CUNY York College Physician Assistant Program
Fall 2020
Mariyanthie Linaris
OB/GYN Rotation – Queens Hospital Center

History and Physical 1

Identifying Data:
- *Name:* AF
- *Sex:* Female
- *Age:* 27 years
- *Date:* 12/3/2020
- *Location:* Queens Hospital Center – OB Triage
- *Source of Information:* Self

Chief Complaint:
Elevated liver enzymes x 1 day

History of Present Illness:
AF is a 27-year-old G1P0000 GDMA1 female at 30w6d gestation with an EDD of 2/5/2021 with no significant PMH being recalled to OB triage following elevated LFTs at evaluation in clinic yesterday (12/2/2020). She established care at the QHC clinic on 11/18/2020 following her return from Bangladesh and endorses some prenatal care in Bangladesh. AF reports that her prenatal course has been complicated by vaginal bleeding described as an initial gush followed by spotting x 1 week at 13 weeks gestation in Bangladesh due to a low-riding placenta treated with daily progesterone 200 mg x 1 month, elevated serum lead levels, and GDMA1 diagnosed on 12/2/2020. Currently, AF reports no complaints and is feeling well. She endorses fetal movement and denies pain, fluid leakage, vaginal bleeding, contractions, abdominal pain, pruritis, jaundice, nausea, vomiting, diarrhea, fever, chills, body aches, irritative voiding symptoms, chest pain, SOB, coughing, or sick contacts. She returned from an extended stay in Bangladesh in 10/2020.

Antepartum Course:
- Late registrant to clinic – 11/18/2020 (28 weeks 5 days gestation)
    - PNC in Bangladesh prior to this
- 2 total prenatal visits (11/18/2020 and 12/2/2020)
- GDMA1 – diagnosed 12/2/2020
    - GCT elevated at 1 hour – 198 mg/dL
- Elevated lead level – 5
    - Treating with calcium carbonate
- Vaginal bleeding at 13 weeks
    - Reports that she was told in Bangladesh that this was due to a low-riding placenta
        - US on 11/27/2020 showed no placental abnormality
- Anatomy sonogram within normal limits

OB History:
- G1P0000

Past Medical History:
- *Present Illnesses:*
    - GDMA1 diagnosed on 12/2/2020
- *Past Illnesses:*
    - Congenital retinoschisis

    - Traumatic retinal hemorrhage x 2 – 2001, 2008
- *Hospitalizations:*
    - Hospitalization for right eye surgery
- *Immunizations:*
    - Up to date
        - Influenza 11/18/2020
        - TDaP 12/2/2020

Past Surgical History:
- Right eye surgery – 2012

Medications:
1. Prenatal vitamins – folic acid – iron QD PO
2. Calcium carbonate 500 mg BID PO
3. Ferrous sulfate 325 mg QD PO
4. Colace 100 mg QD PO PRN

Allergies:
AF denies any known allergies to medications, foods, or environmental factors

Social History:
- 27-year-old married Muslim female
- Denies tobacco, alcohol, or illicit drug use
- Denies history of STIs
- Not currently sexually active
    - Only sexually active with her husband in the past

Review of Systems:
See HPI

Physical Exam:
Vital Signs:
Blood Pressure: 118/77 (left arm, supine)
Heart Rate: 85 beats/minute (regular)
Respiration Rate: 18 breaths/minute (nonlabored)
Temperature: 98.6 F (oral)
O_2 Sat: 100% (room air)
Height: 62 inches
Weight: 138 lbs
BMI: 25.28
General Appearance:
AF is a 27-year-old pregnant female who appears her stated age. A&O x 3. Appears anxious but is cooperative. Well-appearing, in NAD.
Skin:
No pallor or discolorations observed. Skin warm and moist throughout with appropriate turgor

