Chief complaint: “I’m having bad stomach pain” x 3 hours.

HPI: C.D is a 31 year old female with no past medical history who presents to the ED with complaints of constant right upper quadrant abdominal pain for the past 3 hours. Pt reports that earlier in the evening she went to the movies and ate nachos and drank a soda. Approximately 1-2 hours later, she developed severe epigastric pain that radiated to the RUQ. She describes the pain as a stabbing sensation and rates it as 8/10 in severity. The pain has been constant since onset and is associated with nausea. She reports experiencing a similar episode about one month ago that resolved spontaneously. Pt has not taken any medications for her symptoms. Denies vomiting, diarrhea, constipation, fever, chills, chest pain, SOB, dysuria, or urinary symptoms. Pt denies any possibility of pregnancy. No sick contacts or recent travel.

Past Medical History
None

Past Surgical History
None

Medications
None

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.
Occupation: works as a housekeeper
Diet: admits to eating fast-food frequently, including McDonalds and Popeyes. Breakfast: typically a bagel with cream cheese or butter; lunch/dinner: fast-food or take-out food.
Exercise: does not exercise, but is able to walk without difficulty.
Travel: no recent travel.
Sleep habits: endorses healthy sleeping patterns.
Marital status/living situation: not married; lives alone.

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
HEENT: denies headache, lightheadedness, visual changes, congestion, sore throat
Neck: denies localized swelling, lumps, stiffness or decreased ROM
Pulmonary: denies cough, SOB, orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: denies chest pain, palpitations, or swelling of legs or feet
Gastrointestinal: (+) abdominal pain, (+) nausea; denies vomiting, diarrhea, or constipation
Genitourinary: denies urinary frequency or urgency, dysuria, hematuria, incontinence, flank pain or vaginal discharge
Neurological: denies weakness, seizures, numbness, tingling, changes in gait or mental status
Musculoskeletal: denies muscle/joint pain, redness, deformity, or trauma
Hematologic: denies 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: 31 year old female, well nourished, well developed and well groomed. Pt appears in mild distress secondary to pain.

Vital Signs:
Blood pressure: 134/80 mmHg
Respiratory rate: 16 breaths per minute, unlabored
Pulse: 88 beats/min, regular rate & rhythm, 2+
Temperature: 36.6 degrees C, oral
SpO2: 98% on RA
Height: 5 feet, 2 inches
Weight: 164 lbs
BMI: 30

Skin: warm and moist, good turgor. Nonicteric, no lesions.
Pulm: symmetrical expansion with respiration. No intercostal retractions, or tenderness. Breath sounds equal bilaterally. No rales, wheezes, or rhonchi auscultated.
CV: regular rate and rhythm. S1 and S2 heard. No murmur, thrills, or clicks.

Abdomen: soft, non distended, obese abdomen. (+) tenderness to light palpation of RUQ and epigastric region, (+) guarding, (+) Murphy's sign. No rigidity. No palpable masses or organomegaly.

MSK: no swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. FROM of all upper and lower extremities bilaterally.
Mental status/neuro 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. Conversation progresses logically. Strength and sensation intact.

Labs/Imaging:
CBC: within normal limits; no leukocytosis
LFTs: within normal limits
Lipase: within normal limits
Beta-HCG: negative
UA: negative for infection

Bedside RUQ ultrasound: gallbladder sludge visualized without evidence of cholelithiasis, gallbladder wall thickening, pericholecystic fluid, or biliary ductal dilation. Sonographic Murphy's sign present.

Assessment
Patient is a 31 YOF with no PMHx who presents with acute onset epigastric pain radiating to the RUQ, associated with nausea, after consumption of a fatty meal. Physical exam is notable for RUQ tenderness, guarding, and positive Murphy's sign. Lab studies are unremarkable, and RUQ US in the ED demonstrates gallbladder sludge. Clinical presentation most consistent with biliary colic secondary to gallbladder sludge, however, early acute cholecysitits cannot be excluded pending official RUQ US.

Differential Diagnoses

1. Biliary colic secondary to gallbladder sludge
    A. The patient's pain began after a fatty meal and is localized to the epigastric region with radiation to the RUQ. She reports a similar self-resolving episode one month ago, suggestive of an intermittent process. US in the ED demonstrated gallbladder sludge without evidence of acute inflammation or stones, making symptomatic biliary sludge causing transient cystic duct obstruction the leading diagnosis. Additionally, the pt has several risk factors for biliary disease, including female sex, obesity (BMI of 30) and a diet high in fatty and fast foods.
2. Acute cholecystitis
    A. This is also a likely diagnosis given the patient's RUQ tenderness, guarding, and positive Murphy's sign. Again, she also has several risk factors for biliary disease. However, pt is afebrile, hemodynamically stable, and lacks leukocytosis or sonographic findings such as gallbladder wall thickening, pericholecystic fluid, or biliary ductal dilation, making this diagnosis less likely.
3. Cholelithiasis
    A. Gallstones are a common cause of postprandial RUQ pain and may present similarly to biliary colic. Although no gallstones were visualized on US, small stones may occasionally be missed, and gallbladder sludge is often considered a precursor to stone formation.
4. GERD
    A. GERD can present with postpradndial epigastric discomfort and nausea, particularly following consumption of fatty or acidic foods. However, it is less likely in this pt as her pain is severe, localized to the RUQ, associated with positive Murphy's sign, and lacks accompanying symptoms such as heartburn, regurgitation, dysphagia, or a sour/bitter taste in mouth.
5. Acute pancreatitis
    A. Pancreatitis can present with severe epigastric pain, nausea, and pain radiating to the back. Given the pt's epigastric component of pain, pancreatitis should be considered. However, the absence of vomiting, alcohol use, and an elevated lipase level makes this diagnosis unlikely.
6. Gastritis/PUD
    A. Gastritis and PUD may present with epigastric pain, particularly after eating. However, these conditions are less likely given the localization of pain to the RUQ, positive Murphy's sign, and absence of dyspepsia, melena, or hematemesis.

Plan/Workup

- IV access already established
    - Administer 1 L NS IV bonus
    - Administer ketorolac 15 mg IV for pain control
    - Administer ondansetron 4 mg IV for nausea
- Obtain official RUQ ultrasound to further evaluate for cholelithiasis, acute cholecystitis, biliary obstruction, or other hepatobiliary pathology
- Reassess pt's pain and abdominal exam following treatment

Pending official imaging results. Will consider general surgery consult if findings are concerning for acute cholecystitis or biliary obstruction. If negative, will discharge home with strict return precautions if symptoms improve and patient tolerates PO intake.

Patient education:
While waiting for official imaging results, pt was advised to avoid fatty, greasy, and fried foods, as these may precipitate future episodes of biliary colic. Discussed the importance of maintaining adequate hydration and following a balanced diet.

Should imaging results come back negative for cholecystitis or other biliary pathology, pt will be educated on signs and symptoms that warrant immediate return to the ED, including fever, worsening abdominal pain, persistent nausea or vomiting, jaundice, inability to tolerate PO intake, or development

of chest pain or SOB.