Date of visit: January 14th, 2026

Location: NYP Queens, Flushing, NY
Source of information: Self
Reliability: Reliable
Source of referral: PCP
Mode of transport: Son

Chief complaint: “I have had watery diarrhea for the past week.”

HPI: C.G is an 88 YOF with PMHx of HTN, HLD, DM, CKD, CAD, CHF, hypothyroidism, and GERD who presented to the ED for watery diarrhea x 1 week. She was recently admitted to LIJ for hypoglycemic shock during which she developed constipation and was treated with laxatives. Pt was discharged to a rehab center, and has since been having watery diarrhea for the past week. Per ED discussion with son over the phone, her symptoms were discussed with her PMD, who referred her to the ED for evaluation of possible fecal impaction. Per son, PMD did not examine pt. Pt denies fever, abdominal pain, blood in stool, nausea, vomiting, urinary retention, dysuria, or flank pain.

In the ED, a DRE revealed hard stool that was unable to be manually disimpacted, raising concern for overflow diarrhea secondary to fecal impaction. Pt was admitted and reported improvement in her diarrhea. She was found to be anemic with Hg of 8.4 (unknown baseline), hypokalemic to 3.4 with a low bicarbonate of 16. Creatinine was found to be 2.26, with last baseline of 1.29. A renal bladder US showed bilateral hydronephrosis with distended bladder.

Past Medical History
- Diabetes mellitus x present, controlled
- Hypothyroidism x present, controlled
- Hyperlipidemia x present, controlled
- Hypertension x present, controlled
- Chronic kidney disease x present, controlled
- GERD x present, controlled
- Coronary artery disease x present, controlled
- Congestive heart failure x present, controlled

Immunizations: up to date on all immunizations

Past Surgical History
- None

Medications
- Aspirin chewable tablet 81 mg daily
- Atorvastatin tablet 20 mg nightly
- Furosemide tablet 20 mg daily
- Hydralazine tablet 50 mg Q8 hours
- Levothyroxine tablet 100 mcg daily
- Metoprolol tartrate tablet 25 mg Q12 hours
- Nifedipine ER tablet 60 mg daily
- Pantoprazole injection 40 mg Q 12 hours
- Sodium bicarbonate tablet 650 mg Q12 hours
- Vitamin B12 tablet 1,000 mcg daily

Allergies
No known drug or food allergies.

Family History
- No known significant FHx

Social History
Habits: Denies smoking, alcohol or illicit drug use. No caffeine intake.
Diet: patient is able to tolerate PO/intact appetite, but states “nothing stays down, it comes right out.”
Exercise: does not exercise, but is able to walk without a cane.
Travel: no recent travel.
Sleep habits: sleeps about 8 hours per night.
Marital status/living situation: widowed, currently residing in rehab center.
Sexual history: not currently sexually active.

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
Hair, skin, nails: denies rash, itching, excessive sweating or dry skin, new moles, change in existing moles, hair loss, change in hair texture or nail changes
HEENT: denies headache, lightheadedness, head trauma, visual changes, double vision or blurriness, tinnitus, discharge from ears, nose bleed or discharge, congestion, sore throat, mouth ulcers or bleeding gums
Neck: denies localized swelling, lumps, stiffness or decreased ROM
Pulmonary: denies cough, SOB, orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: hx of HTN; denies chest pain, palpitations, syncope, heart murmur, or swelling of legs or feet
Gastrointestinal: endorses diarrhea; denies nausea, vomiting, decreased appetite, abdominal pain, constipation, heartburn or pain with swallowing
Genitourinary: denies urinary frequency or urgency, nocturia, dysuria, hematuria, incontinence, flank pain or vaginal discharge
Neurological: denies weakness, seizures, LOC, numbness, tingling, memory loss or changes in gait or mental status
Musculoskeletal: denies muscle/joint pain, redness, deformity, or trauma
Peripheral Vascular: denies claudication, coldness or swelling of extremities or color change in extremities
Hematologic: denies known hx of anemia, easy bruising, blood transfusions or hx of DVT/PE
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Psychiatric: denies depression, anxiety, mood changes, new difficulty sleeping, difficulty concentrating or suicidal ideations

Physical Exam
General: 88 year old female, well nourished, well developed and well groomed. Pt appears stated age, found laying down in bed sleeping. Upon awakening, pt is AOx3 to person, place and time and does not appear in distress.

Vital Signs:
Blood pressure: 165/68 mmHg
Respiratory rate: 19 breaths per minute, unlabored
Pulse: 95 beats/min, regular rate & rhythm, 2+
Temperature: 98.6 degrees F, oral
SpO2: 92% on RA
Height: 65.5 inches
Weight: 230 pounds
BMI: 37.7