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Heart:
RRR; S1 and S2 present without murmurs, rubs, or gallops.
Lungs:
No increased effort of breathing or asymmetrical chest movement noted. Clear to auscultation bilaterally without adventitious lung sounds.
Abdomen:
Appearance consistent with 30 weeks gestation; linea nigra observed. BS present in all 4 quadrants. Abdomen soft and nontender throughout. Gravid uterus – size consistent with gestational age
Female Pelvic Exam:
Performed with nurse chaperone. External genitalia unremarkable. No obvious bleeding, fluid leakage, or abnormal discharge noted on external exam. Unable to perform internal exam because patient was unable to tolerate due to anxiety and discomfort
Peripheral Vascular:
Extremities unremarkable in appearance, size, and color. Nontender to palpation without edema.
Neurological:
Grossly intact. No observed movement or gait abnormalities.

EFM:

- Fetal heart rate present – baseline 150s
- Category 1 tracing x 20 minutes before discontinued

Imaging:

- *OB triage US*
  - Vertex presentation
  - Posterior placenta
  - AFI 8
  - + Fetal movement and fetal heart rate
  - Estimated fetal weight 1960g

Labs:

- Hepatic Function Panel
  - 12/2/2020
    - Albumin 3.8 | Total Protein 6.6 | TBili 0.4 | Direct Bili 0.1 | AlkPhos 114 | **ALT 131** | **AST 64**
  - 12/3/2020
    - Albumin 3.7 | Total Protein 6.8 | TBili 0.5 | Direct Bili < 0.2 | AlkPhos 116 | **ALT 139** | **AST 70**
- CBC

  11.7
  12.03) --------- (198
  35.1
- BMP

  137 | 104 | 8
  ----------< 91
  3.6 | 22 | 0.53
- Coags WNL

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Assessment:

AF is a 27-year-old G1P0000 GDMA1 female at 30w6d gestation with an EDD of 2/5/20201 with no significant PMH being recalled to OB triage following elevated LFTs at evaluation in clinic yesterday (12/2/2020) to rule out pre-eclampsia vs hepatobiliary pathology.

Plan:

1. Uptrending LFTs – r/o pre-eclampsia vs hepatobiliary pathology
    a. Admit to L&D for continuous monitoring
    b. Start Magnesium 2g/hour x 12 hours for fetal neuroprotection
        i. Check magnesium levels QID
        ii. Clinical mag check Q2-4 hours
    c. Betamethasone x 2 for fetal lung maturation in case of early delivery
    d. Follow up labs
        i. Hepatitis panels
        ii. Morning labs – LFTs
    e. GI consult 12/4/2020
    f. RUQ official sonogram 12/4/2020
    g. Pain management as needed – acetaminophen
2. GDMA1
    a. Finger-stick glucose Q4 hours
    b. Insulin
    c. Low-carb diet
3. Elevated serum lead levels
    a. Continue calcium carbonate
4. Continue FHT, toco
5. Vital signs as per floor protocol
6. DVT prophylaxis – sequential compressive device
    a. Instructed to keep boots on while lying down in bed
7. Reexamine as needed

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History and Physical 2

Identifying Data:
- *Name:* DM
- *Sex:* Female
- *Age:* 17 years
- *Date:* 12/3/2020
- *Location:* Queens Hospital Center – OB Triage
- *Source of Information:* Self

Chief Complaint:
Felt gush of fluid 2 hours ago

History of Present Illness:
DM is a 21-year-old G1P0000 female at 39w1d gestation with an EDD of 12/9/2020 with no significant PMH who presented to OB triage complaining of feeling a "gush of fluid" at about 5:00 PM today. She reports that she a gush of clear fluid pass after she finished urinating. She also complains of 7/10 constant, non-radiating, cramping lower abdominal pain that also began at 5:00 PM. She presented to OB Triage earlier today complaining of vaginal spotting x 1 day and was evaluated to rule out PROM. PROM was ruled out and DM was discharged with instructions to keep her normal prenatal visits and return if she experiences worsening bleeding, a fluid gush, or decreased fetal movement. Currently she reports that the spotting is improved and is currently presenting only as a dark brown discharge. She established care at the QHC clinic on 5/22/2020 at 11 weeks gestation. As per DM and chart review, she was seen in triage on 11/20/2020 to again rule out PROM after noticing a clear white discharge. She endorses fetal movement and denies contractions, nausea, vomiting, diarrhea, fever, chills, body aches, irritative voiding symptoms, chest pain, SOB, coughing, or sick contacts.

