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H&P 1
February 20, 2025

H&P 1- Emergency Medicine

Chief Complaint: "My stomach hurts and I have been throwing up" x this morning.

History of Present Illness:

G.S. is a 71 year old male with a past medical history of hypertension, Type 2 diabetes, peptic ulcer disease, ulcerative colitis, anemia, and adenocarcinoma of the cecum s/p excision of colon and rectum with permanent ileostomy who presents to the emergency room with acute onset abdominal pain and vomiting that began earlier this morning. Patient's family members report that since 2-3 am this morning, the patient has been having severe abdominal pain, described as sharp and stabbing in nature, rated 10/10. The pain has been persistent since onset, localized to the entire abdomen. The pain is not alleviated by anything and is exacerbated with movement. He has also had 6-7 episodes of non-bilious, non-bloody vomiting and has been unable to tolerate oral intake.

His past medical history is significant for colon and rectum excision secondary to adenocarcinoma of the cecum performed on December 15, 2025, and has a permanent ileostomy. Patient's family reports two prior postoperative episodes of pain and vomiting that improved with Tylenol and imodium. However, these medications provided no relief today. Furthermore, there has been no output from his ostomy bag since this morning. He denies fevers, chills, weight loss, syncope, chest pain, shortness of breath, hematemesis, urinary sxs, recent illness, changes in diet, or prior similar episodes.

Past Medical History

Hypertension x present - managed with medication
Type 2 Diabetes x present - managed with medication
Adenocarcinoma of cecum - managed with surgery
Peptic ulcer disease x present - managed with medication
Ulcerative colitis x present - managed with medication
Anemia x present - managed with medication

Immunization: Up to date on all immunizations.

Past Surgical History

Laparoscopic excision of colon and rectum, permanent ileostomy placed - QHC, December 15, 2025

Medications

Amlodipine 5 mg, QD daily, last dose yesterday (2/12/26)
Metformin 500 mg, QD daily, last dose yesterday (2/12/26)
Mesalamine 1.2 g, QD daily, last dose yesterday (2/12/26)
Tamsulosin 0.4 mg, QD daily, last dose yesterday (2/12/26)
Ferrous sulfate 325 mg, QD daily, last dose yesterday (2/12/26)
Patient is compliant with the above medications.

Allergies:
NKDA
No food or seasonal allergies.

Family History
Mother, deceased at 70, PMHx of DM
Father, deceased at 80, uncertain of PMHx

Social History
Habits: Denies smoking or alcohol use. Admits to drinking coffee. Denies usage of illicit drugs.

Travel: Denies any recent travels out of state or country.

Marital History: Married to wife.

Occupational history: Currently not working.

Home situation: Lives with wife and son.

Exercise: Ambulatory, patient denies actively exercising.

Review of Systems:

General: Denies recent weight loss or weight gain, loss of appetite, generalized weakness/fatigue, fever, chills, or night sweats.

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

HEENT: Denies headache, or trauma, vision disturbances, pain or redness. Denies ear pain, deafness, nasal congestion, discharge, or sore throat.

Pulmonary System: Denies dyspnea, cough, or wheezing.

Cardiovascular System: Admits to hx of HTN. Denies edema/swelling of ankles or feet, chest pain, palpitations, or syncope.

Gastrointestinal System: Admits to abdominal pain, nausea, and vomiting. Denies diarrhea, constipation, jaundice, change in bowel habits, hemorrhoids, rectal bleeding, or blood in stool.

Genitourinary System: Denies frequency, nocturia, urgency, dysuria, hematuria, or flank pain.

Nervous System: Denies headache, weakness, numbness, loss of strength, or change in cognition/mental status/memory.

Musculoskeletal System: Denies muscle/joint pain, deformity, or swelling and redness.

Peripheral Vascular System: Denies peripheral edema, coldness, or trophic changes.

Hematologic System: Denies anemia, easy bruising or bleeding, or lymph node enlargement.

Endocrine System: Denies heat or cold intolerance, excessive sweating, thirst, or urination.

Physical Exam

General: 71 y/o male, ill-appearing, in moderate distress. Patient was found lying down on hospital bed, A&O x 3.

Vital Signs:

BP:	163/98 mm/Hg
RR:	19 breaths/min, unlabored
P:	102 beats/min, regular
T:	97.5 ℉, oral
SpO2	98% room air
Ht: 5’8”	Wt: 69.3 kg

Skin: Warm & moist, good turgor. No scars, rashes, or ecchymosis.
HEENT: Noncephalic, sclera no-icteric, oropharynx well hydrated, moist, non-erythematous, neck is supple with no lymphadenopathy.
Lungs: Clear to auscultation bilaterally, no wheezing, rhonchi, or rales.

