Arianne Diaz
September 25, 2023
Physical Diagnosis II
Professor Natalia Lukanina-Wu

History and Physical

History

Identifying Data:

Full Name: M.G
Address: N/A
Date of Birth: 11/28/78
Date & Time: 09/19/2023 at 11:00 AM
Location: Queens Presbyterian Hospital
Religion: N/A
Source of Information: Self
Reliability: Reliable
Source of Referral: PCP
Mode of Transport: Self

Chief Complaint: "I am here for gallbladder removal" secondary to LUQ pain x1 year

History of Present Illness:

44 y/o F w/ PMHIx GERD presents to PAT for cholecystectomy secondary to LUQ pain x1 year. Describes pain as cramping and colicky, radiating towards the lower back and epigastric region. Reports that pain usually starts off as a dull ache that progressively worsens over the course of two hours; rates pain a 4/10 severity at the beginning of these episodes but a 20/10 severity by the time an hour has allotted. As per patient, the episodes of LUQ pain were infrequent when they first began but have become constant as of two weeks ago, resulting in 3-4 episodes of daily postprandial emesis accompanied by flank pain. Patient states that LUQ pain is triggered by the consumption of "greasy" food and alleviated by Oxycodone-Acetaminophen 5-325 mg. Admits that during her first episode of LUQ pain, she was evaluated at New York Presbyterian Queens where an ultrasound of the gallbladder revealed the presence of multiple small stones. Patient followed up with her PCP two weeks ago where it was noted that the stones were enlarged and require removal. Patient states she is compliant with her prescribed medications. Denies fever, chills, hematemesis, change in bowel movements, diarrhea, hemoptysis, pleuritic cough, SOB, unusual weight loss, or palpitations.

Past Medical History:

GERD (Dx in 2018 by PCP, location unknown)
Asthma (Dx in 2018 by PCP, location unknown)
Thyroid Nodule (year of Dx unknown)

Childhood Illness – Anemia (year of Dx unknown, type of Anemia unknown)
Immunizations – Up to date; receives annual vaccination against influenza =
Screening test and results – Colonoscopy and Endoscopy, November 2022, normal.
Annual PAP smear, 2023, normal.
Mammogram, 2021, normal.

Past Surgical History:
Complete Thyroidectomy (location of procedure unknown, 2021, no complications)
B/L Breast Reduction (location of procedure unknown, 2020, no complications)
Blood Transfusion, unknown units (location of procedure unknown, 6 months ago, no complications)
Planned Caesarian Section (location of procedure unknown, 2016, no complications)

Medications:
Levothyroxine 125mg once daily PO for hypothyroidism
OTC Iron Supplements unknown dose PO PRN for anemia

Allergies:
Penicillin (reaction: hives)
Morphine (reaction: palpitations, "heart stops")
No known food allergies
No known environmental allergies

Family History:
Mother – Alive; current medical history of Diabetes Mellitus, Type unknown
Father – Alive, current medical history of HTN
Children – 7-year-old twin boys; denies any medical problems
Maternal grandparents – unknown
Paternal grandparents – unknown

Social History:
M.G. is married F living with her husband and two children.
Habits – Denies use of any tobacco products. Denies smoking. Denies illicit drug use. Admits to social consumption of EtOH.
Travel – Recently traveled to Ecuador
Diet – Admits to eating "more junk than anything". Diet consists of small portions of sweets although she "eats a little bit of everything". States that she will consume 12 oz of Coca Cola over the course of her shift.
Exercise – walks around on shift
Sleep – sleeps approximately 6 hours a night

Safety measures – no safety measures
Sexual Hx – currently sexually active with her husband, denies history of sexually transmitted infections.
Occupation – EKG technician

Review of Systems:

General – Denies fever, chills, night sweats, fatigue, weakness, recent weight gain or loss, or loss of appetite.

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

Head – Denies headache, vertigo, head trauma, unconsciousness, coma, or fracture.

Eyes – Admits she uses glasses and contact lenses for myopia. Denies visual disturbances, fatigue, lacrimation, photophobia, or pruritis. Last eye exam 2022, 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 of dentures. Last dental exam 2 weeks ago, normal.

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

Breast – Denies lumps, nipple discharge, or pain. Last mammogram was 2 years ago, normal.

Pulmonary system – Denies dyspnea, SOB, cough, wheezing, orthopnea, hemoptysis, cyanosis, or PND.

Cardiovascular system – Denies CP, HTN, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope.