Antepartum Course:
- QHC clinic patient – established care 5/22/2020 (11 weeks gestation)
  - Last visit 11/27/2020 – 12 visits
- OB Triage visits:
  - 11/20/2020 – clear white discharge, PROM ruled out
  - 12/3/2020 (AM) – vaginal spotting, PROM ruled out
- Anatomy sonogram at 33 weeks showed EIF
  - Counselled by genetics
- NIPS declined
- Quad screen cancelled by lab because collected at 21w6d
- GBS negative

OB History:
- G1P0000

Past Medical History:
- *Present Illnesses:*
  - Denies
- *Past Illnesses:*
  - Denies

- *Hospitalizations:*
    - Denies

Past Surgical History:

- Tonsillectomy – 2019
    - Reports no problems with general anesthesia

Medications:

1. Prenatal vitamins – folic acid – iron QD PO
2. Ferrous sulfate 325 mg QD PO
3. Colace 100 mg QD PO PRN

Allergies:

DM reports allergies to peaches and tomatoes and denies any known allergies to medications, other foods, or environmental factors

Social History:

- 21-year-old single female
- Denies tobacco, alcohol, or illicit drug use
- Denies history of STIs

Review of Systems:

See HPI

Physical Exam:

Vital Signs:

Blood Pressure: 111/72 (left arm, supine)
Heart Rate: 99 beats/minute (regular)
Respiration Rate: 18 breaths/minute (nonlabored)
O_2 Sat: 100% (room air)

General Appearance:

DM is a 21-year-old pregnant female who appears her stated age. A&O x 3. Calm and cooperative. Appears uncomfortable, but in NAD.

Skin:

No pallor or discolorations observed. Skin warm and moist throughout with appropriate turgor

Heart:

RRR; S1 and S2 present without murmurs, rubs, or gallops.

Lungs:

No increased effort of breathing or asymmetrical chest movement noted. Clear to auscultation bilaterally without adventitious lung sounds.

Abdomen:

Appearance consistent with 39 weeks gestation. BS present in all 4 quadrants. Abdomen soft and nontender throughout. Gravid uterus – size consistent with gestational age

Female Pelvic Exam:

Performed with nurse chaperone. External genitalia unremarkable. No obvious bleeding, fluid leakage, or abnormal discharge noted. Vulva, vagina, and cervix unremarkable on speculum exam. No pooling or

bleeding observed on speculum exam; mucous-like discharge noted. Bimanual exam unremarkable. VE 1/30/-3

Peripheral Vascular:

Extremities unremarkable in appearance, size, and color. Nontender to palpation without edema.

Neurological:

Grossly intact. No observed movement or gait abnormalities.

EFM/Toco:

- Fetal heart rate present – 135 bpm
- Category 2 tracing
- Mild irregular contractions

Imaging:

- *OB triage US*
  - Vertex presentation
  - Anterior placenta
  - AFI 8
  - + Fetal movement and fetal heart rate
  - Estimated fetal weight 3400g

Labs:

- Blood type B+
- UA negative
- **Amnisure positive**

Assessment:

DM is a 21-year-old G1P0000 female at 39w1d gestation with an EDD of 12/9/2020 with no significant PMH who presented to OB triage complaining of feeling a "gush of fluid" and lower abdominal cramping starting at about 5:00 PM today. Positive Amnisure indicates PROM with category 2 tracing as per toco.

