Jeleeta Jolly
H&P 1
May 1, 2026

H&P 1 - Internal Medicine

Chief Complaint: "I am having stomach and lower leg swelling" x 3 weeks

History of Present Illness:
Patient R.P. is a 34 year old male with a past medical history of alcohol use disorder, hx of alcoholic hepatitis, and hx of liver cirrhosis presented to the emergency department for worsening diffuse swelling to his abdomen and lower extremities. He reports swelling began gradually and is diffuse. He denies any pain to the regions. He also reports shortness of breath on exertion but denies shortness of breath at rest. He reports recent travel out of the state (within the country) several weeks ago, and ran out of his medications. He attributes his symptoms to medication non-adherence. He reports drinking during this time, last drink was hard liquor 2 weeks ago. As per his cousin, the patient's most recent drink was last night. He returned last week and restarted his medications, but without efficacy, so he came to the ED. He denies fevers, chills, chest pain, abdominal pain, nausea, vomiting, diarrhea, melena, or hematochezia. He denies any confusion and has regular BM (2-3 yellow stools a day).

In the ED, vitals are significant for tachycardia at 118 bpm but stable otherwise. Labs were significant for anemia (Hgb 6.9, baseline 8-10 in 2023), with normal platelets, INR 1.18, Na 137, K 3.7, Cr 0.71, Albumin 2.8, Alk Phos 168, AST 54, ALT 17, and Tbili 0.6 (MELD 3.0). Chest xray revealed clear lungs. Abdominal ultrasound was significant for cirrhosis and moderate volume ascites within both upper quadrants and large volume ascites within both lower quadrants and pelvis. Patient was admitted to medicine for further management of ascites.

Past Medical History
Cirrhosis, 2023
Alcoholic liver disease, 2023
Ascites, first diagnosed in 2023

Immunization: Covid and TDaP vaccines up to date

Past Surgical History
No significant past surgical history.

Medications
Aldactone 100 mg oral tablet, once daily
Ferrous sulfate 325 mg oral tablet, once daily

Inderal 10 mg oral tablet, 1 tab once daily
Losartan 25 mg oral tablet, 1 tab once daily
Torsemide 20 mg oral tablet, 1 tab once daily

Allergies:
No seasonal or food allergies.
NKDA

Family History
Mother, alive at 65, no PMH
Father, alive at 67, diabetes
Grandparents, (ages uncertain), uncertain of PMHx
Siblings, 2 brothers, living and well

Social History
Habits: Admits to alcohol use (two 24 oz beer cans and 200 cc of vodka several times per week). Denies smoking, drinking coffee or usage of illicit drugs.
Travel: Admits to recent travel outside of the state.
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: Denies fevers, chills, recent weight loss or weight gain, loss of appetite, generalized weakness/fatigue, 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.

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.

Pulmonary System: **Admits to dyspnea**. Denies cough, wheezing, hemoptysis, or cyanosis.

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

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

Genitourinary System: Denies frequency, nocturia, urgency, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate, flank pain, dribbling, or hesitancy.

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: **Admits to BL lower extremity edema**. Denies intermittent claudication, coldness or trophic changes, varicose veins, 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: 34 y/o male, well groomed, in no apparent distress. Patient was found lying on hospital bed, A&O x 3.

Vital Signs:

BP:	102/64 mm/Hg	
RR:	18 breaths/min, unlabored	
P:	118 beats/min, regular	
T:	98.4°F, oral	
SpO2	97% room air	
Ht: 5'8"	Wt: 240 lbs	BMI: 36.5

Skin: Warm & moist, good turgor. No scars, rashes, or ecchymosis. No jaundice.
HEENT: Noncephalic, sclera non-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 distended and tense.** No striae or pulsation noted. Bowel sounds normoactive in all four quadrants. Non-tender to palpation, no palpable masses. No CVA tenderness.
Extremities: **2+ pitting edema bilaterally,** distal pulses 2+ and symmetric.
Neurologic Exam: A&O x3, cooperative, thoughts & speech coherent. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact. No asterixis.

Problem List:

- Hx of alcoholic cirrhosis
- Hx of alcoholic hepatitis
- Alcohol use disorder
- Ascites
- LE edema

Assessment: 34 year old male with past medical history of alcoholic cirrhosis (diagnosed in 2023), alcohol use disorder, and hx of severe alcoholic hepatitis presents with a 3 week history of ascites and bilateral lower extremity edema. Patient's cirrhosis is being managed by outpatient PCP. Patient is hemodynamically stable, with tachycardia to 118. On physical exam, the abdomen is distended with no tenderness, with 2+ pitting edema of lower extremities. Given patient's history, this decompensation is likely in the setting of medication noncompliance. Low

suspicion for SBP but will consider getting a therapeutic/diagnostic paracentesis as patient has never had this done before and will treat empirically.

