Jeleeta Jolly
H&P 1
Site Evaluator: Naeem Sadat
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H&P 1- Family Medicine

Chief Complaint: "I am having stomach pain" x one week

History of Present Illness:
Patient D.S. is a 65 year old female with a past medical history of hypertension, hyperlipidemia, and history of cholelithiasis who presents to the primary care clinic with a complaint of abdominal pain that began one week ago. She describes the pain as dull, and aching localized to the upper abdomen, primarily in the epigastric region. She states the pain is intermittent, lasting for a few minutes at a time, non-radiating, and currently rated 6/10 in severity. She reports that the pain is consistently exacerbated by meals, stating she has been eating less and has had less of an appetite for the past week. She reports taking Pepto bismol and drinking ginger ale with minimal relief. She denies any associated fevers, chills, fatigue, weakness, chest pain, shortness of breath, nausea, vomiting, constipation, diarrhea, hematochezia, hx of abdominal surgeries, chronic NSAID use, recent illness, or recent travels.

Past Medical History
Hypertension x present - managed with medication
Hyperlipidemia x present - managed with medication
Rheumatoid arthritis
Cholelithiasis
Prediabetes x present - managed with medication

Immunization: Up to date on all immunizations.

Past Surgical History
Left foot bunion removal surgery - January and March 2024
Sinus surgery - 2016

Medications
Aspirin 81 MG Tablet Delayed Release Dose 1 tablet (81 mg) by mouth every day
hydrOXYzine HCl 10 MG 1 tablet, PO, QD
Losartan Potassium-HCTZ 50-12.5 MG, 1 tablet by mouth daily for high blood pressure
metFORMIN HCl 500 MG, 1 tablet (500 mg) by mouth 1 time every 12 hours
Simvastatin 20 MG, 1 tablet (20 mg) by mouth daily in the evening

Patient is compliant with the above medications.

Allergies:
No seasonal or food allergies.
NKDA

Family History
Mother, deceased at 71, depression
Father, deceased at 59, uncertain of PMHx
Grandparents, (ages uncertain), uncertain of PMHx
Siblings, none
Children, 1 son, 35, living and well

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

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

Marital History: Married to husband.

Occupational history: Not working.

Home situation: Patient reports living with her son.

Diet: Patient reports having eggs for breakfast. She states having chicken and rice for lunch. She reports having rice with salmon or chicken for dinner.

Sleep: Average 7 hours of sleep per night.

Exercise: Ambulatory, patient denies active exercising.

Safety Measures: Patient admits to using a seatbelt in the car. Patient states feeling safe at home.

Sexual history: Pt is not currently sexually active. Pt denies hx of past STIs. Denies use of barrier methods or contraceptives.

Review of Systems:
General: Admits to loss of appetite. Denies recent weight loss or weight gain, 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.

Head: Denies headache, vertigo, or head trauma.

Eyes: Denies visual disturbances, lacrimation, photophobia, or pruritus. Admits to wearing reading glasses. Last eye exam was last year (date unknown).

Ears: Denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses: Denies discharge, epistaxis, or obstruction.

Mouth and Throat: Denies sore throat, sore tongue, bleeding gums, mouth ulcers, voice changes, or use of dentures. Last dental exam unknown.

Neck: Denies localized swelling/lumps, decreased range of motion, or stiffness.

Breast: Denies lumps, nipple discharge, or pain. Last mammogram unknown.

Pulmonary System: Denies dyspnea, productive cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

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

Gastrointestinal System: Admits to abdominal pain. Denies nausea, vomiting, constipation, diarrhea, intolerance to specific foods, dysphagia, pyrosis, flatulence, eructations, jaundice, change in bowel habits, hemorrhoids, rectal bleeding, or blood in stool. Last colonoscopy was 2 years ago.

Genitourinary System: Denies frequency, nocturia, urgency, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate, flank pain, dribbling, or hesitancy. Color of urine is yellow/clear.

Menstrual/Obstetrical: Menarche age 12. LMP 15 years ago. Menopause at age 50. G1P1001, no complications. Denies bleeding, spotting, or vaginal discharge.

Nervous System: Denies seizures, headache, loss of consciousness, sensory disturbances (numbness, paresthesias, dysesthesias, hyperesthesias), ataxia, loss of strength, change in cognition/mental status/memory, or weakness.

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

Peripheral Vascular System: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color change.

Hematologic System: Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

Endocrine System: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism.

Psychiatric: Denies depression/sadness, feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideations, anxiety, obsessive/compulsive disorder or ever seeing a mental health professional.

Physical Exam

General: 65 y/o female, well groomed, good posture, in no apparent distress. Patient was found sitting on chair, A&O x 3.

