Chief Complaint: "My stomach has been hurting for 4 days"

History of Present Illness:

N.C. is a 28 y/o M w/ PMHx uncontrolled HTN, uncontrolled DM, and alcohol use disorder presenting to the emergency room for worsening epigastric pain x4 days. He states that the pain was intermittent and dull pain during for the first three days, but as of yesterday it has become a constant, burning pressure that radiates to the back. Reports using OTC Tylenol and antiacid medication with minimal relief. Endorses pain is worse with eating, and he is not able to tolerate food or liquids since yesterday. Reports that he has had multiple episodes of NBNB vomiting since yesterday, with the most recent episode occurring this morning around 5:00 AM. He admits to drinking heavily in the past two weeks, stating that he has been consuming a mix of beer and hard liquor after work. As per patient "about 5 beers and some whiskey". Last drink was this morning. Denies fever, chills, blurry vision, chest pain, shortness of breath, palpitations, hematemesis, hematochezia, diarrhea, dysuria, hematuria, urinary urgency, urinary frequency, calf pain/swelling, or numbness/tingling of the extremities.

Past Medical History:

Alcohol use disorder
Uncontrolled HTN
Uncontrolled diabetes

Immunization History:

Immunizations incomplete. Patient is unaware of what vaccines he received as child. As per EMR, patient received tDAP in 2019.

Preventative Medicine Screening:

Colonoscopy – never performed/not indicated
Dental – referral to dentist 04/2024, patient did not schedule appointment
Ophthalmologic – referral to ophthalmology 07/2024, patient did not schedule appointment

Past Surgical History:

Jaw surgery performed in Ecuador
LT wrist surgery performed in Ecuador
RT arm surgery performed in Ecuador

Medications:

Home Medications:

- No home medications aside from PRN Tylenol

Hospital Medications:

- Oxycodone-acetaminophen 5-325 mg for pain control
- Ondansetron 4 mg/2 mL for nausea and vomiting
- Morphine PF 2 mg/mL injection for pain control

- Famotidine 20 mg injection for acid indigestion
- Aluminum-magnesium hydroxide-simethicone 200-200-20 mg/ 5mL suspension 30 mL acid indigestion
- Sucralfate 1 g/ 10 mL suspension 1 g to coat the lining of the stomach

Allergies:

NKDA, no known food or environmental allergies

Family History:

Mother deceased when patient was 1 year old, reason unknown
Paternal history unknown
Patient has no contact with siblings

Social History:

N.C. is a 28 y/o M currently residing in Brooklyn, NY with a family friend x2 years
Habits – drinks 5 beers/day, smokes 1-3 cigarettes/day, occasional marijuana use. Denies other drug use.
Travel – no recent travel
Diet – patient eats once or twice a day, typically food from food trucks near soup kitchen
Sleep – patient does not report any issues sleeping, sleeps 6-8 hours a night
Sexual Hx – not currently sexually active
Occupation – works at a soup kitchen
PCP – patient does not have a PCP

Review of Systems:

General: Reports loss of appetite. Denies fever, chills, night sweats, fatigue, weakness, recent weight gain or loss
***Skin, hair, nails*:** Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, changes in hair distribution
HEENT: Denies headache, vertigo, head trauma, unconsciousness, coma, use of contacts, glasses, visual disturbances, fatigue, lacrimation, photophobia, deafness, pain, discharge, tinnitus, use of hearing aids, nasal discharge, epistaxis, bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, use of dentures
Neck*:* Denies localized swelling/lumps, stiffness/decreased range of motion
Breast*:* Denies lumps, nipple discharge, pain
Pulmonary*:* Denies dyspnea, SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, PND
Cardiovascular*:* Denies chest pain, HTN, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, known heart murmur
Genitourinary: Denies dysuria, hematuria, urinary frequency, urinary urgency, nocturia, incontinence, oliguria, polyuria
Gastrointestinal*:* Reports abdominal pain radiating to back, NBNB vomiting, nausea, pyrosis. Denies, intolerance to foods, dysphagia, eructation, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool

Males: Last prostate exam/PSA: N/A. Denies hesitancy or dribbling
Sexual history: Sexually active? Not currently sexually active
Musculoskeletal**:** Denies muscle/joint pain, deformity or swelling, redness, arthritis
Peripheral Vascular**:** Denies intermittent claudication, varicose veins, or peripheral edema, color change
Hematologic: Denies easy bruising or bleeding, lymph node enlargement, hx of clot
Endocrine**:** Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism
Nervous**:** Denies seizures, loss consciousness, ataxia, loss of strength, change in cognition
Psychiatric**:** Denies depression, anxiety, or OCD.

