CHAPTER 18

Infectious and Parasitic Diseases

BASIC HEALTH RECORD

Discharge Summaries

Discharge Summary Notes

All notes

Author	Service	Author Type	Filed	Note Time
, MD	(none)	Physician	06/26/2008 0916	06/26/2008 0820

Related Notes
Original Note : at 06/26/2008 0847

HOSPITAL DISCHARGE SUMMARY

Patient Name:
Date of Birth: Age: 43 v.o.
Medical Record Number:
Primary Physician: , MD
Phone:
Admission Date: 6/24/2008
Discharge Date: 6/26/2008

She will be discharged from Hospital to home.

PRINCIPAL DIAGNOSIS CAUSING ADMISSION: Abdominal pain

Patient Active Hospital Problem List:
ABDOMINAL PAIN OTHER SPECIF SITE (6/24/2008)
FEVER (6/24/2008)
LEUKOCYTOSIS, UNSPECIFIED (6/24/2008)
NAUSEA WITH VOMITING (6/24/2008)
ADRENAL MASS (6/24/2008)
INTRAMURAL LEIOMYOMA UTERUS (6/24/2008)

DISCHARGE MEDICATIONS
Medications prior to admission that will be resumed at discharge:

Medication	Sig
• MULTIVITAMIN TAB	take 1 tablet by oral route once daily with food

No new medications prescribed at discharge.

FOLLOW-UP: She should see MD in 1-2 weeks.

BRIEF HOSPITAL COURSE: This 43 y.o. female admitted to for further evaluation of abdominal pain. The pain awoke the patient at 6 am. The pain was intermittent, 5/10 in severity, worst in the RUQ, epigastric region. The patient also had significnat pain in the RLQ. Pain radiated around to right flank and some to the left side of the abdomen. The patient had nausea and 1 episode of emesis. The patient had a 103 fever prior to hospitalization. The patient had a CT abd/pelvis in the ED which showed an abnormal appearing uterus - c/w a myomatous uterus, small amount of free fluid in the pelvis, unable to visualize ovaries. The appendix, gallbladder, bowel, kidneys appeared normal. Lab evaluation revealed a mild leukocytosis - 11.7, mildly elevated AST, ALT (50, 49) respectively. UA and blood cultures were negative. A RUQ ultrasound was obtained and did not demonstrate any abnormalities of the gallbladder or biliary tree except for a CBD that was "prominent for age" - measuring 0.6 cm. Due to continued mild tenderness in the RUQ, a HIDA scan was obtained which was normal. The patient's symptoms resolved. She was eating well on discharge. Of note, the patient did not have any fevers after admission to the hospital. The etiology of the patient's pain remains unclear. If the pain returns, she is to seek further medical attention.

Of note, the patient was seen by GYN and did not feel that the abnormalities in the uterus were the source of any pain or febrile illness. The patient can be followed by GYN as an outpatient.

Of note the patient had a 2.1 cm oval adrenal mass on CT of the abdomen and pelvis. The patient will see her primary physician to follow up with this abnormality. At minimum the patient will need repeat imaging done the road to make sure it is stable in size. She will also likely need testing to see if this mass is functional. This can also be done as an outpatient.

PROCEDURES PERFORMED DURING HOSPITALIZATION: CT abd/pelvis, RUQ ultrasound, HIDA

COMPLICATIONS IN HOSPITAL: None

IMPORTANT PENDING TEST RESULTS: None

PERTINENT FINDINGS/RESULTS AT DISCHARGE:
BP 133/63 | Pulse 69 | Temp 98.4 °F (36.9 °C) | Resp 18 | Ht 1.626 m (5' 4") | Wt 67.042 kg (147 lb 12.8 oz) | SpO2 98%
Temp (24hrs), Avg:98.2 °F (36.8 °C), Min:97.9 °F (36.6 °C), Max:98.4 °F (36.9 °C)

Patient Wt. in the past 72 hrs:

	Wt.
06/24/08 1601	67.042 kg (147 lb 12.8 oz)
06/24/08 1112	64.864 kg (143 lb)

Discharge Summaries continued

CONDITION AT DISCHARGE: Improving

Total time spent for discharge on date of discharge: 35 minutes

Physician(s) in addition to primary physician who should receive a copy:
CC1:

MD

Attending addendum: Complete resolution of pain. No fever in hospital. Etiology of pain and fever unclear. If recurs, should have further eval. 2.1 cm left adrenal lesion requires follow up. , MD

ED Provider Notes

ED Provider Notes

All notes

Author	Service	Author Type	Filed	Note Time
, MD	(none)	Physician	06/26/2008 0215	06/26/2008 0215

is a 43 y.o. female

Chief Complaint
Patient presents with
- Abdominal Pain/problem
- Fever
  103 at home

HISTORY OF PRESENT ILLNESS:
I, am serving as a scribe to document services personally performed by , MD based on my observation and the provider's statements to me.

is a 43 y.o. female with no significant PMHx who presents to the ED for evaluation of RLQ abd pain, fevers, chills, and vomiting. The pt states she had a slight unspecified HA last night, which caused her to lose sleep. She was able to sleep but at 0630 this morning (5 hrs 30 minutes ago) was woken up by sharp moderate to severe pain in her RLQ, which has since been constant with new pain in the mid upper abd. Her pain is worse with palpation and is most severe in the RLQ. The pt reports associated fevers, chills, and 5 episodes of vomiting since this morning. She denies experiencing any nausea, diarrhea, urinary sx, SOB, or CP. The pt was actually seen at an outside clinic earlier this morning, where she reported a fever of 103 F. She was sent here for evaluation of possible appendicitis. The pt has had nothing to eat or drink since 0600 this morning (6 hrs ago), when she had a small amount of liquid.