Differential Diagnoses:

1. Decompensated cirrhosis

   This is the most likely diagnosis given the patient's known history of alcoholic cirrhosis, medication non-adherence, and continued alcohol use. His presentation with progressive ascites, BL lower extremity edema, and hypoalbuminemia supports volume overload. Imaging confirming large volume ascites further strengthens this diagnosis.
2. Portal vein thrombosis

   This should be considered in cirrhotic patients who present with worsening ascites despite restarting medications. Cirrhosis creates a hypercoagulable state, increasing the risk of thrombosis. Although he lacks abdominal pain and no thrombus was noted on initial imaging, this diagnosis should still be considered and require follow up imaging, such as abdominal doppler or CT for further evaluation.
3. Spontaneous bacterial peritonitis

   Given his hx of alcoholic cirrhosis and ascites on presentation, this is a must not miss diagnosis in any cirrhotic patient with ascites. This is lower on the differential list as he is afebrile, abdomen is non-tender, there is no altered mental status, and he is overall hemodynamically stable. Will conduct diagnostic paracentesis to rule this out but will also treat empirically with IV ceftriaxone as this is a can't miss complication.
4. Budd-Chiari syndrome

   Patients with Budd-Chiari syndrome would typically present with abdominal pain, hepatomegaly, and ascites. While previous imaging showed hepatomegaly and patient has known ascites at this visit, he lacks abdominal pain. Additionally, he has a known diagnosis of cirrhosis, making Budd-Chiari syndrome less likely to be the cause.
5. Hepatocellular carcinoma

   In any patient with cirrhosis, HCC should be considered, particularly with new or worsening ascites. However, this is less likely in this case given the absence of constitutional symptoms, normal bilirubin, and no evidence of a hepatic mass on ultrasound. Nonetheless, it should still be ruled out.

Labs:

CBC

- Hgb: 6.9 ↓

- Hct: 22.5 ↓
- WBC: 9.99
- Plts: 310

BMP
- Na: 137
- K: 3.7
- Cl: 103
- CO2: 20
- BUN: 14
- Creatinine: 0.71
- Ca: 8.1
- Phos: 3.5
- Mg: 2.0

Hepatic Panel
- Tbili: 0.6
- AST: 54 ↑
- ALT: 17
- AlkP: 168 ↑
- Alb: 2.8 ↓

Coagulation studies
- PT: 13.5
- INR: 1.17
- PTT: 31.0

Imaging:
EKG: Sinus tachycardia, no acute ST-T wave changes
US Abdomen: Significant for cirrhosis and moderate volume ascites within both upper quadrants and large volume ascites within both lower quadrants and pelvis.
CT abdomen/pelvis pending: r/o malignancy, other hepatic pathology

Workup/Plan:

Decompensated cirrhosis likely due to medication nonadherence
- CT abdomen/pelvis pending
- Consider RUQ doppler to rule out portal vein thrombosis
- Consulted hepatology team
- Start IV Lasix 20 mg as BP is able to tolerate
- Continue to hold losartan, outpatient would recommend non-ACE/ARB for BP control
- Continue spironolactone 50mg daily, can increase dose to 100 mg if BP stable
- Continue low sodium diet with 1.2L fluid restriction

- Trend CMP and PT/INR daily
- Start IV ceftriaxone to empirically treat for SBP although low suspicion
- Consult interventional radiology team for potential paracentesis. No prior paracentesis was done, pt first developed ascites in 2023

Acute on Chronic Anemia

Baseline Hgb 8-10 last admission in 2023, on iron supplementation outpatient.

- Continue ferrous sulfate 325 mg PO daily
- Trend Hgb daily
- Consider possible transfusion for goal Hgb >7
- Obtain iron studies (Iron with TIBC, ferritin, reticulocyte count)
- Plan for possible EGD this admission pending anemia trend and CIWA course

Alcohol Use Disorder
Patient reports resumption of drinking 1.5 years ago with last drink 2 weeks prior to admission. Last drink night prior to admission per collateral

- Follow CIWA protocol (most recent score was 4)
- Continue thiamine 100 mg PO daily, multivitamin PO daily, folate 1mg PO daily
- Consult with social work for alcohol cessation resources

Diet: Regular, DASH/TLC (sodium and cholesterol restricted)
GI ppx: Pantoprazole 40 mg IV BID
DVT ppx: Heparin SC
Code status: Full code

/s/ Jeleeta Jolly, PA Student