Abigail Chen

H&P #2 Family Medicine on 01/12/2026

History

Identifying Data:

[redacted]

Chief Complaint: Umbilical pain and discharge x approximately 1 month

B.P. is a 10-year-old female who presents for follow-up after an emergency room visit on 01/10/2026 for abdominal pain localized to the umbilical region associated with purulent drainage. The patient reports having this problem for approximately 1 month and going into the hospital due to the pain. The patient's mother reports that a CT scan was obtained during the ER visit and was reported as normal. The patient was treated with ibuprofen for pain control and discharged without antibiotic therapy.

Since that visit, the patient continues to experience persistent, mild pain localized to the umbilicus, which the mother describes as constant rather than intermittent. The umbilicus has remained red and swollen, with the mother noting less discharge. The patient denies worsening pain, and no additional drainage has been observed since the ER evaluation.

The patient has a significant surgical history of a ruptured appendix complicated by peritonitis in August 2025. Despite this history, the patient and her mother deny associated fever, chills, nausea, vomiting, or other systemic symptoms. The mother also denies any changes in the patient's appetite, sleep patterns, or weight. Given the persistence of localized pain and swelling in the setting of prior intra-abdominal infection and surgery, further evaluation is warranted.

Differential Diagnoses:

1) **Umbilical port-site wound infection/cellulitis –** Despite negative CT, superficial soft tissue infections at the umbilical port site remain the most common explanation. The green discharge, erythema, and crusting are consistent with localized infection that may not produce significant findings on CT if confined to superficial tissues. The umbilicus accounts for 72.6% of laparoscopic port-site infections, with purulent discharge present in 48.4% of cases.
2) **Umbilical stitch abscess or retained suture granuloma –** Retained suture material can create a small, localized abscess or chronic sinus tract that may be too small or superficial to detect on CT. These present with persistent drainage and local inflammation months after surgery. The green discharge represents purulent material draining from the granuloma.
3) **Patent omphalomesenteric (vitelline) duct –** This congenital anomaly allows intestinal contents to drain through the umbilicus, producing green discharge (enteric fluid containing bile). In a study of patients with umbilical drainage, 54.2% initially presented with drainage from the umbilicus. While CT can identify this, small patent ducts may be missed, particularly if not specifically sought or if imaging was performed without oral contrast.
4) **Patent urachus with secondary infection –** A patent urachus causes urine to leak through the umbilicus, which becomes secondarily infected and produces purulent discharge that can appear green-yellow. The abdominal pain may be from concurrent urinary tract infection or bladder irritation. Small urachal remnants may not be visible on standard CT.
5) **Small enterocutaneous fistula –** While CT with oral contrast is highly sensitive for fistulas, very small, low-output fistulas can occasionally be missed, particularly if the study was performed without oral contrast or if the fistula was not actively draining at the time of imaging. The green discharge may represent intermittent drainage of enteric contents.

Past Medical History:

Atrial Septal Defect (ASD): Secundum type
Appendicitis: Appendectomy for AP with Peritonitis on 08/09/2025

Past Surgical History:

Appendectomy (August 2025) – laparoscopic approach was attempted but unsuccessful, requiring conversion to an open procedure.

Immunizations:

Covid vaccine series completed (2021/2022)
Flu vaccine: 9/20/2025
Up to date in all childhood vaccinations

Medications:
Ibuprofen (ER prescribed)

Allergies:
Denies known drug, food, or environmental allergies.

Family History:
Father: 37 years old, alive, Healthy
Mother: 29 years old, alive, Healthy
Paternal Grandfather: Diabetes Mellitus Type II
Siblings: Two brothers, healthy

Social History:
Housing**:** Lives with parents and siblings in a rented home

Language: Preferred language is not English; interpretation services were utilized for this visit

Habits:
Cigarettes: Denies
Alcohol: Denies
Drugs: Denies

Travel:
No recent travel

Diet:
The patient reports irregular eating habits due to chronic abdominal discomfort. She attempts to maintain a strictly bland diet, avoiding spicy or heavy foods, because her "tummy always hurts" following her previous abdominal surgery. Despite these efforts, she continues to experience intermittent umbilical sensitivity.

Exercise:
gym class 3 times a week

Sexual Hx:

Not sexually active

Safety:
Wears seatbelt consistently
Review of Systems:

General: Denies fever, chills, night sweats, weight loss, or fatigue.