Vital Signs:
Temperature: 98.2 degrees Fahrenheit
O2 Sat: 100% on room air
Height: 5'3 (63 inches)
Weight: 140 lb (63.5 kg)
BMI: 24.8
Respiratory Rate: 18
Heart Rate: 77
Blood Pressure: 121/66 LT arm sitting down

Physical:

General: Patient is alert & oriented to time, place, and person. He is leaning forward holding his abdomen. He appears to be a reliable source of information, appears his stated age, and appears uncomfortable secondary to pain.

HEENT: Hair is black in color with silky texture and no sign of lice or nits. Head is normocephalic and atraumatic. Face is symmetrical with no signs of drooping, swelling, or trauma. Eyes are symmetrical OU. Bilateral ears are symmetrical and appropriate in size without lesions, masses, or trauma on external ears. The nose symmetrical without masses, deformities, trauma, or discharge. No gingival hyperplasia or erythema. Pharynx is non-erythematous, uvula is midline.

Skin, and Nails: The skin is warm and moist with good texture and turgor. Non-icteric with no swelling or signs of ecchymosis. Nails do not exhibit digital clubbing, capillary refill less than 2 seconds in upper and lower extremities.

Neck, Thyroid, and Lymph Nodes: Trachea is midline. Neck is supple and non-tender. The lymph nodes are freely mobile, non-tender.

Cardiac: Carotid pulses are 2+ bilaterally w/o bruits. 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. Lungs are clear to auscultation bilaterally. No adventitious sounds noted.

Abdomen: The abdomen is flat with normal contour. Bowel sounds hypoactive in all four quadrants. There is tenderness to palpation in the epigastric area without guarding or rebound. RT CVA tenderness appreciated. There is no LT CVA tenderness. Negative signs include Murphy's, McBurney's, and Rovsing

Peripheral Neurologic Exam: No atrophy, tics, tremors, or fasciculations

Mental Status Exam: Patient is alert and oriented to name, date, time, and location. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically. Insight, judgement, cognition, memory, and attention intact.

Peripheral Vascular Exam: The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted. No calf tenderness bilaterally, equal in circumference.

MSK: No soft tissue swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. No evidence of spinal deformities.

DDx:

1. Alcoholic vs. Gallstone Pancreatitis
2. PUD with possible gastric ulcer
3. GERD/gastritis
4. Acute cholecystitis
5. Bacterial vs. Viral Gastroenteritis

Laboratory Findings

BMP, Mg2+, Hepatic fxn, Lipase

Anion Gap	17
Sodium	143
Potassium	3.5
Chloride	98
Co2	28
BUN	9
Creatinine	0.73
Glucose	107
ALT (SGPT)	198
AST (SGOT)	291
Alkaline Phosphate	153
Total Bilirubin	0.6

CBC and Differential

WBC	3.69
RBC	4.30
HGB	13.9
HCT	42.2
MCV	98.1
MCH	32.3
MCHC	32.9
RDW	14.4
PLT	59
MPV	12.0
Monocyte %	10.8
Monocyte Abs	0.40

Basophil %	1.1
Basophil Abs	0.04
Imm Gran %	0.3
Imm Gran Abs	0.01
NRBC Abs	0.00
NRBC %	0.0