Skin: warm and moist, good turgor. Nonicteric, no lesions.
Nails: no clubbing. Cap refill <2 seconds in upper and lower extremities.
Head: normocephalic, atraumatic.
Eyes: symmetrical OU. No strabismus, nystagmus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink. PERRLA, EOMs intact.
Ears: Symmetrical and appropriate in size. No lesions, masses, trauma on external ears. No discharge or foreign bodies in external auditory canals bilaterally.
Nose: symmetrical; no masses, lesions, deformities, trauma, bleeding or discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated. Septum midline with no lesions, deformities, injection or perforation. No foreign bodies noted.
Throat: lips pink and moist, no cracking or cyanosis. Mucosa pink and well hydrated. Oropharynx with no injection, exudates, masses, lesions, or foreign bodies; tonsils without injection or exudates; uvula pink and midline, no edema.
Pulm: respirations unlabored, no paradoxical respirations or use of accessory muscles. Lungs clear to auscultation; chest rise symmetrical.
CV: regular rate and rhythm, distinct S1 and S2, with no murmur, S3, or S4 on auscultation. No splitting of S2 or friction rubs appreciated.
Abdomen: round and symmetric with no scars or pulsatations. BS normoactive in all 4 quadrants with no bruits. Soft, non tender to palpation. No guarding, rebound, hepatosplenomegaly, or CVA tenderness noted.
Rectal/Anus exam: per ED, no perirectal lesions or fissures. External sphincter tone intact. Hard stool noted. Liquid stool noted upon removal of finger. No blood.
Peripheral vascular: Extremities have good color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis, or edema noted bilaterally. No stasis changes or ulcerations noted.
MSK: no swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. Non-tender to palpation, no crepitus noted throughout. FROM of all upper and lower extremities bilaterally.
Mental status exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to person, place, and time. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically.

Labs/Imaging
Hg: 8.4 (unknown baseline)
K+: 3.4
HCO3: 16
Cr: 2.26 (baseline of 1.29)

RBUS: bilateral hydronephrosis with distended bladder.

Assessment
Patient is an 88 YOF with PMHx of HTN, HLD, DM, CKD, CAD, CHF, hypothyroidism, and GERD with recent hospitalization at LIJ for hypoglycemic shock, complicated by constipation and laxative use, who presents for watery diarrhea x 1 week. Clinical presentation, as well as rectal exam demonstrating hard stool, are concerning for overflow diarrhea secondary to fecal impaction. Upon admission, pt was found to be anemic and slightly hypokalemic, with low sodium bicarbonate and elevated creatinine, likely secondary to GI losses and AKI. RBUS was positive for bilateral hydronephrosis and distended bladder.

Differential Diagnoses
1. Overflow diarrhea secondary to fecal impaction

   A. Patient reports constipation during recent hospitalization for which she was treated with laxatives. She now presents with watery diarrhea, but rectal exam revealed hard stool that was unable to be disimpacted, supporting mechanical obstruction. Especially in elderly patients, liquid stool can leak around impacted feces, and the clinical presentation is typically watery diarrhea without abdominal pain. Absence of fever, leukocytosis, or abdominal tenderness also supports a non-infectious etiology. Further, the pt's low bicarbonate is likely secondary to GI loss from prolonged diarrhea.
2. Postrenal AKI due to urinary retention
   A. Patient was found to have an acute rise in creatinine from baseline (2.26 from 1.29). Renal bladder US was significant for bilateral hydronephrosis and distended bladder, indicating a post renal obstruction. Especially in elderly patients, fecal impaction can compress the bladder outlet. Although patient does not report urinary symptoms, this does not exclude retention in geriatric patients.
3. Medication-induced diarrhea
   A. Patient was recently hospitalized and given laxatives, which can prolong diarrhea especially in elderly patients. Laxatives can also worsen fecal impaction by liquefying stool proximal to the burden. Pt is also on chronic PPI therapy (Pantoprazole) which may also cause diarrhea because they alter gastric acid and change gut flora.
4. Clostridioides difficile
   A. The patient had a recent hospitalization and currently resides in a rehab facility, which increases the risk for healthcare associated infections. Elderly patients may present atypically with C. Diff, such as with the absence of fever or abdominal pain. Any elderly patient with diarrhea should be worked up for infectious causes due to high morbidity.
5. Gastrointestinal bleed
   A. Patient is anemic with a Hg of 8.4 and unknown baseline. Given age and aspirin use, this raises concern for occult GI bleed. The absence of overt bleeding and pain, as well as the hemodynamic stability of the patient suggests a chronic process rather than an acute GI bleed.

Plan/Workup
- Fleet enema given with mixed stool and diarrhea
- Will place pt on clear liquid diet and bowel regimen
- Will place foley for bladder decompression and monitor urinary output
- Stool occult to r/o GI bleed

Meds:
- Replete potassium with KCl
- Oral sodium bicarbonate due to low levels
- Hold on aspirin due to concern of bleed
- Continue home antihypertensives (hydralazine, metoprolol, nifedipine) as tolerated; monitor BP
- Hold home lasix and monitor fluid volume status

Labs:
- Daily BMP to trend renal function, potassium levels and bicarbonate
- Daily CBC to trend Hg/Hct; will consider iron studies (ferritin, iron, TIBC) to r/o iron deficiency vs anemia of chronic disease
- GI PCR to r/o C. Diff

Imaging:
- Abdominal XR to assess impaction

Consults:
- Urology

- GI

Patient education:
Pt was educated that her diarrhea is likely due to a stool impaction, causing liquid stool to leak around the hardened stool. We stressed the importance of maintaining a consistent bowel regimen to prevent the recurrence, and avoiding overuse of laxatives. While in the hospital, pt was encouraged to let staff know if she is having difficulty passing stool or gas. We educated her that diarrhea and urinary retention can affect kidney function, and to let us know if she develops lower abdominal pain or decreased urinary output. We emphasized adherence to prescribed medications and avoiding NSAIDs, due to risk of kidney dysfunction, worsening CHF, and bleeding risk.