Comprehensive Well-Woman paper

Harpreet Dhillon

Dr. DeLong

NRNP-6552-8

Walden university

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Signature: K Jackson

Initials: J.D.

Age: 32

Race: Caucasian

Gender: Female

Marital Status: Married

Informant: Patient

CHIEF COMPLAINT (CC):

"I have been experiencing persistent lower abdominal pain for the past week."

HISTORY OF PRESENT ILLNESS (HPI):

J. D. is a 32-year-old Caucasian, non-Hispanic female, married and living with her spouse. She is an office manager, and she participates in fitness by walking three times a week. Today she presents for evaluation of ongoing lower abdominal pain and irregular menstrual cycles for the last few months. Also, she informs me of increased fatigue, occasional nausea, and mild bloating.

PAST MEDICAL HISTORY (PMH):

J.D. has a history of iron deficiency anemia but denies chronic conditions such as hypertension or diabetes. She's never had any sexually transmitted infection (STI) diagnosis and has never had

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this problem before. In 2015 she had an appendectomy and has no other surgeries or hospitalizations.

FAMILY HISTORY (FH):

J.D.'s mother is 58 and has a history of hypertension. Her father died from heart disease when she was 60. Her mother's mother had breast cancer at age 65. Her one brother is in good health. Family history of endometriosis is not known, nor polycystic ovarian syndrome (PCOS) and other gynecological diseases.

SOCIAL HISTORY (SH):

- Marital Status:

  Married, lives with spouse

- Occupation:

  Office manager

- Exercise:

  Walks 3x per week

- Diet:

  Balanced but high in fried foods

- Substance Use:

  No smoking, occasional alcohol

- Living Arrangements:

  Lives in a suburban home

- Safety:

  Uses seatbelt regularly, no firearms at home

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- Reproductive History:

  LMP 12 days ago, regular cycles, gravida 2 para 1

- Sexual History:

  Heterosexual, monogamous, no known STIs

REVIEW OF SYSTEMS (ROS):

General: The patient will report no unexpected weight loss, fever, or night sweats. She complains rarely of fatigue, usually around her menstrual cycle. She denies any recent change in appetite, sleep disturbance, chills, or weakness.

HEENT: The patient denies headaches, dizziness, or visual disturbances. None of the nasal congestion, sore throat history or hearing problems. In fact, she would never suffer sinus infection or face swelling.

Skin: The patient has no rashes, itching, or change in skin pigmentation. No abnormal moles or lesions. She also denies excessive dryness or unhealed wounds, nor does she report any bruising. No concerns of hair or nail loss.

Cardio: No chest pain, palpitations or SOB. No history of murmurs, arrhythmias, or hypertension. She denies any extremity swelling, exertional dyspnea, syncope, or lightheadedness.

Respiratory: There is no of cough, wheezing or hemoptysis. No history of asthma, pneumonia, or COPD. Her history has no regard to frequent respiratory infections nor to resting or exertional shortness of breath. No persistent nausea, vomiting, diarrhea, or abdominal pain other than what the patient reported for menstrual discomfort. No other history of chronic constipation, heartburn

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or bloating that were not due to her cycle. There is denial of any stool color, consistency or frequency changes. No history of Crohn's disease or irritable bowel syndrome (IBS).

Genitourinary: irregular menstrual cycles, occasional spotting between periods, and mild dysmenorrhea. She denies burning with urination, hematuria, or anything unusual from her vagina. There is no history of recurrent UTIs or kidney stones. No complaints of urinary incontinence or pelvic pressure.

Neurologic: The patient denies dizziness, numbness, tingling or weakness. No history of seizures, migraines, or unexplained headaches. There is no change in coordination, memory or balance, she reports.

Musculoskeletal: There is no pain, swelling or stiffness of joints. The subject has no history of arthritis or back pain, or muscle cramps. She denies any recent injuries or fractured, but mobility is not a problem.

Hematologic: The patient has no history of iron deficiency anemia; however, she denies unexpected bruising, prolonged bleeding, or history of anemia to supplement her known iron deficiency. The result of no clotting disorders or blood transfusions, there were only being investigated the few types of clotting disorders and blood transfusions.

Lymphatic: Patient has no bigger swollen lymph nodes nor tenderness over his neck, axillary and groove region. No history of infections or systemic diseases which are significant to justify the involvement of lymphatic systems. She has no fatigue or unexplained weight loss.

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Endocrine: The patient denies excessive thirst, urination, and weight changes of unknown origin. No history of thyroid disorders or diabetes. She denies being sensitive to heat or cold, having tremors, or symptoms suggestive of hormonal balances.