Gastrointestinal system: Admits to nausea, vomiting, anorexia, abdominal pain, constipation, pyrosis, and intolerance to greasy foods. Denies dysphagia, flatulence, eructation, diarrhea, jaundice, change in bowel habits, hemorrhoids, rectal bleeding, presence of blood in stool, or pain in flank. Reports “normal” Bowel Habits. Last Colonoscopy November 2022, normal.

Genitourinary system – Denies nocturia, dysuria, urinary frequency or urgency, oliguria, polyuria, incontinence, or flank pain. Color of urine is “normal”

Menstrual/Obstetrical – date of LMP: 08/17/2023. Date of menarche unknown. Reports severe menorrhagia prompting her to switch menstrual pads every 10 minutes. Performed D&C in attempt to stop heavy bleeding to no avail. Denies dysmenorrhea, premenstrual syndrome, vaginal discharge, break-through bleeding, associated menopausal sxs, or h/o STI. Last pap smear 2023, normal. G:1 T:1 P:0 A:0 L:2

Musculoskeletal system – Denies muscle/joint pain, deformity or swelling, redness, or arthritis.

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

Hematological system – Reports anemia and easy bruising/ bleeding. Denies lymph node enlargement, or history of DVT/PE. Blood transfusion performed 6 months ago

Endocrine system – Reports cold intolerance and h/o goiter. Denies polyuria, polydipsia, polyphagia, heat intolerance, excessive sweating, or hirsutism.

Nervous –Denies seizures, loss of consciousness, sensory disturbances (numbness, paresthesia, dysesthesias, hyperesthesia), headache, ataxia, loss of strength, changes in cognition/mental status/memory, or weakness.

Psychiatric – Denies depression, sadness, (feelings of helplessness, hopelessness, lack of interest in usual activities, suicidal ideation), anxiety, obsessive compulsive disorder, or h/o of being evaluated by mental health professional.

Physical

General: Patient appears clean & well groomed, alert & oriented to time, place, and person. Has good posture and appears to be a reliable source of information. Appears stated age and is not in acute distress.

Vital Signs:
Temperature: 97.7 degrees Fahrenheit
O2 Sat: 99% on room air
Height: 57 inches
Weight: 149 lbs
BMI: 32.2
Respiratory Rate: 16 breaths/min regular rhythm and unlabored
Heart Rate: 60 breaths/min regular rate and rhythm
Blood Pressure:
(R) Sitting Up 115/79 (L) Sitting Up 110/60
Hair, Head, and Face:

Hair is of average quantity and distribution. Black in color with silky texture and no sign of lice or nits.

Head is normocephalic, atraumatic, and non-tender to palpation.
Face is symmetrical with no signs of drooping, swelling, or trauma.

Skin, and Nails:
The skin is warm and moist with good texture and turgor. Non-icteric with no swelling. Patient has 2 x 2 cm patch of ecchymosis in the RUQ of the abdomen which is non-tender to palpation.

Nails do not exhibit digital clubbing, capillary refill less than 2 seconds in upper and lower extremities.

Eye:
The eyes are symmetrical OU. Conjunctiva is pink, sclera is white, cornea and lens are clear, the pupils and iris are round, there is no shadowing on the opposite side of the iris OU. The patient's lacrimal apparatus is non-tender to palpation bilaterally. There is no exophthalmos OU.

Visual Acuity - 20/30 OS, 20/20 OD, 20/20 OU uncorrected

The patient's visual fields intact OU. PERRLA, EOMs intact with no nystagmus, strabismus, or signs of lid lag. Near point of convergence test is unremarkable.

Red reflex intact OU. Optic disc yellow, sharp, with disc to cup 0.5 OU. No AV nicking, copper wiring, hemorrhages, soft/hard exudates, or neovascularization in any of the four quadrants OU. Macula is yellow with no granulation or degeneration OU.

Ear:
Symmetrical and appropriate in size. No lesions, masses, or trauma on external ears. Cerumen present AU**,** no foreign bodies externally AU. TM's pearly white/intact with light reflex in good position, cone of light is present AU. No foreign bodies, discharge, effusions, perforations, or erythema AU. Auditory acuity intact to whispered voice AU. Weber is midline, Rinne indicates AC>BC AU.

Nose and Sinus:
The nose is symmetrical without masses, deformities, trauma, or discharge. There is no step off, crepitus or tenderness to palpation. Nares are patent bilaterally. Nasal mucosa pink and moist. No discharge, polyps, or swelling of the turbinates on anterior rhinoscopy. Nasal septum is midline without ulcerations, perforations, or deviations.
The frontal and maxillary sinuses are non-tender to palpation and percussion bilaterally.

Mouth and Pharynx:
The lips are pink with no signs of blisters, fissuring, or cyanosis.

