Emily Lancia H&P 3 Due 11/27/23

History

Identifying Data:

Full Name: G.M.V.H.
Address: Maspeth, NY
Date of Birth: September 9th, 1980 (43YOM)
Date & Time of Encounter: November 21st, 2023, 9:15am
Location: NYPQ EM, Flushing, NY
Religion: Catholic
Source of Information: Self
Source of Referral: None, admitted to ED from home
Reliability: Reliable

Chief Complaint: Epigastric and RUQ abdominal pain x 6 months, worsening x 1 week

History of Present Illness:

43YOM w/ PMH migraine headaches presents with epigastric and RUQ pain x 6 months. Pt reports intermittent "cramping" epigastric pain with accompanying intermittent dull RUQ pain that radiates to R upper lumbar area (~4cm caudal to R CVA). Onset of symptomatic episodes were gradual and have increased in frequency and intensity over time, with the worst being the past week. He reports about 5 episodes per day this week with pain 8/10 in severity. He says the pain is unprovoked and comes on suddenly, and is consistently relieved by bending over and touching his toes. Each episode typically lasts less than 5 minutes. He presents today after an episode woke him from sleep this morning; It has since resolved. He has not tried any OTC medications to address symptoms. Denies postprandial symptoms, anorexia, N/V/D, constipation, changes in bowel habits, changes in diet. Denies recent traumatic injury. Denies dysuria, urinary frequency/urgency, sensation of incomplete void, h/o kidney stones. Last oral intake was Chinese food around 9pm last night. He is tolerating liquids normally.

Pt says that his "stomach" and RUQ feel more "heavy" and "full" than 6 months ago. He reports 40lb weight gain over the past 12 months without change in his diet or activity. He denies fever, fatigue, night sweats, sick contacts. He notes intermittent itchiness in R upper lumbar area near the area of radiated pain, but denies rash, lesions, color changes, or vascular changes. He endorses intermittent throat and non-exertional L chest discomfort that is more common at night and resolves completely by morning. He denies any chest discomfort at this time. He denies palpitations, shortness of breath, cough, upper extremity pain, globus sensation, belching, or dysphagia. He reports migraine headaches seemingly unassociated with

his abdominal pain and consistent with his previous h/o migraines, relieved by Advil PRN. He denies dizziness, paresthesias, MSK weakness.

Past Medical History:
Present chronic illnesses – Recurrent Migraine Headaches
Past medical illnesses – Denies past illnesses
Childhood illnesses – Denies childhood illnesses
Immunizations – Up to date, including COVID-19 and influenza vaccines this year
Screening tests and results – Denies h/o screening tests. Pt has never undergone colonoscopy.

Past Surgical History:
L Knee ACL Reconstruction, 2021, NYP Orthopedics, Queens, NY – Without complication.
Denies additional past injuries or transfusions.

Medications:
Advil, 400mg PRN for migraines

Vitamins and Supplement
Denies

Allergies:
NKDA
Denies food and environmental allergies.

Family History:
Maternal grandmother – 91, alive with controlled DM2.
Maternal grandfather – 94, alive with hypertension.
Paternal grandmother – 92, alive and well.
Paternal grandfather – Deceased at unknown age from unknown cancer.
Father – 68, alive with hypertension.
Mother – 66, alive with pre-diabetes.
Brother – 40, alive and well.

Social History:
G.M.V.H. has been married to his wife for 11 years. They live together. They do not have any children.
He works full-time as a personal assistant in the film industry.
He denies alcohol intake.

He denies smoking cigarettes/cigars, or using illicit drugs.
He has 1 cup of coffee daily.
He denies recent travel.
He reports a diet sufficient in fruits and vegetables, but notes that he eats take-out about 1x a day and hopes to increase home-cooked meals.
He reports frequent walking at his job, but has an otherwise sedentary lifestyle.
He reports getting 7-8 hours of sleep each night. He notes that his quality of sleep is sometimes worsened by his abdominal pain.
He is currently sexually active with only his wife. Denies history of sexually transmitted diseases. Reports last STD testing was 11 years ago.