OBJECTIVE DATA (O):

1. Constitutional:

   VS: Temp 98.6F,

   BP 120/76,

   HR 78,

   RR 16,

   Height 5'6",

   Weight 150 lbs

   Well-appearing, no distress

2. Eyes:

   PERRLA, EOMI, no conjunctival injection

3. Ears, Nose, Throat:

   Clear tympanic membranes, normal nasal mucosa, no oropharyngeal lesions

4. Cardiovascular:

   Regular rate and rhythm, no murmurs or gallops, no peripheral edema

5. Respiratory:

   Lungs clear bilaterally, no wheezing, no rales (Sabo et al., 2021)

6. Gastrointestinal:

   Soft, mild tenderness in lower abdomen, no rebound or guarding, bowel sounds normal

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7. Genitourinary:

No CVA tenderness

8. Musculoskeletal:

No joint swelling or tenderness

9. Integumentary/Lymphatic:

No rashes, normal skin turgor

10. Neurologic:

- CN II-XII intact, normal gait

11. Psychiatric:

- Normal affect, no signs of distress

12. Hematologic/Immunologic:

- No lymphadenopathy or signs of anemia

ASSESSMENT (A):

Mental Status Examination:

J.D. is a 32-year-old woman alert, oriented. A good eye contact is kept with her and she is cooperative during the conversation. She says she's mildly anxious about her symptoms, but does not say it is a major cause of distress. She speaks clearly with no problems and normal tone and volume. There are no hallucinations, delusions, or paranoia in the thought processes, and they are logical and goal directed. She still has her memory and concentration. She is appropriately insightful and judgmental and is able to comprehend her symptoms and treatment options. There is no suicide or homicidal ideation.

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Diagnostic Impression:

The patient's complaints; irregular menstrual cycles, pelvic pain and occasional spotting, are consistent with the primary diagnosis of Uterine Fibroids. When I saw the ultrasound, they confirmed multiple small fibroids. Uterine fibroids are benign tumors that are common in reproductive age women and they generally manifest as irregular bleeding and pelvic pain or pressure (Fowler, 2019). Given that there is no fever, acute pelvic discomfort, or sign of infection, this diagnosis is supported.

Endometriosis: Pelvic pain, irregular bleeding and pain during intercourse may also be due to endometriosis. The diagnosis of this is also less likely, since there is no severe dysmenorrhea and the ultrasound finds no ectopic endometrial tissue (Fowler, 2019). The probability of this is further decreased by lack of a history of endometriosis in the patient and her age.

Polycystic Ovary Syndrome (PCOS): Polycystic Ovary Syndrome (PCOS) is a differential diagnosis. However, while this patient does not report weight gain, acne, or hirsutism, PCOS is usually accompanied by these issues. She has normal estradiol levels on her hormonal panel and the absence of an increased LH/FSH ratio also lowers the chances of PCOS (Singh et al., 2023).

Pelvic Inflammatory Disease (PID): Pelvic Inflammatory Disease (PID) is a reproductive tract infection that can lead to fever, abnormal vaginal discharge, and pelvic pain. The patient has an abnormal menstrual bleeding and pelvic symptoms but denies fever, vaginal discharge or past STI history decreasing the risk of PID substantially (Fowler, 2019). Not only do there exist test results that exclude PID as a reasonable diagnosis, but her physical examination findings also demonstrate no cervical motion tenderness or adnexal tenderness

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In the end, uterine fibroids still remain the primary diagnosis because the patient has all the typical symptoms, history, and ultrasound findings which make it a logical diagnosis. Fever, significant weight changes, or systemic illness is not present further in support of this diagnosis (Fowler, 2019). According to the clinical data available, there is a strong likelihood that uterine fibroids are causing the above symptoms of irregular bleeding and pelvic discomfort.

PLAN (P):

PLAN FOR TREATMENT AND MANAGEMENT

Pharmacologic Treatments:

Instruct patients with mild pelvic pain and discomfort with fibroids to take NSAIDs (such as ibuprofen 200 mg as needed).

Use of combination oral contraceptives or progestin-only therapy for hormonal therapy can be used to regulate menstrual cycles and to help decrease fibroid-related bleeding.

Tranexamic Acid during menstruation may help reduce excessive bleeding if symptoms get worse.

For people with severe fibroid symptoms, GnRH agonists may be used short-term to shrink fibroids before surgery begins to be considered.

Nonpharmacologic Treatments:

On how to keep the weight in check, advise the patient to lose existing excess weight through the adoption of a healthy diet and a physically active lifestyle, since obesity can worsen fibroid symptoms.

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Advise the patient to heat therapy (e.g., a heating pad) as a means to help relieve pelvic pain.