PMHx: Fibroidectomy in 2004

I, , MD attest that is acting in a scribe capacity, has observed my performance of the services and has documented them in accordance with my direction.
History Limitations: None

ALLERGIES

Allergen	Reactions
• Nka (No Known Allergies)	

No current outpatient prescriptions on file.

ACTIVE PROBLEM LIST
Diagnoses
- ABDOMINAL PAIN OTHER SPECIF SITE
- FEVER
- LEUKOCYTOSIS, UNSPECIFIED

ED Provider Notes continued

- NAUSEA WITH VOMITING
- ADRENAL MASS
- INTRAMURAL LEIOMYOMA UTERUS

No past medical history on file.

SURGICAL HISTORY

Procedure	Date
• HX MYOMECTOMY	2000

FAMILY HISTORY

Problem	Relation
• Other *healthy*	Mother
• Other *healthy*	Father
• Other *2 brothers, 3 sisters, all healthy*	Brother

SOCIAL HISTORY

Social History

• Marital Status:	Married
Spouse Name:	N/A
Number of Children:	N/A
• Years of Education:	N/A

Occupational History

- Not on file.

Social History Main Topics

• Tobacco Use:	Never
• Alcohol Use:	No
• Drug Use:	No
• Sexually Active:	No

REVIEW OF SYSTEMS:
Review of Systems was positive for:

GENERAL: fever (Reported as 103 F at clinic.), chills
GI: abdominal pain, nausea/vomiting (5 episodes of vomiting without reported nausea since this morning.), SeeHPI
NEURO: headache (Slight, unspecified.)

Pertinent negatives include Cardiac: no chest pain, Resp: no short of breath, Gastro: no diarrhea, GU: Negative

All other systems were reviewed as negative

PHYSICAL EXAM:
VITAL SIGNS: BP 127/54 | Pulse 72 | Temp 97.9 °F (36.6 °C) | Resp 16 | Ht 1.626 m (5' 4") | Wt 67.042 kg (147 lb 12.8 oz) | SpO2 98%

GENERAL APPEARANCE: Alert, Moderate Distress
Comments: BP 132/70 | Pulse 101 | Temp 99.9 °F (37.7 °C) | Resp 20 | Ht 1.626 m (5' 4") |

ED Provider Notes continued

Wt 64.864 kg (143 lb) | SpO2 99%

HEENT:
Head: Normocephalic, Atraumatic
Eyes: EOMI, PERRLA, No Injection, No Discharge, No Icterus
Nose/Oropharynx: FINDINGS: no rhinorrhea, no tonsillar erythema, no tonsillar exudate

NECK: Normal ROM, Supple, No Adenopathy, No Thyromegaly FINDINGS: No Spine Tenderness

LUNGS: Good bilateral air entry, no adventitious sounds.

CARDIAC: Regular Rhythm, No Extra Heart Sounds FINDINGS: Murmurs: Systolic Murmur 1/6

VASCULAR: No Edema, No Calf Tenderness, Peripheral pulses normal in all extremities
Comments: Borderline tachycardic.

SKIN: Normal Color, Dry, No Rashes
Comments: Elevated temperature to palpation.

ABDOMEN:
Comments: Tender to palpation all four quadrants with maximal tenderness periumbilical and R lateral and R lower regions. Rebound tenderness is present. Guarding is present in all four quadrants

NEUROLOGIC: Alert, Oriented X (3), Motor Exam Normal, Sensory Exam Normal, GCS (15)

MUSCULOSKELETAL: Normal ROM, No Deformity, No Thoracic, Lumbar, or Sacral Spine Tenderness

PSYCH: Normal Affect, Normal Speech

EKG:
None

X-Ray(s):
Abd/pelvis CT: Multiple very large degenerative fibroids. Appendix looks normal. Ovaries not visualized. Small amount of fluid in the R posterior pelvis. Partially enhancing adrenal mass measuring 1.2-3 cm in size, which radiology recommends follow-up with MRI.

I have discussed the findings with the radiologist and reviewed the images. Please see radiology dictation for complete report.

PROCEDURES:
None

LAB / ED COURSE:

ED Provider Notes continued

Normal O2 Sats. Temp 100 F.

INTERVENTIONS
acetaminophen suppository 650 mg (TYLENOL)-ONE TIME
morphine 4 mg injection-ONE TIME
IVF - NS
ondansetron 4 mg = 2 mL x 2 mg/mL injection (ZOFRAN)-ONE TIME
potassium replacement protocol-PROTOCOL
morphine 4 mg injection-ONE TIME

LAB RESULTS
Urine Preg: Negative.
UA: Moderate ketones, o/w wnl
UA Micro: Few epithelial
CBC: WBC 11.7 (high), HGB 12.6, PLTs 222, Neuts 91.1 (high), Lymphs 3.9 (low), o/w wnl
Panel 8: K 3.3 (low), o/w wnl
GFR > 60
Liver Panel: Albumin 4.1, Tot Prot 7.4, Globulin 3.3, A/G Ratio 1.2, Tot Bili 0.6, Alk Phos 76, ALT 49 (high), AST 50 (high)
Lipase: 15 (low)
Blood Lactate 0.8

ED COURSE
12:48 PM
Recheck on pt.
2:21 PM
Recheck on pt to discuss results.
2:23 PM
Speaking with OB-GYN regarding pt.
2:30 PM
Reviewed case with Dr. : who will be the admitting physician.

