal	2+	2+	Clonus	neg	neg

- Meningeal Signs - no nuchal rigidity noted
  - Brudzinski's and Kernig's signs negative

Assessment

JG is a 76 year old reliable male with a significant past medical history of gastritis complaining of lower left abdominal pain consistent with diverticulitis. ✓

Plan

① ~~Diverti~~ ML 5/14/2019 ~~lower left abdominal pain consistent with~~ diverticulitis
- Ultrasound and CT scan to confirm diagnosis
- Analgesics for pain IV
- NPO until symptoms resolve, then high fiber diet ✓
- IV fluids
- IV antibiotics
- Sublingual zofran for nausea

② Headache
- Fluids
- NSAIDs as needed ✓ please list which meds you are referring to even though listed under meds

③ Gastritis
- Continue medication as directed ✓ and diet modification

④ Benign Prostatic Hyperplasia
- Scheduled for TURP 5/1/2019 ✓

Problem List

1) Diverticulitis
2) Headache ✓
3) Gastritis
4) Benign Prostatic Hyperplasia

Differential Diagnosis

① Diverticulitis - lower left abdominal pain, nausea, and constipation ✓
- Confirm/rule out with CT/ultrasound

② Sigmoid volvulus - lower left abdominal pain, nausea, and constipation ✓

④

- rule out with abdominal CT

③ Large bowel obstruction - abdominal pain, nausea, and constipation
- Rule out with abdominal CT

④ Gastritis - abdominal pain, nausea, history of gastritis
- Rule out due to lower, not upper left abdomen pain and lack of pyrosis
- Rule out with abdominal CT and endoscopy

⑤ Colon cancer - lower abdominal pain, age, constipation
- rule out with fecal occult blood tests, colonoscopy
- rule out due to recent normal colonoscopy

95.5%