Acupuncture is discussed as another alternative pain management technique, as in some cases it has been linked to symptom relief.

Alternative Therapies:

Advise patient to ask about herbal supplements, such as Vitex (Chaste tree berry) or Green Tea extract, that may help with relief, advising to stay aware of herbal interactions with medications.

However, fibroid discomfort and stress can also be managed with planned relaxation techniques such as Acupressure or Reflexology.

Follow-up:

Schedule a pelvic ultrasound every 3–6 months if the fibroid is growing or the symptoms are progressing.

Perform annual gynecologic exams to examine reproductive health as a whole.

However, if symptoms are severe or if a myomectomy or hysterectomy needs to be considered, the patient should be referred to a gynecologist.

Fibroids near the uterine lining should offer fertility counselling, as they may affect pregnancy outcomes.

To optimize long-term symptom control, it is suggested that the patient perform dietary adjustments and stress management or consult with a dietitian or counselor.

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Patient Education:

Teach the patient about uterine fibroids and let them know that they are a benign condition, which might fluctuate in symptoms.

They should discuss potential complications like severe bleeding or pain and when to seek medical attention.

Describe which treatment options are available (e.g., hormonal therapy, nonpharmacologic methods such as heat therapy, alternative treatments like acupuncture.

Give family planning guidance, including ways that fibroids may affect future pregnancies and fertility preservation options.

Disposition:

Conservatively, the patient will be managed with pharmacologic and nonpharmacologic interventions first.

If symptoms do not improve after 6 to 8 weeks, medical intervention, which could even be surgical, may be suggested.

Referral:

- Consider gynecological consultation if there is no improvement, especially if symptoms suggest endometriosis or ovarian pathology
- Consider gastroenterology referral if symptoms persist despite treatment for possible IBS or gastritis
- Referral to a nutritionist for dietary assessment and improvement

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- Psychological evaluation if stress is suspected as a contributing factor

Reflections:

In a similar patient assessment, I would spend more time talking about factors that influence uterine fibroids, diet, stress, exercise. The growth of fibroid and the reproductive health would be impacted by these factors, hence including them would increase focus on the patient education and management. I would also question more about the family history of uterine fibroids, reproductive health problem areas, and challenges bearing children to the extent that this will inform the referrals and treatment recommendations.

This case illustrates the need for good patient education regarding the disease and the necessity of advising lifestyle modifications, nonpharmacologic treatment as well as pharmacologic treatments. Additionally, cultural factors also need to be taken into account as influences towards adherence to treatment and making patients treatment decision.

My understanding of health promotion and disease prevention support proactive talks to use to discuss long term management of uterine fibroids and fertility preservation, especially in younger patients. Hence, in my future assessments, I will ensure that dietary habits, physical activities and stress management strategies are to be included. A structured follow up plan will help early detection of complications and treatment efficacy leading to an enhancement of patient's quality of life.

Preceptor Verification:

I confirm the patient used for this assignment is a patient that was seen and managed by the student at their Meditrek-approved clinical site during this quarter course of learning.

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References

Fanslow, J., Wise, M. R., & Marriott, J.(2019). Intimate partner violence and women's reproductive healthLinks to an external site.. Obstetrics, Gynaecology & Reproductive Medicine, 29(12), 342–350. https://go.openathens.net/redirector/waldenu.edu?url=https://doi.org/10.1016/j.ogrm.2019.09.003

Fowler, G. C. (2019). Pfenninger and Fowler's Procedures for Primary Care (4th ed.). Elsevier. Section 10, "Obstetrics"

Gluppe, S., Engh, M. E., & Kari, B. (2021). Women with diastasis recti abdominis might have weaker abdominal muscles and more abdominal pain, but no higher prevalence of pelvic floor disorders, low back and pelvic girdle pain than women without diastasis recti abdominis. *Physiotherapy*, *111*, 57-65. https://doi.org/10.1016/j.physio.2021.01.008

Lakhoo, K., Almario, C. V., Khalil, C., & Spiegel, B. M. (2021). Prevalence and characteristics of abdominal pain in the United States. *Clinical Gastroenterology and Hepatology*, *19*(9), 1864-1872. https://doi.org/10.1016/j.cgh.2020.06.065

Lockwood, C. J. (2019). Key points for today's 'well-woman' exam: A guide for ob/gynsLinks to an external site.. Contemporary OB/GYN, 64(1), 2329. https://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=134229869&site=ehost-live&scope=site&authtype=shib&custid=s6527200

Sabo, C. M., Grad, S., & Dumitrascu, D. L. (2021). Chronic abdominal pain in general practice. *Digestive Diseases*, *39*(6), 606-614. https://doi.org/10.1159/000515433

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