Jon Ma.
Rotation #2

N/A

H&P 1 for ER

Identifying Data:

Full Name: G.B.

Date of Birth: xx/xx/1983

Age: 35 y/o

Sex: Male

Date & Time: 02/11/2019, 9:50 am

Location: NYHQ, Flushing, NY

Religion: N/A

Source of Information: Self

Reliability: reliable

Source of Referral: N/A

Chief Complaint: "diffused abd pain followed by RLQ abd pain" x 8 hours.

History of Present Illness: with No sig-PMH, presents to ED c/o diffused abd Pain x ___h

Mr. F, a 35 y/o male c/o diffused abdominal pain for 2 hours, followed by RLQ abd pain for 6 hours. localized-? The original diffused abdominal pain is dull, and 5/10. The RLQ abdominal pain is sharp, 8/10, consistent, radiating to lower back, aggravated by movement, no significant relieving factors. Last BM was 8 hours ago. He took no medication. Denies any previous similar episode. Denies fever, chill, nausea, vomiting, diarrhea, constipation, bleeding in stool or urine, urinary frequency, urgency, pain or STDs. Any sick cont

Past Medical History: ~~N/A~~ Denies Last Meal? Any recent travel?

Past Surgery History: ~~N/A~~ Denies

Past Hospitalization History: ~~N/A~~ Denies

Immunizations – Up to date.

Medications: ~~N/A~~ Denies

Allergies: Denies any drug, environmental or food allergies.

Family History: ~~N/A~~ Non Contributory

Social History: Single, living with sister. Denies drinking alcohol/caffeine, smoking, or illicit drug use. Denies recent traveling. Regular diet. Routine running. Denies sleeping problem. Sexually active, only with his girlfriend ~~without~~ STDs.

Review of Systems: denies - when was his last meal?

General –Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever, chill 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 2018, 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 2016, 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, nausea, vomiting, constipation, diarrhea, or jaundice. No colonoscopy.

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 – – Admits lower back pain. Denies muscle/joint deformity or swelling, redness or arthritis.

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, in no acute distress. Alert and cooperative. ~~Looks just like his~~ Appears stated age. age.

Vital signs:	BP:	R	L
	Seated	118/80	116/78
	Supine	116/82	114/80

R: 16 breaths/min, unlabored

P: 82 beats/min, regular

T: 36.8 degrees C (oral)

O2 Sat: 98% Room air

Height 73 inches Weight 210 lbs. BMI: 27.7

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: Flat/ symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present. No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Soft. Moderate tender over RLQ abdomen. No evidence of organomegaly. No masses noted. No evidence of

all quadrants

guarding or rebound tenderness. No CVAT noted bilaterally. Obtructor sign and psoas sign positive, and Rovsing sign negative.

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.

Assessment: 35 y/o male with diffused abdominal pain for 2 hours, followed by RLQ abd pain for 6 hours, along with PE findings, compatible with diagnosis with RLQ abd pain and appendicitis needs to be ruled out.

This goes at the end.

Plan:

- Rest
- NPO/IVF — LR? NS?
- pain control — Tylenol 650mg q6hrs PRN
- CT test

• Any Labs? Urine Sample? Any Bladder scan?

Coags TS

IVF -> Bolus 2 Liters.

flu. Urologist

Differential diagnosis based on the chief complaint: Appendicitis, Ureterolithiasis, Renal colic, Diverticulitis, Crohn disease, Colonic carcinoma, Rectus sheath hematoma, Cholecystitis, Gastroenteritis, Mesenteric adenitis and ischemia, Omental torsion, Biliary colic, Urinary tract infection (UTI), Enterocolitis, Pancreatitis and Perforated duodenal ulcer.

Differential diagnosis after H&P: Appendicitis, Ureterolithiasis, Renal colic.

Work up: CT scan showed small renal stone (<2cm). After hydration, the pain was relieved and the patient was discharged with tamsulosin. Although appendicitis was mostly suspected due to the characteristics of the pain, but urolithiasis was also considered. Treatment is proper and timely.

Follow up: follow up with urologist within 2 weeks.

Patient education: Kidney stone disease, also known as urolithiasis, is when a solid piece of material (kidney stone) occurs in the urinary tract. Between 1% and 15% of people globally are affected by kidney stones at some point in their lives. Generally, more men are affected than women. Kidney stones typically form in the kidney and leave the body in the urine stream. A small stone may pass without causing symptoms. If a stone grows to more than 5 millimeters (0.2 in) it can cause blockage of the ureter resulting in severe pain in the lower back or abdomen. A stone may also result in blood in the urine, vomiting, or painful urination. About half of people will have another stone within ten years. Most stones form due to a combination of genetics and environmental factors. Risk factors include high urine calcium levels, obesity, certain foods, some medications, calcium supplements, hyperparathyroidism, gout and not drinking enough fluids. Stones form in the kidney when minerals in urine are at high concentration. The diagnosis is usually based on symptoms, urine testing, and medical imaging. Blood tests may also be useful. Stones are typically classified by their location: nephrolithiasis (in the kidney), ureterolithiasis (in the ureter), cystolithiasis (in the bladder), or by what they are made of (calcium oxalate, uric acid, struvite, cystine). In those who have had stones, prevention is by drinking fluids such that more than two liters of urine are produced per day. If this is not effective enough, thiazide diuretic, citrate, or allopurinol may be taken. It is recommended that soft drinks containing phosphoric acid (typically colas) be avoided. When a stone causes no symptoms, no treatment is needed. Otherwise pain control is usually the first measure, using medications such as nonsteroidal anti-inflammatory drugs or opioids. Larger stones may

be helped to pass with the medication tamsulosin or may require procedures such as extracorporeal shock wave lithotripsy, ureteroscopy, or percutaneous nephrolithotomy.