Calcium	9.5
Total Protein	8.7
Albumin	5.1
Magnesium	1.8
eGFR	>60.0
Lipase	85

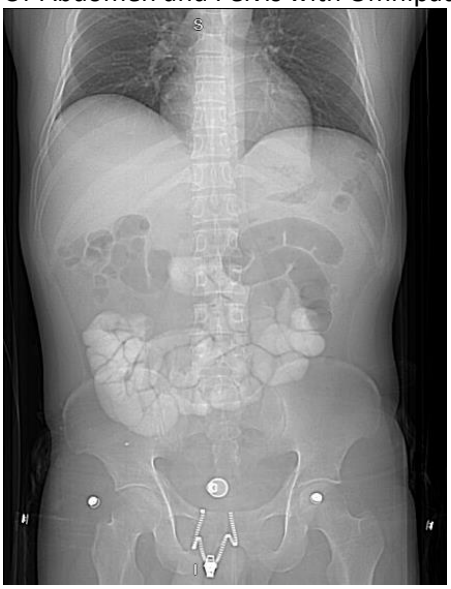
Neutrophil %	61.3
Neutrophil Abs	2.26
Lymphocyte %	26.0
Lymphocyte Abs	0.96
Eosinophil %	0.5
Eosinophil Abs	0.02

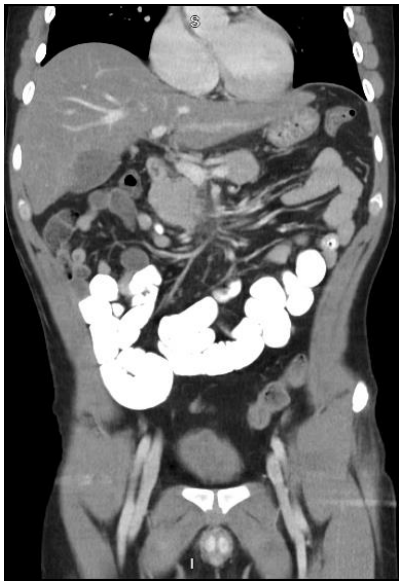
UA w/ Rflx Microscopic

pH	6.5
Color	Yellow
Appearance	Clear
Glucose Qualitative	Negative
Bilirubin	Negative
Ketones	Negative
Specific Gravity	1.010
Blood	Negative
Protein	Negative
Urobilinogen	0.2
Nitrite	Negative
Leukocyte Esterase	Negative
White Blood Cells	N/A
Red Blood Cells	N/A

Imaging:

CT Abdomen and Pelvis with Omnipaque



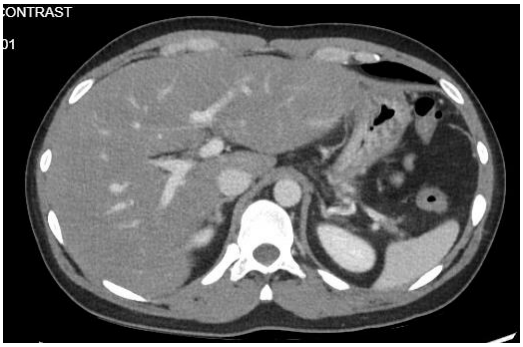


Hepatic steatosis. No appendicitis. The visualized lung bases show no consolidation or effusion.

The liver is normal in size without focal abnormality. There is no evidence of intrahepatic or extra-hepatic ductal dilation. The gallbladder is not distended.

The spleen, pancreas, and adrenals are within normal limits.

There is no abnormal dilation of bowel. There is no evidence of obstruction. There are no abscesses or collections.



The kidneys are normal in size and position. There is no evidence of hydronephrosis or hydroureter.

Bladder is distended and smooth in contour.

IMPRESSION: no appendicitis, diverticulitis, or GI obstruction. Peripancreatic space is clear, no evidence of pancreatitis radiographically either

Assessment:
N.C. is a 28 y/o M w/ PMHx uncontrolled HTN, uncontrolled DM, and alcohol use disorder presenting for worsening epigastric pain x4 days. On physical exam patient had epigastric tenderness to palpation which improved with medication. Patient was able to tolerate intake and stated he wanted to go home.

Plan:
#epigastric pain
- Discharge to home with Pepcid
- BRAT
- Strict return precautions: return to ED if pain recurs and is refractory to Pepcid, if intractable nausea or vomiting, fever/chills, SOB, or CP .

#uncontrolled HTN and DM
- Encourage follow-up with PCP

#alcohol use disorder
- Encourage follow-up with chemical dependency
- Referral for psych