IMPRESSION and PLAN:
During the evaluation of this patient I considered multiple differential diagnosis considerations, including appendicitis, cholecystitis, pancreatitis, hepatitis, mesenteric ischemia, bowel perforation, bowel obstruction, inflammatory bowel diseases, gastritis, GERD, diverticulitis, PUD, pyelonephritis/UTI, renal colic/stone, PID, cervicitis, endometritis, IUP, ectopic pregnancy, dysfunctional uterine bleeding, ovarian cyst/torsion, spontaneous abortion, as well as other etiologies.

After considering the differential diagnosis list in the context of the patient's history, exam, and diagnostic results, my impression is that this patient is experiencing significant abdominal pain associated with fever, elevated WBC and nausea. Pain appears to localize more to RLQ than RUQ. LFTs and lipase and exam are not overly impressive for gallbladder related process, but this cannot be completely excluded. The patient did undergo CT scanning as outlined above and the patient is likely to have her symptoms related to degenerating fibroids with the uterus. The patient has demonstrated general improvement in pain control. Will admit to med/surg ward. Does not appear to have an acute surgical event at this time.

ED Provider Notes continued

ENCOUNTER DIAGNOSES

Code	Name	Primary?	Qualifier
• Dx:	ABDOMINAL PAIN OTHER SPECIF SITE		
Comment:	*no appy seen*		
• Dx:	FEVER		
• Dx:	LEUKOCYTOSIS, UNSPECIFIED		
• Dx:	LEIOMYOMA UTERUS, UNSPECIFIED		
Comment:	*Large, with degen changes,*		

Service Date: 6/24/2008
Provider:

History and Physical

H&P Notes

All notes

Author	Service	Author Type	Filed	Note Time
, MD	(none)	PHYS-Resident	06/24/2008 2335	06/24/2008 2248

ADMISSION HISTORY AND PHYSICAL

43 y.o. female
Admission Date/Time: 6/24/2008 11:17 AM

Primary Care Provider/ Referring Physician: , MD
Hospital Attending Physician: Dr.
Informant: Electronic Health Record, ED Provider, patient and spouse

PATIENT PROFILE:
History
Social History Narrative
Married, no children, immigrated to US approximately 10 years ago

CHIEF COMPLAINT: Abdominal pain

Patient Active Problem List

Diagnoses	Date Noted
• ABDOMINAL PAIN OTHER SPECIF SITE [789.09]	06/24/2008
• FEVER [780.6]	06/24/2008
• LEUKOCYTOSIS, UNSPECIFIED [288.60]	06/24/2008
• NAUSEA WITH VOMITING [787.01]	06/24/2008
• ADRENAL MASS [239.7]	06/24/2008
• INTRAMURAL LEIOMYOMA UTERUS [218.1]	06/24/2008

HPI:
43 year old female, previously healthy awoke this am at around 6 am with abdominal pain. Pain has been intermittent throughout the day, 5/10 in severity when present. Pain in RLQ and RUQ, epigastric region. Patient indicates pain is worst in the RUQ. Pain does radiate some around to right flank and over to the left side of the abdomen and into the right groin. No exacerbating or relieving factors. Patient had some nausea this am and 1 episode of emesis. Emesis was non-bilious, non-bloody. Fever to 103 this am with rigors. The patient went to see her primary care physician and was sent to the ER for further evaluation. Patient denies urinary symptoms, no vaginal discharge, no vaginal bleeding. Patient states she is not sexually active. No diarrhea. Normal BM yesterday. No ill contacts. No cough. No recent travel except to New York in April. No pets.

REVIEW OF SYSTEMS: A comprehensive review of systems was negative except for: Items in HPI

History and Physical continued

Medication	Sig	Dispense	Refill
• MULTIVITAMIN TAB	take 1 tablet by oral route once daily with food		

ALLERGIES/SENSITIVITIES:

Allergies

Allergen	Reactions
• Nka (No Known Allergies)	

History

Social History Main Topics

- Tobacco Use: Never
- Alcohol Use: No
- Drug Use: No
- Sexually Active: No

Family History

Problem	Relation
• Other *healthy*	Mother
• Other *healthy*	Father
• Other *2 brothers, 3 sisters, all healthy*	Brother

PHYSICAL EXAM:

General Appearance: Pleasant, cooperative, no acute distress

BP 120/63 | Pulse 88 | Temp 98.6 °F (37 °C) | Resp 26 | Ht 1.626 m (5' 4") | Wt 67.042 kg (147 lb 12.8 oz) | SpO2 100%

Body mass index is 25.37 kg/(m^2).

EYES: Eyelids, conjunctiva, and sclera were normal. Pupils and eye movements were normal. Cornea, iris, and lens were normal bilaterally.
HEAD, EARS, NOSE, MOUTH, AND THROAT: Head and face were normal. Hearing was normal to voice. Nose appearance was normal and there was no discharge. Anterior and posterior oropharynx were normal.
NECK: Neck appearance was normal. There were no neck masses and the thyroid was not enlarged.
CHEST/BREAST: Chest wall was normal in appearance.
RESPIRATORY: Breathing pattern was normal and the chest moved symmetrically. Lung sounds were normal and there were no adventious sounds.
CARDIOVASCULAR: Heart rate and rhythm were normal. S1 and S2 were normal and there were no extra sounds or murmurs. Peripheral pulses in arms and legs were normal. There was no peripheral edema.
ABDOMEN: The abdomen was normal in contour. Bowel sounds were absent. Percussion revealed tenderness over epigastric and right upper quadrent, palpation detected tenderness over RLQ, RUQ and epigastrium, + Murphy's sign.

History and Physical continued

MUSCULOSKELETAL: Skeletal configuration was normal and muscle mass was normal for age. Overall range of motion was normal and joint appearance was overall normal.
LYMPHATIC: There were no enlarged neck, axillary.
SKIN/HAIR/NAILS: Skin color was normal. There were no skin lesions. Hair and nails were normal.
NEUROLOGIC: Mental status was normal. Cranial nerves II-XII were normal. Motor strength was normal for age in the arms and legs.
PSYCHIATRIC: The patient was oriented to person, place, time, and circumstance. Speech was normal. Mood and affect were normal. The patient's judgment and insight were normal.

Additional Comments:

Component	Reference Range	6/24/2008
SODIUM	135-145 mmol/L	136
POTASSIUM	3.5-5.1 mmol/L	3.3 (L)
CHLORIDE	98-110 mmol/L	104
CO2,TOTAL	22-32 mmol/L	22
ANION GAP	6-16	10
GLUCOSE	65-100 mg/dL	91
CALCIUM	8.5-10.5 mg/dL	8.7
BUN	7-25 mg/dL	9
CREATININE	0.50-1.30 mg/dL	0.56
BUN/CREAT RATIO	10-20	16
GFR if African American	Low: > 60 ml/min/1.73m2	> 60
GFR if not African American	Low: > 60 ml/min/1.73m2	> 60
ALBUMIN	3.5-5.0 g/dL	4.1
PROTEIN,TOTAL	6.0-8.0 g/dL	7.4
GLOBULIN	2.0-3.7 g/dL	3.3
A/G RATIO	1.0-2.0	1.2
BILIRUBIN,TOTAL	Low: < 1.6 mg/dL	0.6
ALK PHOSPHATASE	34-104 IU/L	76
ALT (SGPT)	10-40 IU/L	49 (H)
AST (SGOT)	10-42 IU/L	50 (H)
WHITE BLOOD COUNT	4.5-11.0 thou/cu mm	11.7 (H)
RED BLOOD COUNT	3.90-5.03 mil/cu mm	4.31
HEMOGLOBIN	12.0-15.5 g/dL	12.6
HEMATOCRIT	34.9-44.5 %	38.0
MCV	82-98 fL	88
MCH	27.0-32.0 pg	29.2
MCHC	32.0-36.0 %	33.2
RDW	11.9-15.5 %	15.3
PLATELET COUNT	140-440 thou/cu mm	222
MPV	7.4-10.9 fL	11.3 (H)
NEUTROPHILS	50.0-70.0 %	91.1 (H)
LYMPHOCYTES	25.0-45.0 %	3.9 (L)
MONOCYTES	Low: < 11.1 %	4.8
BASOPHILS	Low: < 3.1 %	0.2

ABSOLUTE NEUTROPHILS	1.7-7.0 thou/cu mm	10.7 (H)
ABSOLUTE LYMPHOCYTES	0.9-2.9 thou/cu mm	0.5 (L)
ABSOLUTE MONOCYTES	0.3-0.9 thou/cu mm	0.6
ABSOLUTE BASOPHILS	Low: < 0.2 thou/cu mm	0.0
COLOR		Yellow
CLARITY		Clear
SPECIFIC GRAVITY,URINE	1.002-1.030	1.021
PH,URINE	5.0-9.0	8.0
UROBILINOGEN,QUALITATIVE	Low: (Normal)	Normal
PROTEIN, URINE	Low: (Negative)	Negative
GLUCOSE, URINE	Low: (Negative) mg/dL	Negative
KETONES,URINE	Low: (Negative)	Moderate (A)
BILIRUBIN,URINE	Low: (Negative)	Negative
OCCULT BLOOD,URINE	Low: (Negative)	Negative
NITRITE	Low: (Negative)	Negative
LEUKOCYTE ESTERASE	Low: (Negative)	Negative
EPITHELIAL CELLS		Few
LIPASE	22-51 IU/L	15 (L)
LACTATE,BLOOD	Low: < 2.6 mmol/L	0.8
PREGNANCY,URINE		Negative

CT abd/pelvis - normal appendix, normal gallbladder, myomatous uterus, small amount free fluid in pelvis, non-visualized ovaries

Patient Active Hospital Problem List:
ABDOMINAL PAIN OTHER SPECIF SITE
FEVER
LEUKOCYTOSIS, UNSPECIFIED
NAUSEA WITH VOMITING

Assessment: Unclear etiology of current symptoms. Most tender in RUQ and epigastrium on my exam. Findings could be consistent with acute cholecystitis, gallbladder appeared normal on CT scan. Also need to consider gyn etiology of symptoms - abnormal uterus and adnexa on CT scan. No urinary or vaginal symptoms but need to consider UTI, pylenephritis, endometris as possible causes. No diarrhea, but could have early gastroenteritis. No exposure history but consider acute hepatitis as well. Normal appearing appendix on CT.

Plan: RUQ ultrasound
- Transvaginal ultrasound
- GYN consult
- Blood culture
- UA
- No abx for now
- Viral hepatitis panel
- If develops diarrhea, then stool cultures etc.
- Follow serial exams
- IVF

- Prn pain medications, nausea meds
- CBC, BMP in am

ADRENAL MASS

Assessment: 2.1 cm adrenal mass on CT abdomen and pelvis.

Plan: - Needs follow up, radiology recommended MRI
- Will testing to see if functioning adenoma - cortisol testing, testing for pheo

INTRAMURAL LEIOMYOMA UTERUS

Assessment: abnormal appearing uterus, ? Degenerating fibroids, fluid in the pelvis - small amount, left adnexa appears abnormal

Plan: GYN consult, TV US

Full Code.

Consults

Consult Notes

All notes

Author	Service	Author Type	Filed	Note Time
, MD	(none)	Physician	06/24/2008 2016	06/24/2008 2000

CONSULTATION NOTE

43 y.o. female
Admission Date/Time: 6/24/2008 11:17 AM
Primary Care Provider: , MD

I was asked to see this patient by Dr for evaluation of uterine fibroids.

HPI: Patient is a 43 PO with Imp 5/26/08 who presents with one day of abdominal pain and vomitting and fever as high as 103. Patient reports she has pain in the RUQ and RLQ. She reports she has not had this kind of pain before. She is feeling much better since admission with pain meds. She reports history of fibroids, but currently has not had problems with heavy vaginal bleeding or pelvic pain or pressure.

REVIEW OF SYSTEMS: A comprehensive review of systems was negative except for items noted in HPI/Subjective.

There are no active problems to display for this patient.

No past medical history on file.
Past Surgical History

Procedure	Date
• Hx myomectomy	2000

Consults continued

Abdominal myomectomy in 2000 by Dr.
No family history on file.
History
Social History Narrative
- No narrative on file

Married works in housekeeping at abnw in women care
History
Social History Main Topics

• Tobacco Use:	Not on file
• Alcohol Use:	Not on file
• Drug Use:	Not on file
• Sexually Active:	Not on file

-tob-wtoh-drugs, not sexually active
Current hospital medications

Medication	Dose	Route	Frequency	Provider	Last Rate
• acetaminophen 650 mg = 2 x 325 mg tablet (TYLENOL)	650 mg	Oral	Q 4H PRN		
• morphine 2-6 mg injection	2-6 mg	Intravenous	Q 3H PRN		
• NaCl 0.9% with Potassium Chloride 20mEq 125 mL/hr infusion	125 mL/hr	Intravenous	CONTINUOUS		
• ondansetron 4 mg = 2 mL x 2 mg/mL injection (ZOFRAN)	4 mg	Intravenous	Q 8H PRN		
• potassium replacement protocol		Protocol	PROTOCOL		
• potassium replacement protocol		Protocol	PROTOCOL		
• prochlorperazine 10 mg = 2 mL x 5 mg/mL injection (COMPAZINE)	10 mg	Intravenous	Q 6H PRN		

ALLERGIES/SENSITIVITIES: Allergies

Allergen	Reactions
• Nka (No Known Allergies)	

PHYSICAL EXAM:

General Appearance: comfortable

Consults continued

BP 120/63 | Pulse 88 | Temp 98.6 °F (37 °C) | Resp 26 | Ht 1.626 m (5' 4") | Wt 67.042 kg (147 lb 12.8 oz) | SpO2 100%
Body mass index is 25.37 kg/(m^2).

ABDOMEN: soft nontender no guarding or rebound, uterus palpable U-4, -cmt
GENITOURINARY: bimaunal pevic exam cerrvix deviated to the right, irregular shaped uterus mobile nontender c/w 16 week size uterus.
LE: nontender no cords

ADDITIONAL COMMENTS: I reviewed the patient's new imaging test results. Pelvic us 13x7.5 x 9.5 cm uterus irregular shaped, numerous myomas and non-visualized ovaries.

CONSULTATION ASSESSMENT AND PLAN:
Abdominal pain and fever unlikely gyn in origin. Myomatous uterus evident but does not account for high fever and right upper quadrant pain. Patient should follow up as an outpatient to continue to monitor fibroids. Did discuss with patient reasons for surgical intervention. At this point patient does not need surgical intervention.
Please call with questions.

All Progress Notes continued

Author	Service	Author Type	Filed	Note Time
., MD	(none)	Physician	06/24/2008 1700	06/24/2008 1653

ATTENDING ADMIT NOTE

I performed a history and physical examination on and discussed her management with the resident. For complete documentation of the history and physical, see the resident admit note for the findings and plan of care. Additional comments: discussed with Dr. please refer to resident and MS3 note for complete details. Briefly, 43 yo female previously healthy with hx of fibroidectomy 2000 presents with acute onset RUQ, midepigastric and RLQ pain this am. Fever to 103 and N/V. Exam with +RUQ TTP and milder RLQ TTP without peritoneal signs. CT with normal appendix, markedly abnormal uterus with degenerating fibroids, small amount pelvic fluid, and 2.1 cm left adrenal mass. Labs with mildly elevated WBC and mildly elevated AST and ALT. Diff dx includes cholecystitis vs. Hepatitis vs. Due to inflam from degenerating fibroids vs. Ovarian ischemia vs. Torsion vs. Endometritis vs. Gastroenteritis vs. other. Plan for RUQ US and likely transvaginal pelvic US. Check viral hep panel. Follow abdomen exam serially. Pain control and antiemetics as needed. Gyn consult pending. observation.

Author	Service	Author Type	Filed	Note Time
MD	(none)	Physician	06/25/2008 1548	06/25/2008 1439

Related Notes
Original Note : at 06/25/2008 1459

ATTENDING PROGRESS NOTE

I saw and examined I reviewed the resident's note and agree with the documented findings and plan of care. Additional comments: discussed with Dr. Will get HIDA scan and ADAT. Anticipate likely d/c tomorrow.

., MD

C2 PROGRESS NOTE

SUBJECTIVE: Patient feeling much better today. No abdominal pain unless you palpate her RUQ. RLQ pain resolved. No nausea/vomiting. Tolerated clears for lunch. No pain meds overnight. Normal BM today. No urinary symptoms.

OBJECTIVE:
General Appearance: Pleasant, cooperative, no acute distress

BP 103/50 | Pulse 94 | Temp 98.2 °F (36.8 °C) | Resp 16 | Ht 1.626 m (5' 4") | Wt 67.042 kg (147 lb 12.8 oz) | SpO2 100% Temp (24hrs), Avg:98.6 °F (37 °C), Min:98.2 °F (36.8 °C), Max:99 °F (37.2 °C)

All Progress Notes continued

Patient Wt. in the past 72 hrs:

	Wt.
06/24/08 1601	67.042 kg (147 lb 12.8 oz)
06/24/08 1112	64.864 kg (143 lb)

Intake/Output Summary (Last 24 hours) at 06/25 1440
Last data filed at 06/25 0600

	Gross per 24 hour
Intake	1200 ml
Output	0 ml
Net	1200 ml

RESPIRATORY: Normal
CARDIOVASCULAR: Normal
ABDOMEN: hypoactive bowel sounds, soft, nontender except mild tenderness in RUQ on palpation
SKIN/HAIR/NAILS: Normal
NEUROLOGIC: Normal
PSYCHIATRIC: Normal

Additional Comments:

I reviewed the patient's new clinical lab test results.

I reviewed the patient's new imaging test results.

I discussed the patient's care with Dr

Patient Active Hospital Problem List:
ABDOMINAL PAIN OTHER SPECIF SITE
FEVER
LEUKOCYTOSIS, UNSPECIFIED
NAUSEA WITH VOMITING
Assessment: Unclear etiology of abdominal pain. RUQ US showed prominent CBD for age - 0.6 cm. No stones in duct or gallbladder. Normal appearing gallbladder on RUQ ultrasound. CT abd/pelvis showed normal appendix, abnormal uterus - fibroids, no evidence of bowel abnormalities, normal kidneys. Hepatitis panel negative. Normal blood cultures. No diarrhea. Still tender mildly in RUQ, concerning for possible gallbladder pathology despite negative RUQ ultrasound and CT abdomen. Will investigate with HIDA scan.
Plan: - DC IVF
- ADAT
- HIDA
- Prn pain meds, nausea meds

All Progress Notes continued

- If no return of symptoms, fevers, and normal HIDA scan, DC in am

ADRENAL MASS
Assessment: 2.1 cm adrenal mass on CT abdomen and pelvis.
Plan: - Needs follow up, radiology recommended MRI
- Will testing to see if functioning adenoma - cortisol testing, testing for pheo, aldosterone, renin
- Will discuss in DC summary for PCP

INTRAMURAL LEIOMYOMA UTERUS
Assessment: abnormal appearing uterus, ? Degenerating fibroids, fluid in the pelvis - small amount, left adnexa appears abnormal. Not contributing to patient's symptoms.
Plan: Follow up with GYN as outpatient.

TRANSFER / DISCHARGE PLANS : Likely home in am.

Progress Notes

All notes

Author	Service	Author Type	Filed	Note Time
, RN	(none)	NURS-Registered Nurse	06/26/2008 0948	06/26/2008 0947

Discharge Note

Data:
has been discharged home at 0945
via ambulatory accompanied by Family.

Action:
Discharge/follow-up instructions were provided to patient and Patient and Spouse. Prescriptions : None. Belongings sent with patient and Patient and Spouse. Equipment none .

Response:
Patient verbalized understanding of discharge instructions, reason for discharge, and necessary follow-up appointments.

Laboratory Results

Results

POTASSIUM (ID#
Status: Completed

Component	Value	Units	Flag	Collected
POTASSIUM	3.9	mmol/L	(none)	06/26/2008 6:17 AM

CBC AND DIFFERENTIAL (ID#
Status: Completed

Component	Value	Units	Flag	Collected
WHITE BLOOD COUNT	12.2	thou/cu mm	**H**	06/25/2008 6:58 AM
RED BLOOD COUNT	3.82	mil/cu mm	**L**	06/25/2008 6:58 AM
HEMOGLOBIN	11.1	g/dL	**L**	06/25/2008 6:58 AM
HEMATOCRIT	33.9	%	**L**	06/25/2008 6:58 AM
MCV	89	fL	(none)	06/25/2008 6:58 AM
MCH	29.1	pg	(none)	06/25/2008 6:58 AM
MCHC	32.7	%	(none)	06/25/2008 6:58 AM
RDW	16.0	%	**H**	06/25/2008 6:58 AM
PLATELET COUNT	204	thou/cu mm	(none)	06/25/2008 6:58 AM
MPV	11.3	fL	**H**	06/25/2008 6:58 AM
NEUTROPHILS	86.0	%	**H**	06/25/2008 6:58 AM
LYMPHOCYTES	10.0	%	**L**	06/25/2008 6:58 AM
MONOCYTES	2.0	%	(none)	06/25/2008 6:58 AM
ABSOLUTE NEUTROPHILS	10.5	thou/cu mm	**H**	06/25/2008 6:58 AM
ABSOLUTE LYMPHOCYTES	1.2	thou/cu mm	(none)	06/25/2008 6:58 AM
ABSOLUTE MONOCYTES	0.2	thou/cu mm	**L**	06/25/2008 6:58 AM
PLT COMMENT	Platelets appear adequate	(none)	(none)	06/25/2008 6:58 AM

HEPATIC FUNCTION PANEL (ID#
Status: Completed

Component	Value	Units	Flag	Collected
ALBUMIN	3.4	g/dL	**L**	06/25/2008 6:58 AM
PROTEIN,TOTAL	6.4	g/dL	(none)	06/25/2008 6:58 AM
GLOBULIN	3.0	g/dL	(none)	06/25/2008 6:58 AM
A/G RATIO	1.1	(none)	(none)	06/25/2008 6:58 AM
BILIRUBIN,TOTAL	0.3	mg/dL	(none)	06/25/2008 6:58 AM
BILIRUBIN,DIRECT	< 0.1	mg/dL	(none)	06/25/2008 6:58 AM

