Raghda
Elshafey

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History
Identifying Data
Full Name: KS
Address: Queens, NY
DOB: 01/01/1980
Date & Time: 4/09/19
Location: Queens, NY
Race: Black
Source of Info: Self

Chief Complaint: "I had sharp pain in my lower abdomen" x 2 days

History of Present Illness:
39 y/o female with a PMH of fibroids s/p laser surgery 5 years ago presents to ED complaining of severe sharp lower abdominal pain. Pt states she was laying down 2 days ago getting ready to sleep when she suddenly felt the pain. She took a Tylenol, but it did not help. She says the pain is constant, feels like a 10/10, does not radiate anywhere, and that nothing helps her feel better and that walking or moving too much makes it worse. Pt states she has felt this pain before. She is not currently sexually active. LMP 3/22/19. Has regular bowel movements daily. Color of urine is yellow. Admits to weight loss, abdominal pain, menorrhagia. Denies loss of appetite, generalized weakness/fatigue, fever or chills, or night sweats. Denies intolerance to spicy foods, nausea and vomiting, dysphagia, pyrosis, unusual flatulence or eructation, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, or rectal bleeding. Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain. Denies dysmenorrhea, metrorrhagia, PMS, or vaginal discharge.

Past Medical History
Present illnesses - Denies
Past Medical Illnesses- Uterine fibroids 5 years ago
Denies any childhood illnesses.
Denies any past hospitalization.
Immunization - Up to date; Flu vaccine yearly.

Past Surgical History:
- Fibroid Laser Surgery - age 34, NYPQ, New York, NY, Due to fibroids.

Denies other injuries or transfusions.

Medications:
Denies taking any medication.

Allergies:
NKDA, no food/environmental allergies

Family History:
Mother - 79, alive and well
Father - 82, alive and well
Siblings - none
Son - 18, alive and well
Maternal/paternal grandparents - Deceased at unknown age & unknown reasons.
Denies family history of cancer.

Social History:
KS is a single mom who works in hospitality at Marriott International. She lives with her parents and son.
Habits- She denies drinking alcohol, smoking cigarettes/cigars, or any drug use. She does not consume much caffeine besides a cup of coffee everyday.
Travel- Denies any recent travel.
Diet- Typically eats egg or cereal for breakfast, and chicken/meat w/ rice/bread for dinner.
Exercise- She does not exercise much.

## Review of Symptoms

-General: See HPI

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

- Head: Denies headaches, vertigo or head trauma.
- Eyes: Denies visual disturbances, lacrimation, photophobia, pruritus. She wears glasses. Last eye exam unknown- doesn't know her visual acuity.
- 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 dentures. Last dental exam Dec 2018.
- Neck: Denies localized swelling/lumps or stiffness/decreased ROM.
- Breast: Denies lumps, nipple discharge, or pain.
- Pulmonary: Denies SOB, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, or PND.
- Cardio: Denies chest pain, HTN, palpitations, irregular heartbeat, edema/swelling of ankles/feet, syncope, or known heart murmurs.
- GI: see HPI
- GU: see HPI.

  Sexual Hx: see HPI
- Menstrual/obstetrical:

- Nervous: Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, weakness or change in cognition/mental status/memory.
- Musculoskeletal: Admits to back pain. Denies deformity or swelling, redness, or arthritis.
- Peripheral vasular: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes.
- Hematological: Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions or history of DVT/PE.
- Endocrine: Denies polyuria, polydipsia, polyphagia, heato c

cold intolerance, excessive sweating, hirsutism, or goiter
- Psychiatric: Denies depression/ sadness, anxiety, OCD, or ever seeing a mental health professional.

Physical:
- General: Average weight, neatly groomed, AOx3, in no apparent distress, looks her stated age of 39 y/o.
- Vital Signs: need two different Bp. or document unable to conduct from different arm

BP: 104/66 Supine RA P: 82, regular
R: 16/min unlabored $O_2$ Sat: 94% RA
T: 98.2°F oral Height: 5'7 Weight: 158lbs BMI: 24.7

- Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, no tattoos
- Hair: Average quantity and distribution
- Nails: no clubbing, capillary refill <2 seconds throughout
- Head: normocephalic, atraumatic, nontender to palpitation throughout
- Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjuctiva & cornea clear.
  Visual acuity (corrected 20/20 OS, 20/20 OD, 20/20 OU).
  Visual fields full OU. PERRLA, EOMs full with no nystagmus.
  Fundoscopy- Red reflex intact OU. Cup:Disk <0.5 OU/no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.
- Ears: Symmetrical and normal size. No evidence of lesions/masses/trauma on external ears. No discharge/ foreign bodies in external auditory canals AU. TM's pearly white/intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC>BC AU.
- Nose: Symmetrical / no obvious masses/lesions/ deformities/ trauma/ discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated. No discharg noted on anterior rhinoscopy. Septum midline without lesions/ deformities/ injection / perforation. No evidence of foreign bodies.
- Sinuses: Non-tender to palpation and percussion over bilalateral frontal, ethmoid and maxillary sinuses.
- Lips: Pink, moist; no evidence of cyanosis or lesions. Non-tender to palpation

- Mucosa: Pink; well hydrated. No masses; lesions noted. Non tender to palpation. No evidence of leukoplakia.
- Palate: Pink; well hydrated. Palate intact with no lesions; masses; scars. Nontender to palpation; continuity intact.
- Teeth: Good dentition / no obvious dental caries noted.
- Gingivae: Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.
- Tongue: Pink; well papillated; no masses, lesions or deviation noted. Non-tender to palpation.
- oropharynx: Well hydrated; no evidence of injection; exudate; masses, lesions, foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions.
- Neck: Trachea midline. No masses, lesions, scars, pulsations ~~Needle~~ RE noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulse, no thrills, bruits noted bilaterally, no palpable adenopathy noted
- Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.
- Chest: Symmetrical, no deformities, no evidence of trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation.
- 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 the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm. $S_1$ and $S_2$ are normal. There are no murmurs, $S_3$, $S_4$, splitting of heart sounds, friction rubs or other extra sounds.
- Abdomen: Slightly protuberant / symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits noted over aortic / renal / iliac / femoral arteries. Tympany to percussion throughout. Tender to percussion and light / deep palpation in suprapubic region. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

- Breast: symmetric; no dimpling or masses, nipple w/o discharge. No axillary nodes palpable.
- Female genitalia (Exteral) normal pubic hair pattern, no erythema, inflammation, ulcerations, lesions or discharge noted. BUS wnl Vaginal mucosa without inflammation, erythema, or discharge. Cervix nulli/multiparous without inflammation, erythema or discharge. Uterus anteflexed, mobile, tender and or normal size, shape and consistency. Adnexa tender and w/ masses.
- Rectal: 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.
- Peripheral Vascular: The extremities are normal in color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis, or edema noted bilateraly ~~No cyanosis~~ RE No stasis changes or ulcerations noted.
- Musculoskeletal: No soft tissue swelling/erythema/ecchymosis/ atrophy/ or deformities in bilateral upper and lower extremities. Nontender to ~~palpitation~~ RE palpation, no crepitus noted throughout. FROM of all upper and lower extremities bilaterally. No evidence of spinal deformities.
- 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.
VII- Facial movements symmetrical and without weakness.
VIII- Hearing intact to whispered voice bilaterally bilaterally. Weber midline. Rinne AC>BC
IX-X-XII Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.
XI- Shoulder shrug intact. SCM and trapezius muscles strong.

Assessment: 39 y/o female w/ PMH of fibroids s/p laser surgery 5 years ago presents to ED c/o severe sharp lower abdominal pain. Suspect fibroid regrowth.

Differential Diagnosis:

① Uterine fibroid because of hx. order US to confirm dx.

② Adenomyosis: because of abdominal pain & heavy bleeding. R/o w/ US/MRI.

③ Endometrial polyp: b/c of abdominal pain & heavy bleeding. R/o w/ transvaginal US or hysteroscopy

④ Ovarian cyst: obtain transvaginal US to R/o

⑤ Ovarian torsion: obtain transvaginal US to R/o

UTI since it is suprapubic
~~PID~~ PID should also be considered.

Plan: US to confirm fibroids. Discuss surgery w/ pt or Rx of Percocet 2.5mg 1-2 tablets q6h

≠ no dose as 2.5 mg. It's too low.
I would probably give tramadol.

Problem List:

- Abdominal Pain: follow plan

Do you want to check blood?
-I would do CBC, CMP, Pregnancy test, Urinalysis, urine culture, ultrasound. Tx pain ± tramadol.
Consider CT abdomen if US is neg.