Plan:

1. Category 2 FHT
   a. Admit to L&D for continuous monitoring
   b. Collect routine labs
   c. COVID-19 swab pending
2. PROM – Amnisure positive
   a. Admit for labor
   b. Pain management as needed – acetaminophen, morphine
3. NPO, IVF
4. Continue FHT, toco
5. Vital signs as per floor protocol
6. DVT prophylaxis – sequential compressive device
   a. Instructed to keep boots on while lying down in bed
7. Reexamine as needed

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History and Physical 3

Identifying Data:

- *Name:* KL
- *Sex:* Female
- *Age:* 45 years
- *Date:* 12/3/2020
- *Location:* Queens Hospital Center – Emergency Department Consultation
- *Source of Information:* Self
- *Source of Referral:* QHC Hematology Clinic

Chief Complaint:

Severe anemia secondary to abnormal uterine bleeding

History of Present Illness:

KL is a 45-year-old G0 female with a significant history of fibroids (s/p myomectomy in 2010) who presents to the ED due to a hemoglobin level of 6.2 as per labs drawn by the hematology clinic today secondary to heavy menstrual bleeding over the last week. She reports that she has had heavy periods due to known growing fibroids for the last 2 years. Her periods are regular and last for 3 weeks with heavy bleeding and clot passage for the first 3 days such that she soaks through and has to change her pad every 2 hours and lighter bleeding for the rest of the duration such that she changes her pad twice daily. Her LMP began on 11/26/2020 and is currently ongoing. She reports moderate flow with 1.5 cm clots today. KL reports that she takes aspirin when she notices clots because she believes it will keep her from producing further clots but has never been advised to do so by a medical provider. She last took aspirin today at 11:00 AM. She has presented to the ED for several blood and iron transfusions over the last 2 years, with the most recent in 7/2020 and 9/2020, respectively. She follows with her gynecologist and hematologist for symptomatic iron deficiency anemia due to fibroids. She has been treated unsuccessfully in the past with oral hormonal contraceptives and has been offered a hysterectomy for symptom resolution but refused due to her nulliparity. Currently, she endorses intermittent episodes of palpitations and SOB and denies fever, chills, chest pain, coughing, nausea, vomiting, diarrhea, hematuria, blood in her stool, easy bruising, or any other symptoms.

OB History:

- G0

GYN History:

- Menarche at age 13
- Menses regular and with prolonged bleeding
    - 28-30 day cycle
    - 14-15 days of bleeding; heavy for first 3 days
- History of fibroids
    - Myomectomy 2010
    - New growing fibroids over last 2 years
    - Treated in the past with hormonal oral contraceptives (norethindrone) but discontinued due to unfavorable side effects
- Denies history of endometriosis, polyps, STIs, PID, abnormal pap, GYN cancer, and ovarian cyst
- Last pap 2019 - normal

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Past Medical History:

- *Present Illnesses:*
  - Fibroids x 15 years
- *Past Illnesses:*
  - SBO 9/2020
    - Treated conservatively with NGT

Past Surgical History:

- Myomectomy – 2010
  - Reports no problems with general anesthesia
- History of several blood transfusions in the past
  - Most recently 7/2020

Family History:

- Cervical cancer in maternal grandmother

Medications:

1. Ibuprofen 200 mg PRN
2. Baby aspirin PRN
   a. Last dose 11:00 AM

Allergies:

KL reports allergies to clarithromycin and norethindrone and denies any known allergies to other medications, foods, or environmental factors

Social History:

- 45-year-old single female
- Denies tobacco, alcohol, or illicit drug use
- Denies history of STIs

Review of Systems:

See HPI

Physical Exam:

Vital Signs:

Blood Pressure: 120/66 (left arm, sitting)
Heart Rate: **117 beats/minute (regular)**
Respiration Rate: 14 breaths/minute (nonlabored)
Temperature: 98.4 F (oral)
O_2 Sat: 100% (room air)

General:

45-year-old female seen at bedside in GYN evaluation room. A&O x 3. Appears mildly agitated. Well-appearing, in NAD

Skin:

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No discolorations or cyanosis noted throughout. Conjunctiva pale, mucous membranes moist. Skin is warm and moist throughout. Appropriate skin turgor. No ecchymosis or petechiae observed. Capillary refill <2 seconds throughout

Heart:

Tachycardic with regular rhythm; S1 and S2 present without murmurs, rubs, or gallops.

