**H&P 3**

**Identifying Data:**

Full Name: H.F.

Date of Birth: xx/xx/1987

Age: 31 y/o

Sex: Male

Date & Time: 01/17/2019, 2:00 pm

Location: NYHQ, Flushing, NY

Religion: Catholicism

Source of Information: Self

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** “constipation, abd pain, tenesmus” x 3 months, “worsening abd pain with nausea, vomiting, fever and chill” x 2 days.

**History of Present Illness:**

Mr. F, a 31 y/o male c/o abdominal pain, constipation and tenesmus for 3 months and worsening abdominal pain for 2 days. Pain is general, colicky, intermittent, 8/10, no radiation, no significant aggravating or relieving factors. Accompanied by nausea, bilious vomiting, fever and chill. Last BM and gas was 2 days ago. He took no medication. Denies any previous similar episode. He has a history of RLQ bowel perforation 6 years ago without known underlying cause. He received IV abx abd at NYPQ and was discharged to OPAT. Follow up colonoscopy negative. Denies diarrhea, bleeding or STDs.

**Past Medical History:** history of RLQ bowel perforation 6 years ago at NYPQ

**Past Surgery History:** left femur ORIF and right knee surgery s/p traumatic injury 8 years ago at NYPQ

**Past Hospitalization History:** RLQ bowel perforation 6 years ago at NYPQ, left femur ORIF and right knee surgery s/p traumatic injury 8 years ago at NYPQ

**Immunizations** – Up to date.

**Medications:** N/A

**Allergies:** penicillins (hives) and shellfish (hives)

**Family History:** Brother with Crohns disease

**Social History:** Married, living with wife. Denies drinking alcohol/caffeine, smoking, or illicit drug use. Denies recent travelling. Regular diet. Routine running. Denies sleeping problem. Sexually active, only with his wife without STDs.

**Review of Systems:**

General – Admits fever and chill. Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, or night sweats.

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

Head – Denies headaches, vertigo or head trauma.

Eyes – Denies pain, redness, swelling, visual disturbances, or photophobia. No glasses. Last eye exam 2016, normal.

Ears – Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or use dentures. Last dental exam 2018, normal.

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion.

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Denies chest pain, palpitation, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system – See Hpi. Denies change in appetite, intolerance to specific foods, dysphagia, diarrhea, or jaundice. Last colonoscopy 2012, normal.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysura, incontinence, awakening at night to urinate or flank pain.

Nervous – Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

Musculoskeletal system – See hpi.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

Endocrine system – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric – Denies depression/sadness, anxiety, OCD or ever seeing a mental health professional.

**Physical Exam:**

General: Well developed, well nourished male, moderately distressed. Alert and cooperative. Looks just like his age.

Vital signs: BP: R L

 Seated 112/78 110/78

 Supine 110/80 108/76

 R: 18 breaths/min, unlabored

 P: 88 beats/min, regular

 T: 36.9 degrees C (oral)

 O2 Sat: 98% Room air

 Height 68 inches Weight 158 lbs. BMI: 24.0

Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair: average quantity and distribution.

Nails: no clubbing, capillary refill <2 seconds throughout.

Head: normocephalic, atraumatic, non tender to palpation throughout

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity (uncorrected - 20/20 OS, 20/20 OD, 20/20 OU). Visual fields full OU. PERRLA. EOMs full with no nystagmus. Fundoscopy - Red reflex intact OU. Cup:Disk < 0.5 OU/no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.

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.

Neck: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no palpable adenopathy noted.

Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted.

Chest: Symmetrical, no deformities, no evidence 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 2.5 cm 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. Regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

Abdomen: Mild distension. Symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS hyperactive. No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Soft. Mild tender over abdomen. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Rectal: refused.

Peripheral Vascular: Skin normal in color and warm to touch upper and lower extremities bilaterally. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No cyanosis, clubbing / edema noted bilaterally.

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- 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- PERRLA, 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+ Babinski neg neg

Abdominal 2+/2+ 2+/2+ Clonus negative

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

Musculoskeletal: No soft tissue swelling / erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Non-tender to palpation / no crepitus noted throughout. FROM (Full Range of Motion) of all upper and lower extremities bilaterally. No evidence of spinal deformities.

**CT suggested partial SBO.**

**Assessment:** 31 y/o male with abdominal pain, constipation and tenesmus for 3 months and worsening abdominal pain with nausea, bilious vomiting, fever and chill for 2 days, along with PE and CT findings, compatible with diagnosis with SBO.

**Plan:**

SBO:

- NPO/IVF

- Nasogastric tube decompression

- Steroid treatment

- Antibiotics

- Colonoscopy with double balloon

- Pain control

Differential diagnosis based on the chief complaint: SOB, Ileus, Pseudo-obstruction or Ogilvie's syndrome, Intra-abdominal sepsis, Esophageal rupture or tear, Gastrointestinal foreign body, Gastroenteritis, Inflammatory bowel disease, Mesenteric ischemia, Large-bowel obstruction.

Differential diagnosis after H&P: SOB, Ileus, Gastrointestinal foreign body, Inflammatory bowel disease

Work up: Patient was admitted for small bowel obstruction. He had nasogastric tube decompression with npo and Intravenous fluid. Empirical steroid treatment started. His obstruction resolved; nasogastric tube removed. He was evaluated by GI and was scheduled for colonoscopy with double balloon. He tolerated bowel prep. Colonoscopy done and he tolerated low fiber diet. In addition, he ambulated and voiding well. He is sent home on steroid taper per GI. Diagnosis and treatment are accurate and optimal. The diagnosis is accurate and the treatment is timely and effective.

Follow up: after discharge, follow up within 2 weeks.

Patient education: Bowel obstruction, is a mechanical or functional obstruction of the intestines which prevents the normal movement of the products of digestion. Either the small bowel or large bowel may be affected. Signs and symptoms include abdominal pain, vomiting, bloating and not passing gas. Mechanical obstruction is the cause of about 5 to 15% of cases of severe abdominal pain of sudden onset requiring admission to hospital. Causes of bowel obstruction include adhesions, hernias, volvulus, endometriosis, inflammatory bowel disease, appendicitis, tumors, diverticulitis, ischemic bowel, tuberculosis and intussusception. Small bowel obstructions are most often due to adhesions and hernias while large bowel obstructions are most often due to tumors and volvulus. The diagnosis may be made on plain X-rays; however, CT scan is more accurate. Ultrasound or MRI may help in the diagnosis of children or pregnant women. The condition may be treated conservatively or with surgery. Typically intravenous fluids are given, a tube is placed through the nose into the stomach to decompress the intestines, and pain medications are given. Antibiotics are often given. In small bowel obstruction about 25% require surgery. Complications may include sepsis, bowel ischemia and bowel perforation.