Emily Yeung
Rotation 2: Family Medicine, Dr. Richter
Mid Rotation Site Evaluation

Identification:

- Date: 2/21/19
- Time: 3:30 PM
- Name: HF
- Sex: F
- Race: Caucasian
- Age: 21
- Marital status: Single
- Address: Rego Park, Family Medicine, Dr. Richter

Informant:

- Source of history: Patient and mother, reliable

Referral Source: Self

Chief Complaint:

- Abdominal pain and vomiting x 5 days

Present Illness:

- 21 year old female, accompanied by mother, with no significant PMHx, presents to family medicine today c/o "abdominal pain and vomiting" x 5 days. Patient states that the abdominal pain is sharp, burning, and is constant around the periumbilical area without any radiation of pain. She admits to vomiting 6 times on Saturday. Her vomitus consisted of mainly food and she denies any blood or coffee grounds. Patient was studying for the LSAT when the abdominal pain occurred. She reports that the pain was so severe that she called EMS and was hospitalized at St. Vincent's Hospital in Connecticut where she goes to school on Saturday, 2/16/19 where she stayed overnight before being discharged the next morning. During her stay, she developed a fever of 101.8F but was given Reglan, Zofran, Toradol, and Tylenol that resolved her fever, nausea, and vomiting. Patient had an X-ray of the abdomen, CT abdomen, and US of the abdomen done at the hospital, all WNL. One day later, patient experienced some diarrhea so she took Loperamide 2mg and has not had a bowel movement since then (4 days ago). No one else became ill that she ate with. Patient has had periumbilical pain on and off for many years and no diagnosis of hernia was given. She had an upper endoscopy at age 17 for umbilical pain, was WNL. Father has history of Crohn's disease. Patient is currently under a lot of stress at school with a 3.64 GPA. She enjoys social life at school and drinks 5-6 drinks of ETOH per week. Patient admits to current periumbilical pain, bloating, early satiety with decreased appetite, and constipation secondary to Imodium. She denies any melena, cough, diarrhea, dysphagia, current fever/chills or vomiting, incontinence, SOB, weight gain/loss, headache, recent abx use or travel, or sick contacts.

Past Medical History:

- No significant past medical history.
- Immunizations up to date, including the flu shot.
- Patient denies any childhood illnesses.

Past Surgical History:

- Denies any surgical history.
- Denies past transfusions and injuries.
- Hospitalized at St. Vincent's Hospital in Connecticut on 2/16/19 for 1 day due to the same chief complaint.

Medications:

- Reglan 10mg PO QD, last dose this morning
- Loperamide 2mg PO prn, last dose 2/17/19
- Junel FE 1.5/30 MG-MCG PO QD, last dose this morning

Allergies:

- Admits to Metronidazole allergy – urticaria
- Denies any other drug, food, or environmental allergies.

Family History:

- Mother, alive 42 YO, HTN
- Father, alive, 42 YO, Crohn's disease
- Brother, alive and well, 23
- Paternal grandfather, alive, 65 YO, heart disease
- Paternal grandmother, alive, 65 YO, diverticulitis
- Maternal grandfather, decreased from old age
- Maternal grandmother, deceased from old age

Social History:

- Non-smoker. Denies drinking caffeine at present.
- Admits to drinking 5-6 mixed drinks per week on the weekends.
- Sleeps 7 hours per day, on average.
- Denies exercising regularly.
- Single, lives in campus dorm with roommates.
- Occupation: full time undergraduate student, plans on getting into law school.
- Denies any recent travel.
- Sexually active with men only, uses condoms every time and is on OCPs. Denies any past or current STIs.

ROS

- General
    - Admits to loss of appetite, weakness/fatigue, and fever 5 days ago of 101.8 that has subsided.
    - Denies any recent weight gain/loss, current fever, chills, night sweats.
- Skin, hair and nails

