

**Full Name:** AS

**Address:** Flushing, NY

**Date of Birth:** 03/26/1970

**Date & Time:** March 27, 2022 @10pm

**Location:** Main NYPQ ER

**Source of Information:** Self

**Reliability:** reliable

**Mode of Transport:** Drove herself to ER

HPI: 51y F with pmhx of cholelithiasis and diverticulitis presents to ED for vomiting and epigastric pain x 10 hours. 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. She did not eat anything new; it was rice and beans as she normally eats. Denies any blood in vomitus. Last time she vomited was at 9:30pm and has had some water since then. 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, fever, diarrhea/constipation, unexpected weight loss, recent travel, URI symptoms.

PMHX:

- Cholelithiasis, 2016
- Diverticulosis without diverticulitis, 2016

Past surgical hx:

- bilateral buttock implants, 2010

Medications

- Denies taking any medications

Allergies: NKDA

Social: Lives at home alone. Works as a teacher. Denies smoking, alcohol or drug use. No recent travel.

**PE:**

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

**Neck:** Supple, No nodes, No JVD/Carotid Bruits

**Pulses:** +2 bilateral pulses

**Eyes:** PERRLA, EOMI, scleral anicteric

**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.

ROS:

- Constitutional: Negative for chills and fever.
- Respiratory: Negative for shortness of breath.
- Cardiovascular: Negative for chest pain, leg swelling, palpitations.
- Gastrointestinal: Positive for abdominal pain, nausea and vomiting. Negative for diarrhea, constipation.
- Neurological: Negative for headaches.
- All other systems reviewed and are negative.

Assessment:

Differential diagnosis:

1. Cholelithiasis/ Cholecystitis
  - a. 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 and with the age, Pmhx this is still high on differential
    - i. Orders:
      1. US of abdomen
      2. CBC with diff

3. BMP with LFT
2. Pancreatitis
  - a. This would fit clinical vomiting picture and pain presentation; she denies ETOH but does have history of cholelithiasis and would need to check lipid panel for further risk factor assessment
    - i. Order:
      1. CT scan with IV contrast
      2. Lipid panel for further risk stratification
      3. Lipase
      4. CBC with diff
      5. BMP with LFTs
3. Appendicitis
  - a. This could be the early stages of appendicitis in which there is epigastric pain before it migrates to RLQ
    - i. Orders:
      1. CT with IV contrast
      2. CBC with diff
4. Hepatitis
  - a. Could be cause of epigastric pain and vomiting, pt states she is fully vaccinated, cooks her own food and denies recent travel but
    - i. Order:
      1. CT with IV contrast
      2. CBC with diff
      3. BMP with LFTs
5. MI
  - a. 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
    - i. Order
      1. CXR
      2. Troponin
      3. EKG
6. Gastritis
  - a. 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
    - i. CBC with diff
    - ii. BMP with LFTs
7. PUD
  - a. 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
    - i. CMB with diff
    - ii. BMP with LFTs

8. Other infectious cause/ DKA
  - a. This stomach pain, nausea and vomiting could be from another source of infection. It is unlikely due to no other systemic responses such as hypotension, tachycardia, or fever but this cannot be missed
    - i. Orders:
      1. Ketones
      2. Lactate
      3. Urinalysis
9. Pregnancy
  - a. Patient has not gone through menopause and is sexually active
    - i. Orders
      1. HCG

**Orders:**

- Fluid: NaCl 1000ml @ 1000ml/hr

**Medication**

- 1. Famotidine 20mg IV
- 2. Zofran 4mg
- 3. Acetaminophen 975mg

**Labs:**

- CBC with diff
- BMP with LFTs
- Lipase
- Troponin
- Urinalysis
- HCG
- Ketones & lactate
- PTT/INR/ Prothrombin ( For admission/surgical planning if need to not delay anything)
- Type and screen ( For admission/surgical planning if need to not delay anything)

**Imaging at this time:** ( CT with IV contrast was not initially done)

- US of abdomen
- CXR (PA, Lat)
- EKG

**Pertinent Findings from labs:**

- Lipase: >3000
- AST: 332
- ALT: 170
- Alk phos: 118

**Ultrasound** results:

Reason for examination : Epigastric and right upper quadrant pain. Comparison: None.

Sonographic evaluation of the upper abdomen reveals:

MEASUREMENTS:

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.

No abnormal findings on EKG or CXR

**Added orders:**

- Fluid: NaCl 1000ml @ 1000ml/hr was given as the diagnosis was made of Pancreatitis
- Imaging:
  - o CT abdomen and pelvis with IV contrast was done for possible surgery planning
- Labs
  - o LDH
  - o Triglycerides
- Medication:
  - o Morphine 4mg for pain
- Consults
  - o Inpatient consult to surgery for admission