Gastrointestinal: Reports abdominal pain as described above. Endorses chronic constipation with infrequent bowel movements. Denies nausea, vomiting, diarrhea, abdominal distention, or blood in stool. Denies the relationship between eating and umbilical discharge.

Genitourinary: Denies urinary frequency, urgency, dysuria, hematuria, or changes in urine color. Denies the relationship between urination and umbilical discharge.

Skin: Reports redness and crusting around umbilicus with green discharge. Denies redness, drainage, or pain at other surgical sites.

Cardio/Pulm: Denies chest pain, SOB, palpitations

Endo: Denies cold/heat intolerance

Heme: Denies easy bruising or bleeding

Neuro: Denies dizziness, weakness or numbness

Psych: Denies anxiety or depression

Physical Exam
Vital Signs:
Temp: 98.2° F
HR: 76 bpm
BP: 118/68 mmHg
SpO_2: 99% RA
Height: 59 in
Weight: 105 lbs
BMI: 21.21

Physical:

GENERAL: Alert and oriented x3, well-appearing, in no acute distress
HEAD: normocephalic, atraumatic.
EYES: pupils equal, round, reactive to light and accommodation.
EARS: normal.
NOSE: nares patent, no lesions, septum intact.
ORAL CAVITY: mucosa moist.
THROAT: clear.
NECK/THYROID: neck supple, full range of motion, no cervical lymphadenopathy.
LYMPH NODES: no lymphadenopathy.
SKIN: no suspicious lesions, warm and dry. Well healed scars on right and left lower Quadrant from appendectomy
Heart: Regular rate and rhythm, normal S1/S2, no murmurs.
Lungs: Lungs clear to auscultation bilaterally.
Abdomen: Soft, non-distended; bowel sounds present. Umbilicus is prominent and red with mild swelling; non-tender to palpation. Also with remnants crusting around the umbilicus. Well healed scars on Right and Left lower Quadrant from appendectomy
RECTAL: not examined.
BACK: straight.
MUSCULOSKELETAL: normal strength x 4 extremities Active and passive ROM intact
Extremities: No clubbing, cyanosis, or edema
Neurologic: Motor strength and sensory exam intact
Psych: Denies depression, anxiety, or recent stress

Assessment

This 10-year-old presents after hospitalization discharge 2 days ago with green umbilical discharge, a crusty and red umbilicus, and abdominal pain 6 months after laparoscopic appendectomy for appendicitis with peritonitis, with a history of constipation and a negative CT scan. The negative CT significantly reduces the likelihood of intra-abdominal abscess or large enterocutaneous fistula but does not exclude superficial port-site complications or small congenital tract anomalies.

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too small or superficial to detect on CT. These present with persistent drainage and local inflammation months after surgery. The green discharge represents purulent material draining from the granuloma.

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Plan:

1) **Umbilical Drainage – Post Laparoscopic Surgery**
    a) Likely umbilical port-site infection or cellulitis
    b) Start Mupirocin Ointment 2%: Apply externally twice a day for 5 days
    c) Obtain wound culture and Gram stain
    d) Obtain urinalysis
    e) CBC, CMP and CRP if systemic symptoms present
    f) Order high-resolution Ultrasound if symptoms persist to rule out urachal anomalies or deep fluid collections missed by *(CAN'T DO IN OFFICE)*
    g) Fistulography if fistula suspected and ultrasound inconclusive *(CAN'T DO IN OFFICE)*
    h) Local wound care with gentle cleansing and keeping area dry
    i) Refer to pediatric surgery if congenital tract or fistula identified
2) **Abdominal Pain**
    a) Likely multifactorial (constipation, periumbilical inflammation, functional pain)
    b) Monitor for worsening pain, vomiting, or peritoneal signs
    c) Reassess in 48–72 hours
3) **Constipation**
    a) Start polyethylene glycol 3350 for maintenance
    b) Encourage hydration and regular toileting habits
4) **Cardiac Management:**

    a) Refer to Pediatric Cardiology (Dr. Jayendra Sharma) for evaluation of Atrial Septal Defect
5) **Follow-Up**
    a) Close follow-up within 48–72 hours
    b) Return sooner for fever, bilious vomiting, bloody stools, or worsening pain

Prevention

1) Educate caregivers on early signs of post-appendectomy complications (worsening abdominal pain, fever, bilious vomiting, umbilical erythema or drainage) and advise prompt medical evaluation.
2) Prevent constipation with daily polyethylene glycol, adequate hydration, fiber intake, and regular bowel habits to reduce abdominal pain, wound stress, and secondary complications.

Abigail Chen PA-S