    - Denies any discoloration, moles/rashes, pruritus, changes in hair distribution, excessive dryness/sweating, change in hair/skin texture, lacerations.
- Head
    - Denies headache, vertigo, head trauma, facial swelling.
- Eyes
    - Denies photophobia, pruritus, blurring, diplopia, lacrimation, other visual disturbances. Does not wear glasses. Last eye exam August 2018.
- Ears
    - Denies any deafness, pain, discharge, use of hearing aids.
- Nose/Sinuses
    - Denies any epistaxis, obstruction, discharge, congestion.
- Mouth and throat
    - Denies any dry mouth/lips, bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, use of dentures. Last dental exam August 2018.
- Neck
    - Denies localized swelling/lumps, stiffness/decreased range of motion.
- Breast
    - Denies any lumps, nipple discharge, pain.
- Pulmonary system
    - Denies any SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, PND, choking, chest tightness, stridor.
- Cardiovascular system
    - Denies any chest pain, palpitations, irregular heartbeat, syncope, heart murmur, edema.
- Gastrointestinal system
    - Admits to constipation currently, secondary to taking Loperamide 4 days ago. Has not had a bowel movement since then. Admits to periumbilical pain, loss of appetite, bloating, nausea, vomiting.
    - Denies any indigestion, pyrosis, flatulence, diarrhea, jaundice, anal bleeding, rectal pain.
- Genitourinary system
    - Denies any frequency, polyuria, urgency, nocturia, oliguria, dysuria, incontinence, flank pain.
- Menstrual and Obstetrical
    - Age of menarche = 12
    - LMP 2/10/19, 5 days, 5 pads used QD, regular.
    - G0P0. Last GYN visit August, 2018, WNL.
    - Denies any menorrhagia, metrorrhagia, menometrorrhagia, dyspareunia.
- Nervous system
    - Denies headaches, loss of consciousness, sensory disturbances, ataxia, change in cognition, loss of strength, weakness.
- Musculoskeletal system
    - Denies any muscle/joint pain, deformity, erythema, edema, tenderness, arthritis.
- Peripheral vascular system
    - Denies any peripheral edema, intermittent claudication, varicose veins.
- Hematologic system

    - Denies any easy bruising, bleeding, lymph node enlargement, blood transfusions.
- Endocrine system
    - Denies any polyuria, polydipsia, polyphagia, goiter, excessive sweating, Hirsutism, heat intolerance.
- Psychiatric
    - Denies any past or current psychiatric illnesses, feelings of depression or anxiety. Has never seen a mental health specialist or therapist.

General Survey:

- Small build female, well developed and well nourished, well groomed, looks her stated age of 21 years, breathing unlabored. A/O x3.

Vital Signs:

- HR: 60 beats per minute, regular
- Respiratory rate: 12 breaths per minute, unlabored
- BP: 100/70, bilateral arms, sitting
- Temperature: 98.4°F, orally
- O2 sat: 99%, room air
- Height: 65 inches
- Weight: 123 lbs.
- BMI: 20.47

Physical Examination:

- Skin: Warm and moist, good turgor. Nonicteric, no lesions, no scars, no tattoos, no lacerations.
- Hair: Average quantity and distribution.
- Nails: No clubbing, capillary refill <2 seconds throughout.
- Head: Normocephalic, atraumatic, no specific facies, nontender to palpation throughout.
- Eyes: Symmetrical OU; no strabismus, exophthalmos or ptosis; sclera white, conjunctiva & cornea clear. Visual acuity 20/20 OU. Visual fields full OU. PERRLA. EOMs full, no nystagmus. Fundoscopy – red reflex intact OU. Cup to disk ratio <0.5. No evidence of copper wire, AV nicking, papilledema, hemorrhage, cotton wool spots, exudates, neovascularization OU.
- Ears: Symmetrical, normal size. No lesions, masses, trauma on external ears. No discharge, foreign bodies in external auditory canals AU. Tympanic membrane pearly white, cone of light intact in normal position AU. Auditory acuity intact with whispered voice AU. Weber midline and Rinne reveal air conduction > bone conduction AU.
- Nose: Symmetrical with no obvious masses, lesions, deformities, trauma, discharge. Nares patent bilaterally. Nasal mucosa pink and well hydrated. No discharge on anterior rhinoscopy. Septum at midline without any lesions, deformities, infection, perforation. No foreign bodies.
- Sinuses: Non-tender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.
- Lips: Pink, moist, no cyanosis or lesions.
- Mucosa: Pink, hydrated. No masses, lesions, leukoplakia.
- Palate: Pink, hydrated. Palate intact with no lesions, masses, or scars.
- Teeth: Good dentition, no obvious dental caries noted.
- Gingivae: Pink, moist. No masses, lesions, erythema, discharge, hyperplasia.

