LTC – H&P #2 [Interim]

Chief Complaint: “abdominal distension and pain” x 7 AM (3hrs)

HPI

82-year-old female with a past medical history of hypertension, HFpEF, pulmonary hypertension, asthma, osteoporosis, inguinal hernia (s/p repair in 2021), and chronic venous insufficiency presents with acute onset epigastric discomfort and abdominal distension beginning around 7 AM this morning upon awakening. The discomfort is constant, non-radiating, and described as a generalized discomfort. She reports mild improvement after receiving 650 mg acetaminophen PRN. Patient and RN state three episodes of retching with minimal output overnight and one episode of non-bloody vomiting this morning around 9 AM without nausea. She is able to tolerate PO intake this morning, eating eggs. Her last bowel movement was last night and was normal in consistency. Patient states that she has not passed flatus since she woke up. Patient states that she is having similar symptoms when she was hospitalized for an SBO back in November 2025. Denies fever/chills, chest pain, hematemesis, shortness of breath.

PMHx

- Rheumatic Fever
- HTN
- HFpEF
- Pulmonary HTN
- Asthma
- Chronic Venous Insufficiency with Stasis Dermatitis
- Osteoporosis
- Inguinal Hernia
- Vitamin D Deficiency
- Hx of SBO (11/2025)

PSHx

- Hysterectomy at Age 30
- Inguinal Hernia Repair 11/2021

Medications

- Albuterol Sulfate Nebulizer Solution 6mL PRN for Asthma
- Ammonium Lactate Lotion 12% for Dry B/L LE’s
- Cholecalciferol 25mcg (1000UT) for Vitamin D Deficiency
- Nephplex (B-Complex w/ C-Zn & Folic Acid) for Vitamin Deficiency
- Senna 8.8mg QHS for Constipation
- Docusate Sodium 100mg BID for Constipation
- MiraLax (PEG) QD for Constipation
- Spironolactone 100mg QD for HTN
- Torsemide 20mg QD for Pulm HTN & HFpEF
- Compliant with her daily medications per RN

Allergies

- No known drug, food, or environmental allergies.

FHx:
- Mother → DM 2, HTN
- Father → DM 2, HTN

SHx
- S.C. is a friendly 82y/o F in the LTC unit.
- Habits → No past alcohol, tobacco smoking, or illicit drug use.
- Diet → eats a consistent carbohydrate diet with soft foods and thin consistency, RN states that she tends to snack a lot and consumes food in huge portions and continuously.
- Exercise → does not get much physical exercise as she is mostly on the bed and is wheelchair-bound, requires a Hoyer lift to transport in and out of bed.

ROS
General – Denies fever, chills, and night sweats.

Skin – Denies any new lesions or wounds.

HEENT – Denies headaches, vision changes, or sore throat.

Neck – Denies any neck pain or stiffness.

Chest/Cardiovascular – Denies any chest pain or palpitations.

Pulmonary – Denies shortness of breath, cough, wheezing, or hemoptysis.

Gastrointestinal – Admits to bloating and epigastric abdominal discomfort. Admits to 1 vomiting episode today. Denies passing flatus. Denies nausea/diarrhea today.

Neurologic – Denies numbness or tingling of the upper and lower extremities, headaches, or dizziness

Musculoskeletal – Denies joint pain, back pain, calf pain

Peripheral Vascular – Denies swelling of the legs or elsewhere

Vital Signs (04/21/2026 9:30 AM)
BP: Seated 127/80 mmHg

P: 99 bpm

RR: 18 breaths/min, unlabored breathing with no accessory muscle use

T (oral): 98.2 F

O2 Sat: 97% on room air

Height: 63 in | **Weight:** 191.1 lbs | **BMI:** 33.8

Physical Exam

General: NAD, lying in bed. Appears well-nourished. Appears to be 82 years old.

Skin: No signs of diaphoresis, cyanosis, or pallor. Warm and dry to palpation throughout. No rashes, skin breakdown, or pressure injuries seen.

Cardiac: RRR. S1 and S2 are audible. No S3 or S4 gallops. No murmurs, rubs, or extra heart sounds noted.

Lungs: Able to speak in full sentences without use of accessory muscles. Lung sounds are vesicular bilaterally without rales, rhonchi, or wheezing.

Abdomen: soft, distended, mildly tender throughout, tinkling sound heard in RUQ, diminished bowel sounds in other quadrants, dullness to percussion throughout

Rectal: soft rectal mucosa, internal hemorrhoids appreciated, mildly soft stool felt, no scant blood seen on gloved finger

Peripheral Vascular: capillary refill <3 seconds in upper & lower extremity nailbeds. No BLE pitting edema noted. Brawny brown discoloration of the lower BLE due to CVD. No erythema, warmth, or skin breakdown noted. No cyanosis or clubbing. Dorsalis pedis and posterior tibial pulses are not palpable bilaterally, likely limited by increased adipose tissue.

<u>Labs/Imaging</u>
Abdominal XR pending.

<u>Assessment</u>
82-year-old female with significant PMHx, including prior small bowel obstruction (11/2025) and prior abdominal surgery (hysterectomy, hernia repair), presenting with acute epigastric discomfort, abdominal distension, vomiting without nausea, and obstipation (no flatus) since this morning. Exam notable for abdominal distension, diffuse mild tenderness, tinkling bowel sounds, and decreased bowel activity elsewhere. Concerned about recurrent SBO.

<u>D/Dx</u>

1. Small Bowel Obstruction
    a. <u>Rationale:</u> Pt has prior Hx of SBO and inguinal hernia surgery and presents with distension, vomiting, no flatus, and prior similar episode. Tinkling bowel sounds on RUQ indicates early obstruction finding.
2. Ileus
    a. <u>Rationale:</u> Presents with distension and decreased bowel function as well, but less likely due to pt's history and findings on PE.
3. Large Bowel Obstruction
    a. <u>Rationale:</u> Presents with distension and obstipation, but less likely than SBO because LBO does not commonly present with upper abdominal discomfort and vomiting.
4. Sigmoid Volvulus
    a. <u>Rationale:</u> Pt presents with abdominal distension, vomiting, and inability to pass flatus, which are concerning for bowel obstruction, but prior hx of SBO and abdominal surgeries make SBO more likely. In sigmoid volvulus, there would be more severe abdominal pain and/or asymmetric distension.
5. Ogilvie Syndrome
    a. <u>Rationale:</u> Pseudo-obstruction that presents with distension, decreased bowel function, and vomiting, mimicking SBO, however, is a very rare condition that typically occurs in hospitalized pts s/p surgery, trauma, or severe infection.

Problem Lists & Plan

#Abdominal Discomfort

#R/O SBO

- Abdominal XR **FIRST** before enema
- Give 1 Fleet Enema today, followed-up by another enema in 30 mins if there is no BM
- Insert Rectal Tube
- Start Simethicone 80mg q24hr for Indigestion
- NPO & Clear Liquid Diet
- Abdominal XR
- Monitor BMs & Serial Abdominal Exams
- Hold Senna, Docusate, and MiraLax until obstruction is ruled out
- Acetaminophen 650mg q6h PRN for pain
- Consider sending to the hospital if no BM, no flatus, and continuous vomiting

#Pulm HTN

#HFpEF

- Monitor weight weekly
- Continue Spironolactone 100mg PO QD
- Continue Torsemide 20mg PO QD
- Monitor for SOB or respiratory distress
- Pulmonary and Cardiology consult PRN
- Monitor VS

#Asthma

- Albuterol Nebulizer PRN
- RT consult PRN

#Osteoporosis

- Continue Cholecalciferol
- Fall Prevention (Bed/Wheelchair Safety Measures)
- Hoyer Lift Assistive Device
- WBAT

#Venous Insufficiency w/ Stasis Dermatitis

- Continue Ammonium Lactate Lotion BID
- Continue leg elevation when in bed to reduce venous pooling
- Continue compression stocking therapy
- Monitor for skin breakdown, ulcers, cellulitis
- Encourage mobility/position changes as tolerated in bed
- Routine Skin Check

#Vitamin Deficiencies

- Continue Cholecalciferol 25mcg & Nephplex B-Complex

#Patient Education

- Educated on s/sx of bowel obstruction (increasing abd pain/distension, inability to pass stool or gas, vomiting, inability to tolerate PO intake) & notify staff if any of these happens
- Encouraged gradual dietary moderation and avoidance of overeating/snacking in large portions

Code Status: Full Code/CPR

Labs/Imaging & Disposition

KUB (3-View) → colon is mildly dilated, filled with gas and stool. Colonic ileus with constipation. Radiology dx is partial intestinal obstruction.

Patient was transferred to an acute care hospital (NYP Lower Manhattan) for evaluation for abdominal pain, distension, and vomiting to relieve obstruction. Admitted to NYP Weill Cornell for possible surgical management.