Vital Signs:

BP:		
Seated:	136/86 mm/Hg	
RR:	16 breaths/min, unlabored	
P:	97 beats/min, regular	
T:	98.4 ℉, oral	
SpO2	98% room air	
Ht: 5’2”	Wt: 159 lbs	BMI: 29.08

Skin: Warm & moist, good turgor. Nonicteric, with no tattoos. No scars, rashes, or ecchymosis.
Head: Noncephalic, atraumatic. Nontender to palpation throughout.

Eyes: PERRLA, EOMS intact with no nystagmus. Sclera non-icteric, upper and lower eyelids normal.
Ears: No discharge or foreign bodies in external auditory canals AU. TM's are pearly white and intact with light reflex in good position
Nose: Symmetrical with no masses or discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated.
Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.
Oropharynx: Well hydrated, with no erythema, exudates, masses, or lesions. Tonsils are present with no erythema or exudates. Uvula midline, with no lesions.
Neck: Trachea midline. Supple and non-tender to palpation. Full range of motion. No palpable cervical adenopathy.
Thyroid: Non-tender, no thyromegaly. No palpable nodules.
Lungs: Clear to auscultation BL. Chest expansion and diaphragmatic excursion symmetrical.
Heart: 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: Abdomen is soft and symmetric. No striae or pulsation noted. Bowel sounds normoactive in all four quadrants. **Epigastric and right upper quadrant tenderness to palpation**, no guarding or rebound noted. Non-distended, no palpable masses. Negative Murphy's and Rovsing sign. Negative McBurney's point. No hernias present, no hepatosplenomegaly. No CVA tenderness.
Peripheral Vascular: Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis, or edema noted bilaterally. No stasis changes or ulcerations noted.
Neurologic Exam: A&O x3, cooperative, thoughts & speech coherent. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.

Problem List:

- Hypertension
- Hyperlipidemia
- Cholelithiasis
- Epigastric and RUQ pain

Assessment: 65 year old female with past medical history of hypertension, hyperlipidemia, and cholelithiasis presents with a one week history of intermittent, dull, aching abdominal pain, localized to the epigastric region. The pain is exacerbated with meals, with associated decreased appetite. In office, she is hemodynamically stable. Physical exam is notable for epigastric and right upper quadrant tenderness, without guarding or rebound. Murphy's sign is negative. Currently most concerned for symptomatic cholelithiasis/acute cholecystitis.

Differential Diagnoses:

1. Biliary colic

   Given the patient's history of cholelithiasis, her symptoms of epigastric and right upper quadrant pain is most likely due to biliary colic. With biliary colic, the pain is often posprandial, especially after fatty foods, and resolves once the obstruction is relieved. The intermittent nature of the pain and its association with meals strongly suggests biliary colic. The absence of fever and systemic symptoms further suggests a non-inflammatory process.
2. Acute cholecystitis

   The patient's symptoms of epigastric/right upper quadrant pain could indicate acute cholecystitis. Her symptoms are currently intermittent, but can progress to becoming constant. Although most patients classically have associated fever, nausea, vomiting, and a positive Murphy's sign, early or mild cases may present without these symptoms. Considering her history of gallstones, it is important to consider cholecystitis. While the absence of fever and constant pain make this less likely, it is a differential that must be ruled out.
3. Peptic ulcer disease

   The patient has symptoms of intermittent abdominal pain exacerbated by meals, often a presentation seen with peptic ulcer disease. The pain is localized to the epigastric and right upper quadrant and described as dull. Although she lacks the burning sensation often associated with PUD, epigastric discomfort and reduced appetite could be signs of a gastric ulcer. However, the intermittent nature of her pain makes biliary causes more likely.
4. Gastritis

   Gastritis can also present with epigastric discomfort and early satiety. It also presents with bloating and nausea, which this patient does not have. Pain is often persistent burning or aching. While the patient's decreased appetite and epigastric pain could suggest gastritis, the absence of nausea and association with meals make this diagnosis less likely.
5. Pancreatitis

   The patient presents with epigastric pain and decreased appetite which are also commonly seen in pancreatitis. However, the pain is more severe and constant, radiating to the back with associated nausea and vomiting. This patient has more mild intermittent pain without radiation or systemic symptoms, making pancreatitis lower on the differential list.

Workup/Plan:

- Obtain labs - CBC, CMP, and lipase to r/o pancreatitis and assess for leukocytosis, liver function, and electrolyte status
- Start omeprazole 20 mg for symptom relief QD

- Refer patient for abdominal ultrasound - evaluation of gallstones, wall thickening, pericholecystic fluid
- Refer patient to general surgeon due to history of cholelithiasis

Patient Education:

- Advised patient to start taking the omeprazole as prescribed and take Tylenol as needed for pain.
- Educated patient on having a low fat diet and to avoid fatty, greasy, or heavy meals.
- Advised patient to stay well hydrated and monitor symptoms closely.
- Educated on strict return precautions and advised patient to go to the ER if symptoms worsen.

/s/ Jeleeta Jolly, PA Student