Review of Systems:
General – Reports 40lb weight gain over the past 12 months. Denies fever, night sweats, fatigue.

Skin, hair, nails – Reports intermittent itching in R thoracic back. Denies vascular changes, color changes, rashes, or skin lesions.

Head – Reports intermittent migraines consistent with migraine hx. Denies dizziness, syncope, or head trauma.

Eyes – Denies changes in vision, discharge, or erythema. Visual acuity 20/20 OU uncorrected.

Ears – Denies changes in hearing, pain, or discharge.

Nose/sinuses – Denies nasal congestion, sinus congestion or sinus tenderness.

Mouth/throat – Denies sore throat, difficulty swallowing, or voice changes. Last dental exam 2021.

Neck – Denies swelling, tenderness, or stiffness.

Pulmonary system – Denies cough, wheezing, pleuritic pain, or dyspnea.

Cardiovascular system – Reports intermittent R chest pain. Denies palpitations or edema.

Gastrointestinal system – Reports intermittent epigastric and RUQ pain. Denies change in appetite, nausea, vomiting, diarrhea, or blood in stool.

Genitourinary system – Denies urinary frequency or urgency, dysuria, or flank pain.

Nervous – Denies weakness, ataxia, paresthesias, or loss of strength.

Musculoskeletal system – Denies pain, tenderness, or abnormal range of motion.

Peripheral vascular system – Denies varicose veins, peripheral edema, or cold extremities.

Hematological system – Denies easy bruising or bleeding, h/o blood transfusions, or h/o DVT/PE.

Endocrine system – Denies heat or cold intolerance, excessive sweating, or excessive thirst.

Psychiatric – Denies anxious or depressive mood, denies h/o psychological or psychiatric care.

Physical

Vital Signs:

Wt: 210
Ht: 5'7"
BMI: 32.9
Temp: 37°C, oral
Pulse: 68 bpm, regular rate and rhythm
Resp: 16 rpm, unlabored
Sp02: 99 % on room air
BP:

	Right Arm	Left Arm
Seated	130/90	112/72
Standing	110/72	108/70

General:

Well-nourished, neatly groomed Hispanic male that looks younger than his stated age, dressed appropriately for the weather. Pt appears comfortable, lying supine on a stretcher with no obvious signs of distress.

Skin:

Warm & moist, good turgor. Nonicteric, no lesions noted, no scars. No visible tattoos or markings.

Hair:
Average quantity and distribution.

Nails:
No clubbing, no discolorations, capillary refill <2 seconds in upper and lower extremities.

Head:
Normocephalic, atraumatic, non tender to palpation throughout.

Eyes:
Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity uncorrected - 20/30 OS, 20/20 OD, 20/20 OU.
Visual fields full OU. PERRLA, EOMs intact with no nystagmus or lid lag.
Fundoscopy - Red reflex intact OU. Cup to disk ratio< 0.5 OU. No AV nicking, hemorrhages, or exudates OU.

Ears:
Symmetric and appropriate in size. No lesions, masses, or evidence of trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TMs are pearly white and intact with light reflex in a good position AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne reveals AC>BC AU.

Nose:
Symmetrical with no masses, lesions, deformities, or trauma. Nares patent bilaterally. Nasal mucosa is well hydrated. Septum midline without lesions, deformities, or 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.

Oral Mucosa:

Pink, well hydrated. No masses or lesions noted. No leukoplakia.

Palate
Pink, well hydrated, and intact with no lesions or masses.

Teeth
Good dentition with no obvious dental caries noted.

Gingivae
Pink, moist. No hyperplasia or masses.

Tongue
Pink, moist. No masses, lesions or deviation.

Oropharynx
Well hydrated, with no exudates, masses, erythema, or lesions. Tonsils are present with no erythema or exudates. Uvula midline, with no lesions.

Neck:
Trachea midline. No masses, lesions, scars, or visible pulsations noted. Supple and nontender to palpation. No palpable cervical adenopathy.

