51y F with pmhx of cholelithiasis and diverticulitis presents to ED for vomiting and epigastric pain x 10 hours.

Answers to questions asked for history:

- Pt states her pain is currently a 9/10 and constant but she is not actively nauseas now
- She states that she vomited 10-15 times, starting at 2pm after she ate and the last few times, she vomited it was yellow.
- Denies any blood in vomitus.
- She did not eat anything new; it was rice and beans as she normally eats
- Pt states that she has been to the hospital before in 2016 for stomach pain and vomiting but cannot recall if this pain was similar.
- Pt has tried pepto but it did not help.
- Moving around makes the pain worse and she has not found anything that alleviates it
- Denies any sick contacts.
- Denies any chest pain, diaphoresis, SOB, dizziness/syncope
- Denies fever, diarrhea/constipation
- Denies unexpected weight loss, recent travel
- Denies recent URI symptoms
- She has not started menopause and still gets monthly periods and is sexually active
- She has a not had her gall bladder or appendix removed
- She does not take any medications daily
- Denies ETOH use or smoking

Physical exam:

- Vitals: BP: 136/81 HR: 70 RR: 18 SpO2: 99%
- Wt: 176lb Ht: 5'4" BMI: 30.2
- General, subjective**:** A&O x 3 female sitting upright in bed; appears stated age appears slightly uncomfortable with pain but is interactive to questioning.
- Cardiovascular: S1 S2 present, RRR, no murmurs/rales/gallops
- Respiratory: CTA B/L, no wheezing, rales or rhonchi
- Abdomen**:** Soft, non-distended, (+) tender to epigastric area, (-) tenderness to RUQ, RLQ, LQU, LLQ and suprapubic area, (-) obturator, (-) rovsing, (-) murphys
- Extremities: No leg swelling or tenderness. No ecchymosis, petechia or limited ROM/strength.
- Neuro: AAO x 3, physiological exam with no focal deficits
- Mental Status: She is alert and oriented to person, place, and time; mood is cooperative.
- Skin: no rashes or open lacerations or wounds.

Differential Diagnosis

1. Cholecystitis
    - Due to epigastric pain with nausea/vomiting, age, sex, pmhx of cholelithiasis

        - This “constant” pain presentation is not the typical clinical picture of Cholelithiasis/cholecystitis but don’t want to rely too heavily on patient description of pain
2. Cholelithiasis
    - Due to epigastric pain with nausea/vomiting, age, sex, pmhx of cholelithiasis
        - This “constant” pain presentation is not the typical clinical picture of Cholelithiasis/cholecystitis but don’t want to rely too heavily on patient description of pain
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3. Pancreatitis
    - Due to epigastric pain with nausea/vomiting, age, sex, pmhx of cholelithiasis;
        - she denies ETOH but does have history of cholelithiasis and would need to check lipid panel for further risk factor assessment
4. Appendicitis
    - This could be the early stages of appendicitis in which there is epigastric pain before it migrates to RLQ; she still have her appendix
5. Hepatitis
    - Could be cause of epigastric pain and vomiting; lower on list because pt states she is fully vaccinated, cooks her own food and denies recent travel
6. MI
    - Due to her age and sex, cannot completely say this is not ACS; she denies any risk factors such as HTN, DM, HLD however she may be forgetting to mention or not aware she has these
7. Gastritis
    - This could be the cause for epigastric pain and vomiting however this is a relatively benign ddx and is mostly clinically diagnosed only once other more urgent ddx have been disproven
8. Peptic ulcer
    - This could be the cause for epigastric pain but would less explain the intractable vomiting. This is a relatively benign ddx and is mostly clinically diagnosed only once other more urgent ddx have been disproven
9. Diabetic ketoacidosis or an infectious cause
    - This stomach pain, nausea and vomiting could be from another source of inflammation. It is unlikely due to no other systemic responses such as hypotension, tachycardia, or fever but this cannot be missed
10. Pregnancy
    - Patient has not gone through menopause and is sexually active

Tests ordered:

<u>Labs</u>:

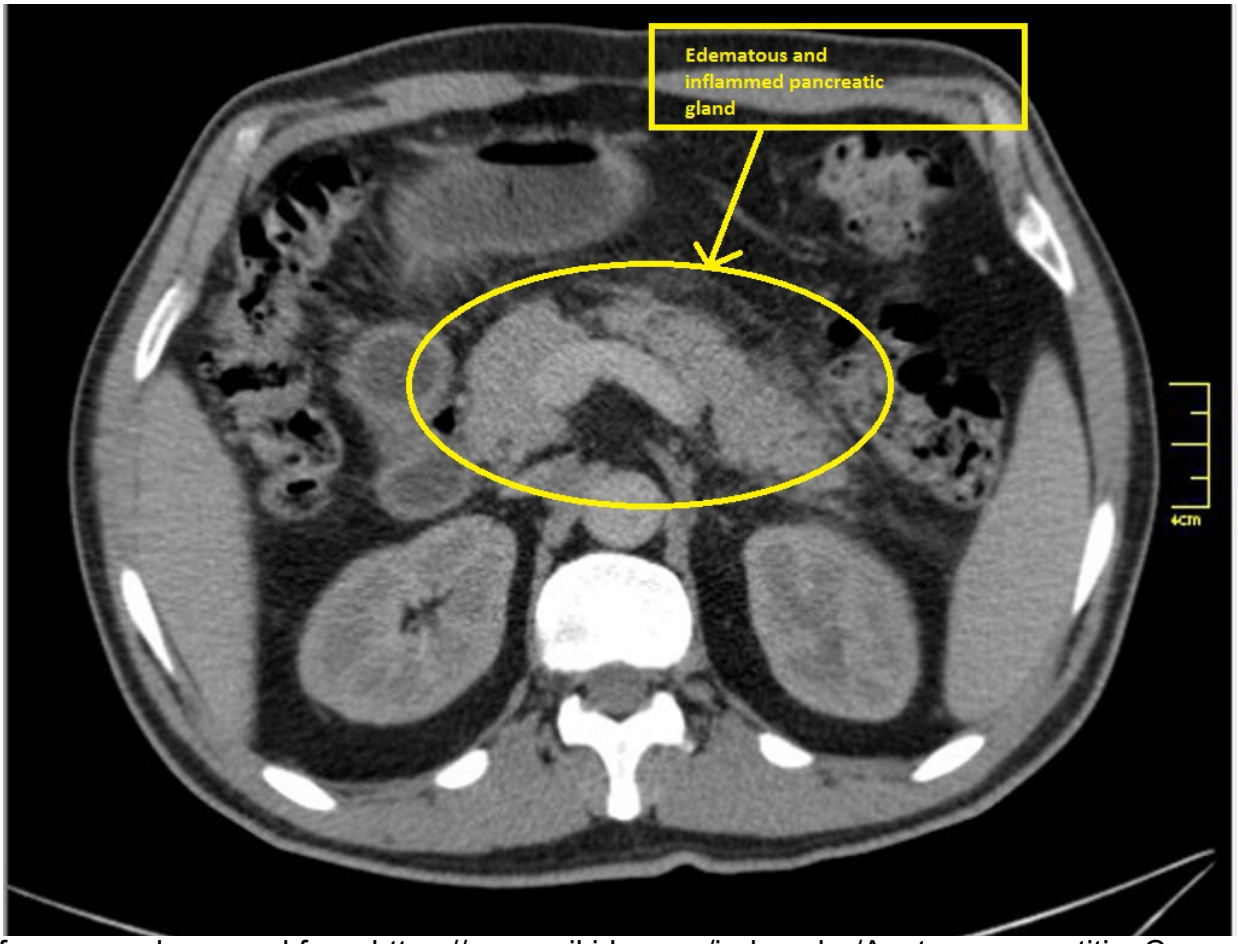
1. CBC with diff
    - WBC: 13K

2. BMP
    - Result:
        - AST: 332
        - ALT: 170
3. Lipid panel
    - Total: 250
    - HDL: 40
    - LDL: 210
    - Triglycerides: 280
4. Lipase
    - Results: Lipase > 3000
5. Ketones
    - Results: normal
6. Lactate
    - 2.8
7. Urinalysis
    - Not abnormal findings
8. Urine HCG
    - Result: negative
9. Troponin
    - Results: Negative troponin

Imaging

1. US of abdomen
    - Results:
        - CBD:4 mm
        - RIGHT KIDNEY:9.3 cm
        - LEFT KIDNEY:10.6 cm
        - SPLEEN:9.7 cm
        - LIVER: Mildly echogenic parenchyma.
        - GALL BLADDER : Cholelithiasis. No wall thickening. No sonographic
            - Murphy's sign was observed, but the patient was administered pain medication prior to the study.
        - BILE DUCTS: No intrahepatic or extrahepatic dilatation..
        - PANCREAS : Visualized portion unremarkable.
        - SPLEEN: without focal mass.
        - KIDNEYS: Mild fullness of the right renal collecting system. There is no evidence of calculus or left-sided hydronephrosis.
        - ASCITES : None
        - VASCULAR : Proximal aorta and IVC are unremarkable.
        - IMPRESSION: Cholelithiasis without definite sonographic evidence of acute cholecystitis. HIDA scan should be considered for further evaluation. Mild right hydronephrosis. Echogenic hepatic parenchyma, suggestive of steatosis versus hepatocellular disease.

2. CT scan WITH Iv contract
    - Result:
        - peripancreatic fluid/stranding
        - dilatation of main pancreatic duct and its side branches
        - several small stones within the cystic duct
            - Impression: Pancreatitis from choledocholithiasis



Not from case; borrowed from https://www.wikidoc.org/index.php/Acute_pancreatitis_C

3. Chest x-ray
    - Result: no abnormal findings
4. EKG
    - Result: Normal EKG

Treatment:

- Fluid: NaCl 1000ml @ 1000ml/hr
- Famotidine 20mg IV Q 6 hours
- Zofran 4mg as needed; Q4-6 hours; max: 24mg/day
- Acetaminophen 975mg PO q6h; max dose is 4,000 mg in 24h
- If needed: Morphine 4mg for pain Q 2-4 hr
- Inpatient consult to surgery for admission

Education:

- Diagnosis education
- Surgery education
- Diet education:
- Weight loss education