Lungs:

No increased effort of breathing or asymmetrical chest movement noted. Clear to auscultation bilaterally without adventitious lung sounds.

Abdomen:

Abdomen flat and nondistended. No abnormal pulsations visualized. BS + in all 4 quadrants. Soft and nontender to palpation with no palpable masses throughout.

Female Pelvic:

Patient became agitated when provider expressed interest in performing pelvic exam and ultrasound; patient refused due to concerns that the exam would precipitate heavier bleeding and pain based on past experiences. Agreed to show provider her pad which had been on for several hours; lightly soiled not suggestive of hemorrhage

Labs:

- EKG
  - Sinus tachycardia; normal EKG
- CBC

  5.8
  7.55) --------- (**505**
  20.2
- T&S
  - A+
- Coags WNL
- BMP

  140 | 105 | 14
  ----------< 88
  4.1 | 22 | 0.81
- Iron Panel
  - Ferritin 43 | TIBC 416 | **Iron 4** | **%Saturation 18** | **UIBC 398**
- Urine Hcg negative

Assessment:

KL is a 45-year-old G0 female with a significant history of fibroids (s/p myomectomy in 2010) who presents to the ED due to a hemoglobin level of 6.2 as per labs drawn by the hematology clinic today secondary to heavy menstrual bleeding over the last week. Hemoglobin on presentation to the ED was 5.8. GYN service was consulted due to known history of menometrorrhagia secondary to fibroids.

Plan:

1. Severe symptomatic iron deficiency anemia secondary to AUB-L
   a. Significance of incomplete evaluation due to lack of pelvic exam and pelvic ultrasound explained to the patient; patient understood and agreed
      i. GYN team to round on patient in the morning and offer pelvic exam

b. Has outpatient GYN follow-up on 12/9/2020
c. Patient refused counselling on hysterectomy as treatment
d. Blood transfusion in ED
    i. Received 3 U PRBCs
        1. Hgb improved to 8.6
    ii. Keep in ED for overnight observation
e. ED educated patient on iron rich foods and offered oral iron supplementation – patient refused oral iron due to side effects

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History and Physical 4

Identifying Data:

- *Name:* CT
- *Sex:* Female
- *Age:* 32 years
- *Date:* 12/3/2020
- *Location:* Queens Hospital Center – Emergency Department Consultation
- *Source of Information:* Self

Chief Complaint:

LLQ pain x 4-5 days

History of Present Illness:

CT is a 32-year-old P3023 female with a significant history of bilateral ovarian cyst (s/p left laparoscopic ovarian cystectomy in 2012) who presents to the ED complaining of worsening LLQ pain x 5 days. She describes the pain as an intermittent sharp and aching 10/10 pain that radiates to her back and is aggravated by movement. She took Motrin for mild pain relief and denies any other alleviating factors. CT's LMP began on 11/12/2020. She admits to sexual intercourse this morning but denies any change or precipitation of the pain as a result. She reports that the pain is similar to episodes of ovarian cysts that she has had in the past, so she did not report to the ED until today because her pain got significantly worse. She received morphine for pain management in the ED for moderate relief but also experienced an episode of vomiting after receiving the morphine. She denies fever, chills, nausea, diarrhea, chest pain, coughing, irritative voiding symptoms, hematuria, abnormal vaginal discharge, and sick contacts. GYN consult was called to rule out ovarian torsion.