Thyroid:
Non-tender, no thyromegaly. No palpable nodules noted.

Chest:
Symmetrical, no deformities, no trauma. Respirations unlabored with no paradoxical respirations or use of accessory muscles noted. Non-tender to palpation throughout.

Lungs:
Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.

Heart:
JVP is 3 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 (RRR). S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdomen:

Epigastric and RUQ tender to palpation, no guarding or rebound noted. Epigastrium appears slightly distended. Abdomen is otherwise non-tender, flat, and symmetric. No scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. No hepatosplenomegaly to palpation, no CVA tenderness appreciated. Murphy's sign is negative to palpation.

Genitalia:

Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes Descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias noted.

Rectal:

No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate smooth and non-tender with palpable median sulcus Stool brown and Hemoccult negative.

Motor/Cerebellar

Symmetric muscle bulk with good tone. No atrophy, tics, tremors or fasciculation. Strength 5/5 throughout. Romberg negative, no pronator drift noted. Gait steady with no ataxia. Tandem walking and hopping show balance intact. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis.

Sensory

Intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally

Reflexes

2+ throughout, negative Babinski, no clonus appreciated

Meningeal Signs

No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Peripheral Vascular Exam

Skin normal in color and warm to touch upper and lower extremities bilaterally. No calf tenderness bilaterally, equal in circumference. Homan's sign is not present bilaterally. No

palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No cyanosis, clubbing/edema noted bilaterally.

Musculoskeletal Exam

No soft tissue swelling / erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Non-tender to palpation / no crepitus noted throughout. FROM (Full Range of Motion) of all upper and lower extremities bilaterally. No evidence of spinal deformities.

Differential Diagnoses:

1. Cholelithiasis
    a. Obese 43YOM with likely poor nutrition including daily intake of high fat meals presents with intermittent RUQ pain with radiation to back. Assess with RUQ ultrasound.
2. Nephrolithiasis
    a. Obese 43YOM with likely poor nutrition including daily intake of high salt meals presents with intermittent and worsening epigastric, RUQ, and R lumbar back pain that resolves positionally. Assess with UA and renal U/S initially, will consider CT imaging pending reevaluation of initial test results.
3. GERD
    a. Obese 43YOM with likely poor nutrition presents with intermittent epigastric and RUQ pain with radiation to chest and throat that is worst at night and resolves positionally. Consider GI consult pending reevaluation of initial test results.
4. Malignancy
    a. Obese 43YOM with family h/o unknown malignancy presents with epigastric and RUQ pain and distention and 40lb unplanned weight gain in the past 12 months. Consider CT imaging pending reevaluation of initial test results. My suspicion is lower for this given lack of other systemic symptoms, however, it is important to r/o given possibility of associated mortality.
5. ACS – Stable Angina
    a. Obese 43YOM with family h/o hypertension and likely poor nutrition including daily intake of high fat meals presents with intermittent upper abdominal and L chest pain that resolves positionally and with rest. Assess with ECG, cardiac enzymes, cholesterol panel. Consider further w/u pending initial test results. My suspicion is lower for this given that Pt reports the abdominal pain often presents as an isolated symptom, however, it is important to r/o ACS given risk factors and possibility of atypical presentation.

Assessment:

Pt presents for evaluation of intermittent epigastric and RUQ pain. He appears stable at this time with no acute signs of distress. Further workup required including initial abdominal U/S, urinalysis, ECG, and bloodwork including CBC, CMP, cardiac enzymes, cholesterol panel, amylase, lipase. Plan for observation, pain management, and reevaluation pending test results. Will consider further w/u and consult at that time.

Plan

Problem List:

1. Abdominal Pain
    a. Pain management with analgesics
    b. NPO status until further notice
    c. Monitor closely for any changes in symptoms or signs of complications
2. Obesity
    a. Assess for presence of causative pathology
    b. Promote healthy diet and lifestyle
3. Migraine headache
    a. Continue Advil PRN