The buccal mucosa is pink and well hydrated. Non-tender to palpation.

The tongue is pink and covered in papillae with no signs or leukoplakia.

The gingiva is pink. No hyperplasia, erythema, masses, lesions, or bleeding. Non-tender to palpation.

The hard palate is continuous, with no bony deformities, or bleeding. Yellow, scaly-appearing hyperkeratotic plaques noted on the hard palate. Non-tender to palpation.

The soft palate rises with phonation.

The floor of the mouth is well vascularized, the frenulum is intact, there is no discoloration.

The oropharynx is well hydrated, there is no tonsillar adenopathy, the uvula is pink, moist, and midline, there is no post-nasal drip.

The patient's gag reflex is present.

Neck, Thyroid, and Lymph Nodes:
The trachea is midline without masses or scars, it is supple and non-tender to palpation. The thyroid is consistent in size and shape and non-tender to palpation. The lymph nodes are freely mobile, non-tender and about 1 cm. 2+ carotid pulses; no thrills, or bruits on auscultation.

Cardiac:
JVP is 2.5 cm above the sternal angle w/ the head of the bed at 30 degrees. Point of maximal impulse is in the 5th intercostal space in the midclavicular line. Carotid pulses are 2+ bilaterally w/o bruits. No heaves or retractions evident in the four quadrants of the chest wall. No vibrations, thrills, or pulsations are evident except at the point of maximal impulse. S1 and S2 are normal. No murmurs, S3, or S4 sounds on auscultation. No S2 split or friction rubs present.

Thorax and Lung:
Chest is symmetrical with no signs of deformity, or trauma. Chest wall is non-TTP. Respirations are unlabored without use of any accessory muscles. Lung sounds were clear in all lobes bilaterally without rales, rhonchi, or wheezes. Resonance is normal upon percussion of all lung fields.

Abdomen:
2 x 2 cm patch of ecchymosis in the RUQ of the abdomen which is non-tender to palpation. Abdomen flat and symmetric with no scars, striae, or pulsations noted.

Bowel sounds normoactive in all four quadrants with no aortic/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebounding noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated.

Breast Exam:
B/L breasts are symmetric, no dimpling, no masses to palpation, nipples symmetric without discharge or lesions. No axillary nodes palpable.

Genitalia:
External genitalia without erythema or lesions. Vaginal mucosa pink without inflammation, erythema, or discharge. Cervix parous (or multiparous), pink, and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. Pap smear obtained. No inguinal adenopathy.

Rectal:
Rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation, or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative.

Assessment:

44 y/o female w/ a PMHIx GERD p/w worsening LUQ pain x1 year. As per patient, attacks were initially infrequent but have recently become constant, causing her to experience postprandial emesis 3-4 times a day. LUQ pain starts off as a dull ache which becomes colicky and cramping radiating to the lower back and epigastric region. States that episodes are triggered by the consumption of greasy foods but alleviated by oxycodone/acetaminophen. VSS, NAD, abdominal exam unremarkable. Ultrasound of the gallbladder performed one year ago revealed the presence of multiple small stones. Recent ultrasound revealed the stones were enlarged and require removal.

Plan:

First, I would like to get the patient's vomiting under control by using an antiemetic. I would likely prescribe a 5HT3 receptor blocker such as ODT Zofran. I would advise her to place the tablet sublingually 30 minutes prior to eating since her episodes seem to be triggered by meals. Since the LUQ is especially exacerbated by the consumption of greasy foods, I would counsel my patient to avoid these foods as to not trigger an episode. I would also order a CBC and CMP to monitor the patient's H/H, liver function, and kidney function. Since our patient

already had an established diagnosis at the time of evaluation, I am listing my differentials as if this were her initial visit.

DDx:

1. Chronic Cholecystitis

Chronic Cholecystitis results from multiple episodes of acute cholecystitis or from constant irritation of the gallbladder wall by cholelithiasis. The patient has had multiple episodes of acute cholecystitis, making it more likely that she has developed chronic cholecystitis. Her attacks are precipitated by greasy meals and her pain starts off as dull and steady before radiating to the epigastric region which is common in those with chronic cholecystitis. The rationale against chronic cholecystitis is the location of her pain. Chronic cholecystitis would commonly present with pain in the RUQ, radiating below the right shoulder blade, and acholic stools which the patient does not have. In this case, had the patient not been evaluated, I would have ordered an ultrasound of the gallbladder to check for the presence of gallstones. Based on findings and her history, I would recommend a laparoscopic cholecystectomy.