Heart: Regular rate and rhythm (RRR), with **tachycardia**. S1 and S2 are distinct with no murmurs, gallops, or friction rubs.
Abdomen: Abdomen is soft, protuberant, and symmetric, minimal scarring from surgery. No striae or pulsation noted. Bowel sounds normoactive in all four quadrants. **Generalized abdominal tenderness** throughout, no guarding or rebound noted. Non-distended, no palpable masses. Negative Murphy's and Rovsing sign. Negative McBurnery's point. No hernias present, no hepatosplenomegaly. No CVA tenderness.
Extremities: No peripheral edema, distal pulses 2+ and symmetric.

Problem List:

- Hypertension
- Type 2 Diabetes
- Hx of adenocarcinoma
- PUD
- Anemia
- Abdominal pain
- Emesis

Assessment: 71 year old male with past medical history of HTN, DM, PUD, ulcerative colitis, anemia, and adenocarcinoma of the cecum s/p excision of colon and rectum with permanent ileostomy presents to ED with sudden onset abdominal pain and multiple episodes of non-bilious, nonbloody emesis since 2-3 am this morning. The pain is persistent, and worsening. The last episode of emesis was right before arrival to the ED. Vitals revealed tachycardia and elevated blood pressure. Physical exam is significant for generalized abdominal tenderness. Special tests were all negative. Currently most concerned for small bowel obstruction. Will rule out other GI pathology. Will obtain EKG, labs, CT abdomen/pelvis, and treat pain, will monitor patient closely.

Differential Diagnoses:

1. Small bowel obstruction

   The patient's clinical presentation is most consistent with small bowel obstruction. He has classic sxs, including sudden onset of severe, generalized abdominal pain, multiple episodes of emesis, inability to tolerate oral intake, and no output from his ostomy bag, which strongly suggests impaired intestinal flow. His history of recent colorectal surgery significantly increases likelihood of adhesion formation, the most common cause of SBO.
2. Acute appendicitis

   The patient's symptoms of sudden onset abdominal pain, nausea, emesis, and leukocytosis are often seen in appendicitis. In older patients, the presentation is often atypical, with pain that may not be localized to the RLQ. Although the

patient had an elevated WBC, the absence of McBurney's point tenderness, and Rovsing's sign makes appendicitis less likely.

3. Peptic ulcer disease flare

   Given his history of PUD, a flare or complication should be considered. PUD commonly causes epigastric pain, nausea, and vomiting. However, the patient's pain is more diffuse, severe, and acute in onset, rather than the more localized and burning pain typically seen with PUD. There is no reported NSAID use or hematemesis and PUD would not account for decreased ostomy output, making this diagnosis less likely as well.

4. Acute cholecystitis

   Cholecystitis can present with abdominal pain, nausea, vomiting, and leukocytosis and elderly patients may lack classic RUQ pain. However, the patient has no fever, and a negative Murphy's sign, which lowers suspicion. This diagnosis also does not explain the decreased output in the patient's ostomy bag.

5. Mesenteric Ischemia

   Given the patient's age and comorbidities, mesenteric ischemia is a critical diagnosis to consider in any older patient with acute abdominal pain. It classically presents with pain out of proportion to exam and elevated lactate. Although this patient has risk factors, his pain correlates with exam findings and is accompanied by obstructive features and recent surgery, which makes SBO more likely.

Workup/Plan:

- Labs
  - CBC w/ diff. → r/o infection, inflammation, anemia
    - Findings: WBC - 13.3
  - BMP → to assess dehydration, fluid losses, electrolyte abnormalities
  - LFTs → to assess liver function, r/o biliary obstruction
  - Lipase → to r/o pancreatitis
  - Magnesium → due to vomiting, need to assess if hypomagnesemia
  - VBG w/ lactate → r/o bowel ischemia, acid-base status due to vomiting/dehydration
    - Findings: Lactate - 3.3
- Imaging
  - EKG → normal sinus rhythm, no ST-T changes, no acute ischemia
  - CT abdomen/pelvis w/ IV contrast → high grade SBO related to hernia in right lateral abdominal wall
- Management
  - IV fluids (sodium chloride 0.9% 1000 mL and lactated ringers)
  - Give IV ondansetron 4 mg for nausea and vomiting
  - Give IV morphine 2 mg for pain

- Start empiric IV ceftriaxone 1g and metronidazole 500 mg → r/o sepsis
- Consult surgery for admission
- Educated patient on need for admission and surgical evaluation to prevent worsening of condition.

/s/ Jeleeta Jolly, PA Student