OB History:

- P3023
    - 3 Cesarean sections
    - 1 spontaneous abortion
    - 1 termination of pregnancy

GYN History:

- Menses regular and monthly – 28 day cycles
- LMP 11/12/2020
- History of bilateral ovarian cysts
    - Left ovarian cystectomy in 2012
- Denies history of fibroids, polyps, STIs, PID, abnormal paps, and GYN malignancy
- Last pap 2020 - normal

Past Medical History:

- *Present Illnesses:*
    - Denies
- *Past Illnesses:*
    - Ovarian cysts

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Past Surgical History:

- Cesarian section x 3
- Laparoscopic left ovarian cystectomy – 2012
  - Jacobi Hospital – no complications
- Eye surgery at age 12

Family History:

Unknown – patient is adopted

Medications:

Denies

Allergies:

CT reports allergies to shellfish and seafood and denies any known allergies to medications, other foods, or environmental factors

Social History:

- 32-year-old female in long-term relationship with 1 male partner
- Denies tobacco, alcohol, or illicit drug use
- Denies history of STIs

Review of Systems:

See HPI

Physical Exam:

Vital Signs:

Blood Pressure: 108/68 (left arm, sitting)
Heart Rate: 65 beats/minute (regular)
Respiration Rate: 16 breaths/minute (nonlabored)
Temperature: 98.1 F (oral)
O_2 Sat: 100% (room air)

General:

32-year-old female seen at bedside in GYN evaluation room. A&O x 3. Calm and cooperative. Well-appearing, in NAD

Heart:

RRR; S1 and S2 present without murmurs, rubs, or gallops.

Lungs:

No increased effort of breathing or asymmetrical chest movement noted. Clear to auscultation bilaterally without adventitious lung sounds.

Abdomen:

Abdomen flat and nondistended. No abnormal pulsations visualized. BS + in all 4 quadrants. Soft and mildly tender to palpation in the LLQ with no palpable masses throughout. No guarding or rebound tenderness

Female Pelvic:

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Performed with chaperone present. External genitalia unremarkable. No obvious bleeding, masses, or discharge noted externally. Vagina and cervix normal appearing without masses, lesions, or discharge noted on speculum exam. Difficult to appreciate adnexa on bimanual exam due to voluntary patient guarding. Normal size uterus.

Labs:

- CBC
  11.9
  8.95) --------- (313
  36.8
- T&S
  - B+
- Coags WNL
- BMP
  134 | 102 | 7
  ----------< 96
  4.3 | 24 | 0.66
- UA
  - Negative
- Urine Hcg negative
- Serum Hcg negative

Imaging

- CT Abdomen/Pelvis
  - Left adnexal cystic lesions, enlarged left adnexa measuring 8.0 x 5.1 x 3.7 cm.
- Bedside US:
  - Uterus normal size. Right adnexa normal looking. Left adnexa 8.5 cm with 2 ovarian cysts, complex in nature with solid components inside one of them. Measuring 3 x 3 cm and 5.5 x 5.5 cm each. No free fluid seen

Assessment:

CT is a 32-year-old P3023 female with a significant history of bilateral ovarian cyst (s/p left laparoscopic ovarian cystectomy in 2012) who presents to the ED complaining of worsening LLQ pain x 5 days. Imaging and clinical evaluation are consistent with complicated left ovarian cysts with possible intermittent ovarian torsion.

Plan:

1. Complicated left ovarian cysts
   a. Condition explained and risks/benefits of surgical vs medical vs expectant management explained
      i. Patient understood
   b. Pain management
      i. Ibuprofen 800 mg PO PRN
   c. Official pelvic ultrasound scheduled for tomorrow at 9:00 AM
   d. Follow-up arranged with Dr. Juron at 12:00 PM tomorrow following ultrasound
   e. Discharge home with follow-up information on discharge paperwork

i. Instructed to return to the ED if symptoms worsen or she experiences, nausea, vomiting, SOB, chest pain, and fever