2. Peptic Ulcer Disease (PUD)

A peptic ulcer is a break in the gastric or duodenal mucosa. Gastric ulcers are more common in patients between 55 and 70 while duodenal ulcers tend to occur in those between 30 and 55 years of age. Since the patient is 44 years old, it is likely that the patient would have a duodenal ulcer. PUD symptoms are characterized by rhythmicity and periodicity meaning that the ulcer symptoms always occur at the same time during the day and the patient experiences these symptoms every day for a certain timeframe. In the patient's case, her nausea and vomiting present with rhythmicity and periodicity as they occur 3-4 times a day after the patient has a meal. Although the incidence of duodenal ulcer disease has been declining due to helicobacter pylori eradication, the patient is a hospital technician where she is more likely to be exposed to virulent pathogens such as h. pylori. The rationale against PUD is the severity of the patient's pain. Epigastric pain in PUD tends to be well localized, not severe, and relived with food intake or antacids. The patient's pain progressively worsens once it begins and is alleviated by non-opioid analgesics. I would want to perform a noninvasive assessment for h. pylori w/ fecal antigen assay or urea breath testing. If h. pylori is the causative agent then the patient must be put on therapy to eradicate h. pylori before starting pharmacologic treatment with acid-antisecretory agents such as PPIs.

3. Acute Pancreatitis

Acute pancreatitis is inflammation of the pancreas characterized by abrupt onset of deep epigastric pain, often w/ radiation to the back. Episodes are usually triggered by alcohol intake and the patient will experience, fever, nausea, vomiting, diaphoresis, weakness, and abdominal tenderness/distension. Smoking, high dietary glycemic load, and abdominal adiposity increase the risk of acute pancreatitis. According to the patient, her LUQ pain radiates to the back, and she experiences, nausea, and vomiting. Her BMI is 32.2 kg/m2 with minimal exercise and her diet consists of foods with a high glycemic load such as cookies and sweets. She also occasionally engages in some EtOH consumption but only during social events. The rationale against acute pancreatitis is the patient's overall presentation of symptoms. Her abdominal pain does not originate in the epigastric region although it does radiate to the back. She also does not consume alcohol frequently enough to trigger episodes of acute pancreatitis. She denies feeling

febrile during these episodes and does not experience weakness or diaphoresis. Her abdominal exam was unremarkable without any guarding/rebound, tenderness, or distention. I would order LFTS to monitor serum amylase and lipase and I would order an unenhanced CT of the abdomen. Lastly, I would use the Ranson Criteria to assess for severity of disease.

4. Hepatitis B

Patients with Hepatitis B tend to present with a prodrome of low-grade fever, anorexia, vomiting, malaise, and aversion to smoking. These symptoms tend to be mild, and patients do not recognize they are the initial manifestations of liver disease. The greatest number of cases of HBV result from heterosexual transmission. Medical workers who directly interact with patients are at higher risk for contracting HBV. Hepatitis B is low on the differential because the presentation of HBV is variable. The patient is at higher risk than the general population because of her occupation and because she engages in heterosexual sex but otherwise, the only symptom that coincides with Hepatitis B is her recurrent episodes of emesis. I would order serologic tests to screen for hepatitis B surface antibody (HBsAb), and hepatitis B core antibody (HBcAb).

5. Chronic Appendicitis

Appendicitis is on this list of differentials because it is a do not miss diagnosis. In acute appendicitis blood supply becomes compromised due to bacterial infiltration and the lumen distends due to the accumulation of purulent material. In approximately 24 hours, the patient is at risk of gangrene and perforation without surgical intervention. Although unlikely, there are situations where acute appendicitis can spontaneously resolve on its own and the patient develops what is known as chronic appendicitis, a relatively unfamiliar diagnosis with no true diagnostic criteria. The cause is often idiopathic but believed to be due to inflammation or obstruction of the appendix. Symptoms include fever, sharp abdominal pain, lethargy, and malaise, all of which the patient does not have. In this case, I would order a CT of the appendix and recommend laparoscopic appendectomy if the patient had evidence of inflammation or obstruction on imaging.

Reference for Chronic Appendicitis (I wanted to include):
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8827293/#:~:text=Chronic%20appendicitis%20is%20a%20diagnosis,and%20chronic%20appendicitis%20%5B3%5D.

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History and Physical Verification Form

Class: Physical Diagnosis II (HPPA 522)

Student Expectation:

- Obtain medical history and perform physical exam up to the point covered in class.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

Student: Arianne Diaz

Clinical Site: NYPQ → PAT

Date of Visit: September 19, 2023

Activity performed: pre-admission testing

Supervisor: Naeem Sadat, PA-C
PRAC

Name and Credentials: —

Supervisor Signature:

Supervisor Comments: