Lily Fremaux
Surgery Rotation H&P 1
03/27/2026

Name: A.M.
DOB: 12/18/1959
MRN: ########
Location: Queens Hospital Center- NYC Health and Hospitals
Date of Service: 03/20/2026
Source of information: Self
Reliability: Reliable
Address: Jamaica, NY

HPI

66 y/o male with a PMHx of HTN (not on medications) and right inguinal hernia, current smoker, presents to the ED with sudden onset right testicular mass and pain. In 06/2025 of last year, patient presented to the ED with a reducible inguinal hernia and was referred to the surgery clinic for further management. Patient states that he did not follow-up with the clinic, as he missed his initial appointment. States that since then the bulge has come and gone and that he has been able to push it back in. Today at work (in construction) patient was lifting something heavy (40 pounds) when he had sudden onset right testicular pain and mass with inability to reduce, approximately 4 hours prior to arrival. Associated with nausea and one episode of emesis. Patient reports that he has urinated and passed his bowels prior to onset of pain today. States that he last ate at 8:00am today, a donut and some coffee.

PMHx: HTN, right inguinal hernia
PSHx: Denies
Medications: None
Social history: Current smoker (less than a pack per day for 10 years). Denies EtOH or drug use. Works in construction.
Allergies: Denies allergies, including no known drug allergies

ROS
GI: Endorses nausea and vomiting. Denies constipation.
GU: Endorses right testicular mass and pain. Denies urinary retention.

Physical Exam:

Vital signs:

BP: 133/85
Pulse: 76bpm
Temperature: 97.5F PO
Respiratory rate 18 breaths per minute
SPO2: 98%

General: Uncomfortable appearing thin man in pain. Non-toxic appearing. Not disheveled or malodorous.

Cardiovascular: Regular rate and rhythm.

Pulmonary: Normal effort and in no respiratory distress. Speaking clearly with tachypnea. Lungs clear to auscultation bilaterally.

Abdominal: Right lower quadrant tenderness without rebound or guarding, no distension

GU: Large right-sided testicular mass approximately 7 x7 cm that is hard to touch and irreducible with associated tenderness. No overlying erythema.

Assessment:
66 y/o male with a PMHx of known right inguinal hernia presenting with acute-onset right-sided testicular pain with associated irreducible mass after heavy lifting along with nausea and vomiting. On an exam, patient with a large irreducible right 7 x 7cm scrotal mass with tenderness that is hard to touch and without overlying erythema.

DDx:
Most likely:
Indirect right inguinal hernia, incarcerated vs strangulated
Direct right inguinal hernia, incarcerated vs strangulated

Also consider:
Bowel obstruction secondary to hernia
Testicular torsion
Incarcerated femoral hernia
Orchitis
Epididymitis
Varicocele

Plan:
4mg Odansetron (Zofran)
2mg Morphine every 4 hours as needed for pain
Another attempt at reduction after analgesia
Pantoprazole for GI prophylaxis
IV antibiotics (cefazolin) and cefoxitin
IV fluids (LR)
CT abdomen/pelvis with IV contrast
Labs including CBC, CMP, PTT, PT/INR, Type and screen, POC glucose, UA with reflex
EKG

Results:

CT:

Findings: right inguinal hernia measuring 5.2cm x 7.1cm containing cecum and ascending colon including the terminal ileum. No significant bowel wall thickening. No intestinal pneumatosis. Small amount of simple fluid in the hernia sack.

Impression: Right inguinal hernia with small amount of simple fluid in the hernia sac. There is no evidence of intestinalis pneumatosis or significant bowel wall thickening to suggest complicated hernia.

Labs:

- CBC:
    - WBC normal
    - RBC 3.93 (4.70-6.10)
    - Hgb 12.2 (14-18
    - Hct 37.7 (42-52)
    - Neutrophil 90.5 (44-70)
    - Lymphocyte 7.0 (20-45)
    - Eosinophil 0.1 (1.0-4.0)
    - Neutrophil Abs 7.83 (2.10-7.60 x10^3)
    - Lymphocyte Abs 0.61 (1.00-4.90 x10^3)
    - Eosinophil Abs 0.01 (0.10-0.40 x10^3)
    - Interpretation: Anemia. Elevated neutrophils indicate possible acute stress, inflammation, and/or infection
- CMP:
    - Glucose 128 (74-110)
    - Calcium 10.5 (8.6-10.3)
    - ALK Phos 92, ALT 14, AST 17
    - Anion Gap 11
    - BUN 10
    - Creatinine 1.05
    - eGFR 78

Surgical intervention: Right inguinal hernia repair with possible exploratory laparotomy, possible colectomy, possible ostomy placement

Under anesthesia an open repair was pursued. Indirect hernia was reduced with minimal difficulty. The hernia sac was identified and opened to find serous ascites with no bowel or other intraabdominal contents at that time along with the sac having severe scarring with cord structures.The sac was removed. Team discussed and opted not to place Mesh at this time, as there was concern for bacterial translocation as patient with serous ascites and increased neutrophil count at this time.

Post-op Plan:

Analgesics with Acetominophen-codeine

Antibiotics with Cefazolin IV infusion 2,000mg once

Diet of clear liquids and advance as tolerated
DVT prophylaxis with subcutaneous Enoxaparin (Lovenox) and encouragement of early ambulation
Incentive spirometer
Possible Colace for constipation
Patient education regarding the importance of follow-up in surgery clinic for mesh placement to reduce risk of recurrence

Patient discharged 03/22/2026. During hospital stay patients remained a-febrile and tolerating PO. Plan to send PO pain medication and stool softener to pharmacy with follow-up in clinic on 04/10/2026.