H&P 1
Rotation 2 - Emergency Medicine

Chief complaint: "I vomited blood twice this morning."

75 year old male with a history of GERD and peptic ulcer disease presents to the ED with two episodes of coffee-ground emesis today, first at home around 8 AM and again in the ED around 1 PM. The emesis was dark, coffee-ground in appearance without bright red blood or clots, and of moderate volume. He reports a prior upper GI bleed years ago requiring endoscopic intervention (clipping). He endorses associated nausea and dizziness, but denies syncope, chest pain, shortness of breath, palpitations, or lightheadedness. He denies abdominal or epigastric pain, hematochezia, and has not noticed melena; his last bowel movement this morning was normal in color and consistency. He denies any preceding retching or vomiting prior to the first episode. He denies use of NSAIDs, anticoagulants, or antiplatelet medications, and denies alcohol use. He also denies fever, chills, diarrhea, recent illness, recent trauma or recent travel.

Past Medical History
Gastric Ulcer - with prior endoscopic intervention - clipping
GERD
Osteoarthritis

Past Surgical History
None

Medications
Pantoprazole 40 mg PO daily (last dose yesterday morning)
Acetaminophen 500 mg PO PRN for leg pain (last dose 3 days ago)
Patient is compliant with all medications.

Allergies
Denies medication, environmental or food allergies.

Family History
Unknown

Social History
Travel: Denies any recent travel outside of the state or country
Marital history: Widow

Occupational history: unknown

Home Situation: Lives with friend

Drugs/Alcohol: Denies any past use of alcohol, no drug use.

Smoking history: Denies smoking

Diet: Consumes 2/3 meals per day, with meals typically consisting of breakfast with rice chicken, coffee with/without milk, bread and lunch/dinner with curry, soups, omelets, vegetables, chicken, fish, beef, pork and rice.

Exercise: He reported going for 30 minute walk everyday

ROS

General: Denies fever, chill, weight loss/gain, loss of appetite, generalized weakness, fatigue, fever, 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: **Admits dizziness.** Denies lightheadedness, headache, trauma, visual changes, double vision or blurriness, change in hearing, 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 orthopnea, SOB, dyspnea on exertion, cough, sputum, hemoptysis, or wheezing

Cardiovascular: Denies chest pain, palpitations, syncope, irregular heart beat, heart murmur, or swelling of legs or feet

Gastrointestinal: **Admits heart burn, nausea, vomiting**; Denies changes in appetite, abdominal pain change in bowel habits, diarrhea, constipation, blood in stool, or pain with swallowing

Genitourinary: Denies urinary frequency or urgency, dysuria, nocturia, hematuria, incontinence, flank pain or penile discharge

Neurological: Denies loss of cognition/memory, headaches, sensory disturbances, seizures, or weakness

Musculoskeletal: **Admits intermittent pain of bilateral leg due to arthritis.** Denies redness, deformity.

Peripheral Vascular: Denies claudication, coldness trophic changes, varicose vein, peripheral edema, or color change

Hematologic: Denies anemia, easy bruising blood transfusions or hx of DVT/PE

Endocrine: Denies thyroid enlargement, heat/cold intolerance, changes in facial or body hair, change in weight or excessive hair growth

Psychiatric: Denies depression, anxiety, mood changes, sleep disturbances, difficulty concentrating or suicidal ideations

Physical Exam:

General: 75 year old male is well-groomed and appears to be stated age. Patient appears A&O x3, without any acute distress. Good posture.

Vital Signs:

BP: 131/78

HR: 77 bpm, regular

RR: 19 rpm unlabored

T: 98.00, ear

O2 Sat : 99% on Room air

Weight: 72.6kg Height: 65.7 in BMI: 26.02

Cardiovascular: Regular rate and rhythm (RRR). No murmurs.
Respiratory: Lungs clear to auscultation bilaterally. No wheezes, rales, or rhonchi.
HEENT: Normocephalic, atraumatic. Mild Conjunctival pallor, no scleral icterus, PERRLA, EOMI. Oral mucosa is moist, no oropharyngeal lesions
Neck: Supple, no cervical lymphadenopathy or thyromegaly
GI: Soft, non-tender, mildly distended, no rebound or guarding. No hepatosplenomegaly.
MSK: Full ROM of all extremities. No joint swelling or deformities.
Neuro: CN II-XII intact. Strength 5/5 bilaterally in upper and lower extremities. Normal gait.
Skin: warm, dry. No cyanosis or rash.

Assessment:

75-year-old male with a history of GERD and prior peptic ulcer disease requiring endoscopic intervention presenting with two episodes of coffee-ground emesis, associated with nausea and dizziness, concerning an upper gastrointestinal bleed. He denies melena, hematochezia, or use of anticoagulants or antiplatelet agents. On exam, he is hemodynamically stable with a soft, non-tender, mildly distended abdomen and mild conjunctival pallor. Given his history and presentation, the most likely diagnosis is a recurrent upper GI bleed secondary to peptic ulcer disease. Other considerations include gastritis or esophagitis, with Mallory-Weiss tear less likely given absence of preceding retching, and variceal bleeding unlikely given no history of liver disease or alcohol use.

1. Upper Gastrointestinal Bleed secondary to Peptic Ulcer Disease (PUD)

This is the most likely diagnosis based on the patient's presentation of coffee-ground emesis, which is highly suggestive of an upper GI bleed. His history of peptic ulcer disease with prior endoscopic intervention further increases the likelihood of recurrent bleeding. Associated nausea and dizziness may reflect early volume depletion.

2. Gastritis

Gastritis is another consideration, as it can cause slow mucosal bleeding presenting as coffee-ground emesis. Although he lacks typical risk factors such as NSAID or alcohol use and denies epigastric pain, it remains a common cause of upper GI bleeding in elderly patients.

3. Esophagitis (Reflux-related)

Given his history of GERD, esophagitis may cause mucosal irritation and minor bleeding. However, absence of odynophagia, dysphagia, or chest pain makes this less likely than ulcer-related bleeding.

4. Mallory-Weiss Tear

A Mallory-Weiss tear causes bleeding due to mucosal laceration at the gastroesophageal junction, typically after forceful or repeated retching. This is less likely given absence of preceding vomiting, and these tears more commonly present with bright red hematemesis.

5. Esophageal Varices

Variceal bleeding is an important cause of upper GI bleeding, particularly in patients with cirrhosis or alcohol use disorder. This is less likely given no known liver disease, no alcohol use, and absence of large-volume hematemesis.

6. Upper GI Malignancy (Gastric or Esophageal Cancer)

In an elderly patient with new-onset upper GI bleeding, malignancy must be considered. Although he denies weight loss, dysphagia, or anorexia, his age places him at increased risk. This remains less likely but requires evaluation with endoscopy.

Labs Ordered : CBC, CMP, hepatic function panel, PT/INR, PTT, type and screen

- **CBC:** Within normal limits, no evidence of anemia

Plan:

- Lactated Ringers
- Start IV pantoprazole
- IV metoclopramide for nausea
- NPO
- Monitor vital signs and trend hemoglobin
- Administer IV fluids as needed
- Consult Gastroenterology for endoscopic evaluation and admission

Anjana Thomas PA-S