Component	Units	Flag	Collected
BILIRUBIN,INDIRECT	(none)	(none)	06/25/2008 6:58 AM

Value: Unable to calculate, Direct Bili <0.1

Component	Value	Units	Flag	Collected
ALK PHOSPHATASE	49	IU/L	(none)	06/25/2008 6:58 AM
ALT (SGPT)	31	IU/L	(none)	06/25/2008 6:58 AM
AST (SGOT)	26	IU/L	(none)	06/25/2008 6:58 AM

POTASSIUM (ID#
Status: Completed

Component	Value	Units	Flag	Collected
POTASSIUM	3.9	mmol/L	(none)	06/25/2008 6:58 AM

Laboratory Results continued

MANUAL DIFFERENTIAL (ID#
Status: Completed

Component	Value	Units	Flag	Collected
BAND CELLS	2.0	%	(none)	06/25/2008 6:58 AM
ABSOLUTE BAND CELLS	0.2	thou/cu mm	(none)	06/25/2008 6:58 AM
ANSIOCYTES	moderate	(none)	(none)	06/25/2008 6:58 AM
PLT COMMENT	Platelets appear adequate	(none)	(none)	06/25/2008 6:58 AM

BLOOD CULTURE (ID#
Status: Completed

Component	Value	Units	Flag	Collected
SOURCE	Blood	(none)	(none)	06/24/2008 7:10 PM
PRELIM RESULT	No growth to date	(none)	(none)	06/24/2008 7:10 PM
FINAL RESULT	No growth	(none)	(none)	06/24/2008 7:10 PM

BLOOD CULTURE (ID#
Status: Completed

Component	Value	Units	Flag	Collected
SOURCE	Blood	(none)	(none)	06/24/2008 5:20 PM
PRELIM RESULT	No growth to date	(none)	(none)	06/24/2008 5:20 PM
FINAL RESULT	No growth	(none)	(none)	06/24/2008 5:20 PM

Narrative
One Bottle Drawn

CBC and Diff (ID#
Status: Completed

Component	Value	Units	Flag	Collected
WHITE BLOOD COUNT	11.7	thou/cu mm	**H**	06/24/2008 12:34 PM
RED BLOOD COUNT	4.31	mil/cu mm	(none)	06/24/2008 12:34 PM
HEMOGLOBIN	12.6	g/dL	(none)	06/24/2008 12:34 PM
HEMATOCRIT	38.0	%	(none)	06/24/2008 12:34 PM
MCV	88	fL	(none)	06/24/2008 12:34 PM
MCH	29.2	pg	(none)	06/24/2008 12:34 PM
MCHC	33.2	%	(none)	06/24/2008 12:34 PM
RDW	15.3	%	(none)	06/24/2008 12:34 PM
PLATELET COUNT	222	thou/cu mm	(none)	06/24/2008 12:34 PM
MPV	11.3	fL	**H**	06/24/2008 12:34 PM
NEUTROPHILS	91.1	%	**H**	06/24/2008 12:34 PM
LYMPHOCYTES	3.9	%	**L**	06/24/2008 12:34 PM
MONOCYTES	4.8	%	(none)	06/24/2008 12:34 PM
BASOPHILS	0.2	%	(none)	06/24/2008 12:34 PM
ABSOLUTE NEUTROPHILS	10.7	thou/cu mm	**H**	06/24/2008 12:34 PM
ABSOLUTE LYMPHOCYTES	0.5	thou/cu mm	**L**	06/24/2008 12:34 PM

Laboratory Results continued

Component	Value	Units	Flag	Collected
ABSOLUTE MONOCYTES	0.6	thou/cu mm	(none)	06/24/2008 12:34 PM
ABSOLUTE BASOPHILS	0.0	thou/cu mm	(none)	06/24/2008 12:34 PM

Comprehensive Metabolic Panel (ID#
Status: Completed

Component	Value	Units	Flag	Collected
SODIUM	136	mmol/L	(none)	06/24/2008 12:34 PM
POTASSIUM	3.3	mmol/L	L	06/24/2008 12:34 PM
CHLORIDE	104	mmol/L	(none)	06/24/2008 12:34 PM
CO2,TOTAL	22	mmol/L	(none)	06/24/2008 12:34 PM
ANION GAP	10	(none)	(none)	06/24/2008 12:34 PM
GLUCOSE	91	mg/dL	(none)	06/24/2008 12:34 PM
CALCIUM	8.7	mg/dL	(none)	06/24/2008 12:34 PM
BUN	9	mg/dL	(none)	06/24/2008 12:34 PM
CREATININE	0.56	mg/dL	(none)	06/24/2008 12:34 PM
BUN/CREAT RATIO	16	(none)	(none)	06/24/2008 12:34 PM
GFR IF AFRICAN AMERICAN	> 60	ml/min/1.73m2	(none)	06/24/2008 12:34 PM
GFR IF NOT AFRICAN AMERICAN	> 60	ml/min/1.73m2	(none)	06/24/2008 12:34 PM
ALBUMIN	4.1	g/dL	(none)	06/24/2008 12:34 PM
PROTEIN,TOTAL	7.4	g/dL	(none)	06/24/2008 12:34 PM
GLOBULIN	3.3	g/dL	(none)	06/24/2008 12:34 PM
A/G RATIO	1.2	(none)	(none)	06/24/2008 12:34 PM
BILIRUBIN,TOTAL	0.6	mg/dL	(none)	06/24/2008 12:34 PM
ALK PHOSPHATASE	76	IU/L	(none)	06/24/2008 12:34 PM
ALT (SGPT)	49	IU/L	H	06/24/2008 12:34 PM
AST (SGOT)	50	IU/L	H	06/24/2008 12:34 PM

Lipase (ID#
Status: Completed

Component	Value	Units	Flag	Collected
LIPASE	15	IU/L	L	06/24/2008 12:34 PM

Lactate, Blood (ID#
Status: Completed

Component	Value	Units	Flag	Collected
LACTATE,BLOOD	0.8	mmol/L	(none)	06/24/2008 12:34 PM

ACUTE HEPATITIS PANEL (ID#
Status: Completed

Component	Value	Units	Flag	Collected
HBSAG	Non-reactive	(none)	(none)	06/24/2008 12:34 PM
IGM ANTI HBC	Non-reactive	(none)	(none)	06/24/2008 12:34 PM
IGM ANTI HAV	Non-reactive	(none)	(none)	06/24/2008 12:34 PM
ANTI HCV	Non-reactive	(none)	(none)	06/24/2008 12:34 PM

POC Pregnancy, Urine (ID#
Status: Completed

Component	Value	Units	Flag	Collected

Result Summary for CT Abd/Pelvis with IV Contrast ONLY

Result Information

Status		Provider Status
Normal	Final result (6/25/2008 7:57 AM)	Open

Result Narrative

CT SCAN OF THE ABDOMEN AND PELVIS, 06/24/08

CLINICAL DATA: 43-year-old woman with abdomen pain and fever.

TECHNIQUE: Contiguous axial images were obtained from the domes of the diaphragm through the pubic symphysis following the administration of nonionic intravenous. Oral contrast was not administered.

FINDINGS: The uterus is markedly abnormal. It is lobular and enlarged, measuring 11.0 x 9.5 cm (image 146). In addition, there are abnormal cystic areas and degenerative calcifications, both most likely reflecting multiple leiomyomas. Small amount of fluid is noted in the patient's right cul-de-sac and adjacent to the left adnexa. The ovaries are not clearly identified.

The appendix is nicely visualized on image 126, series 2, in the right lower quadrant and is normal.

The visualized lower lungs are unremarkable.

The liver, spleen, pancreas, gallbladder are unremarkable.

There is a partially enhancing, oval 2.1 cm mass in the left adrenal gland for which an MRI is suggested for further characterization. This could reflect a mixed adenoma. MRI is suggested for further characterization. The right adrenal gland and both kidneys are normal. There is no hydronephrosis nor hydroureter.

The bowel and mesentery are unremarkable. There is no CT evidence of intestinal obstruction.

Result Impression

1. Abnormal uterus with degenerating cystic leiomyomas. Gynecological evaluation is suggested.

2. Abnormal 2.1 cm left adrenal lesion for which MRI is suggested for further characterization.

3. No CT evidence of appendicitis.

Result Summary for US ABDOMEN LIMITED

Result Information

Status		Provider Status
Normal	Final result (6/25/2008 11:48 AM)	Open

Result Narrative

LIMITED ABDOMINAL ULTRASOUND, 06/24/08

CLINICAL DATA: Abdominal pain.

FINDINGS: The gallbladder is normal. There are no echogenic foci to suggest cholelithiasis.

There is no intrahepatic biliary dilatation. The liver is of normal contour and echotexture. Common bile duct measures 0.6 cm, which is prominent in this 43-year-old patient. Please note that this finding was not appreciated on the CT scan performed earlier today.

Result Impression

Prominent common bile duct, but no ultrasound or CT evidence of choledocholithiasis. Consider MRCP or ERCP for further evaluation, if deemed clinically appropriate.

Result Summary for US PELVIS COMPLETE W TRANSVAG NON OB

Result Information

Status		Provider Status
Normal	Final result (6/25/2008 11:47 AM)	Open

Result Narrative

TRANSABDOMINAL-TRANSVAGINAL PELVIC ULTRASOUND, 06/24/08

CLINICAL DATA: Abnormal uterus and left adnexa noted on CT scan performed earlier today.

This exam was correlated with the CT scan of the pelvis performed earlier today.

FINDINGS: The uterus is abnormally enlarged and bulky and lobular in contour. It measures 13.2 x 7.5 x 9.5 cm. Innumerable calcified and noncalcified leiomyomas are seen throughout the uterus. The endometrium is not visualized. Neither ovary is visualized.

Result Impression

1. Bulky, leiomyomatous uterus.

2. Nonvisualization of ovaries.

Result Summary for NM HEPATOBILIARY SCAN W EF

Result Information

Status		Provider Status
Normal	Final result (6/26/2008 1:04 PM)	Reviewed

Result Narrative

NUCLEAR MEDICINE HEPATOBILIARY SCAN WITH GALLBLADDER EJECTION FRACTION EVALUATION, 06/25/08

CLINICAL HISTORY: 43-year-old female with abdominal pain. Evaluate for gallbladder abnormalities.

TECHNIQUE: Hepatobiliary scan was performed after the intravenous injection of 5.5 ml of Tc99m-Choletec. Then after the intravenous injection of 1.36 mcg of CCK, reimaging of the hepatobiliary system was performed to evaluate gallbladder ejection fraction.

FINDINGS: Normal filling of the gallbladder was seen consistent with at least partial patency of the common bile duct. Tracer accumulation within the liver was homogeneous. Passage of tracer from the liver through the biliary system into the small bowel was within normal limits.

After the administration of CCK, the gallbladder ejection fraction was determined to be 35% which is at the junction of normal and abnormal with normal gallbladder ejection fraction being 35% or greater. Remainder negative.

Result Impression

1. Normal filling of the gallbladder and normal passage of the tracer from the liver through the biliary system into the small bowel indicating at least partial patency of the cystic duct and common bile duct.

2. Gallbladder ejection fraction was determined to be 35% which is at the junction between normal and abnormal as described above.