- Tongue: Pink, well papillated. No masses, lesions, deviation noted.
- Oropharynx: Hydrated but slightly erythematous. No masses, lesions, foreign bodies, infection, exudate. Tonsils present with no infection or exudate. Uvula pink, no lesions or edema.
- Neck: Trachea midline. No masses, lesions, scars, pulsations, stridor noted. Supple, non-tender to palpation. No thrills, bruits noted bilaterally, no palpable adenopathy.
- Thyroid: Non-tender to palpation, no palpable masses, no thyromegaly, no bruits noted.
- Chest: Symmetrical, no deformities, trauma. Respirations unlabored. No use of accessory muscles noted. Lat to AP diameter 2:1.
- 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 head of bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. S1 and S2 are normal. No murmurs.
- Abdomen: Soft, symmetrical. No scars, striae, caput meducsea or abnormal pulsations. BS present in all 4 quadrants. No bruits over aortic, renal, iliac, femoral arteries. Tympany to percussion throughout. No organomegaly, masses, guarding, rebound tenderness. No CVAT noted bilaterally. Non-tender to percussion but tenderness upon palpation of the periumbilical region. Small umbilical hernia, reducible.
- Breast: patient denied.
- Female genitalia: patient denied.
- Rectal: patient denied.
- Peripheral vascular: Extremities unremarkable in color, size, temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis, edema bilaterally. No stasis changes or ulcerations.
- 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. Mastication normal
    - 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 upper: No soft tissue swelling, erythema, ecchymosis, atrophy, deformities in upper extremities. Non-tender to palpation. No crepitus noted throughout. FROM of all upper extremities bilaterally. No spinal deformities.

Lab Results & Radiological Studies

- Urinalysis
    - Color = yellow
    - Appearance = clear
    - pH = 7.5
    - Specific gravity = 1.010
    - Glucose = negative
    - Protein = trace
    - Ketone = negative
    - Blood = hemolyzed, trace
    - Urobilinogen = 1
- Blood work
    - Patient did not get copies of this from the hospital upon discharge.
- Abdominal XR, CT, US
    - Patient did not get copies of this from the hospital upon discharge.

Assessment: 21 y/o female with no significant PMHx presents to family medicine with periumbilical pain and vomiting x 5 days. Symptoms consistent with acute gastritis, secondary to increased stress levels and ETOH consumption.

1. Acute gastritis, secondary to increased stress and ETOH consumption
    - Patient has been having periumbilical pain for the past 5 days with acute onset.
    - Gastritis could be caused by stress or ingesting irritants such as ETOH, especially since she drinks 5-6 drinks per week.
    - Gastritis also presents with loss of appetite, nausea, vomiting, and early satiety.

2. Crohn’s disease
    - Patient is at increased risk of developing Crohn’s disease due to family history.
    - Even though the patient presented with diarrhea, fever, fatigue, and abdominal pain, she denied any melena, recent weight loss, or ongoing episodes of diarrhea.
    - We can test for anemia or infection and do a fecal occult blood test to further R/O Crohn’s disease.

3. Viral gastroenteritis
- Patient presents with nonbloody diarrhea, abdominal pain, nausea, vomiting, and fever.
- Patient denies any sick contacts and the people that she ate with ate the same food but did not become sick, thus ingesting contaminated food or water remains unlikely.
- Could perform rapid stool test to detect for rotavirus or norovirus but patient is already feeling better as compared to 5 days ago.

4. Peptic ulcer disease (PUD)
- Patient presents with burning abdominal pain, early satiety, bloating, and nausea.
- However, patient denies any NSAID use regularly.
- Her endoscopy at age 17 was WNL without any presence of peptic ulcers.

5. Gastroesophageal reflux disease (GERD)
- Patient experiences burning abdominal pain.
- However, her pain is not worsened after eating or lying down after eating.
- Her endoscopy at age 17 was WNL without any esophageal involvement.
- Could perform H. pylori breath test

6. Pregnancy
- Patient presents with nausea, vomiting, constipation, bloating, and fatigue.
- She is sexually active but is on OCP and uses condoms for protection.
- R/O via testing for beta hCG.

Plan:
1. Abdominal pain – suspect acute gastritis, secondary to increased anxiety and stress
- Order UA.
- Obtain blood work and imaging results from hospital to review during next visit.
- Educate patient about association between anxiety/increased stress levels and abdominal pain
    - 4 square breathing for anxiety
- Educate patient about diet
    - Decrease consumption of caffeine, alcohol, acidic foods, fatty foods, spicy foods
    - Eat high fiber foods like apples, oatmeal, broccoli, carrots, beans
    - Eat low-fat foods like fish, chicken, turkey breast
    - Possible supplementation of probiotics
- If abdominal pain gets worse, vomiting blood, or unrelenting fever, go to nearest ER.

2. Nausea/vomiting
- Currently not experiencing nausea or vomiting.
- If symptoms persist, continue Reglan 10mg PO prn.

3. Umbilical hernia without obstruction or gangrene
- Currently not causing any GI symptoms except for umbilical pain.
- Referred to Dr. Friedman for GI consult