Aisef Ahmed
Rotation #4 - OB/GYN

H&P #1

Identifying Data:
Full Name: A.J
Address: Brooklyn, NY
Date of Birth: 03/15/1998
Location: Woodhull Hospital
Religion: Christian
Source of Information: self
Reliability: reliable
Mode of transport: car
Race: African American
Marital status: single
Chief complaint: Abnormal menstrual bleeding x 3 months

History of Present Illness:

28 year old G0P0000 female with a past medical history of type 2 diabetes mellitus, hypertension, hyperlipidemia, and obesity, BMI 37.5 with known PCOS and Mirena IUD insertion one year ago, presents with progressively worsening dysmenorrhea, heavy menstrual bleeding, and abnormal bloating for the past 3 months. Patient describes the pain as dull and pressure-like, rated 6/10 in severity. The pain occurs both during menses and intermenstrually and is exacerbated by movement. She reports significant improvement with Tylenol and heating pads. She endorses heavy bleeding requiring frequent pad changes, soaking through pads 5-6 times per day during her menstrual cycle. The last reported menstrual cycle was on April 5 and ended approximately on April 9. The patient has endorsed additional symptoms associated with abnormal bleeding, including bloating, headache, dizziness, and fatigue. She denies nausea, vomiting, fever, chills, foul-smelling vaginal discharge, or pain with intercourse. She is currently taking Metformin and Mirena IUD. She has not had any recent IUD string check or imaging.

Differential diagnosis

1. Mirena IUD-related Abnormal Uterine Bleeding: The patient's new onset of heavy menstrual bleeding and dysmenorrhea starting 3 months ago, one year after Mirena IUD insertion, raises strong concern for IUD-related bleeding. This is especially common in patients with PCOS and obesity. Pain occurring both during and outside menses, with associated bloating, is consistent with this diagnosis. Pelvic ultrasound is the test of choice to confirm IUD placement and rule out other intrauterine pathology.
2. Endometriosis: In this 28-year-old patient with PCOS, worsening dysmenorrhea, heavy menstrual bleeding, intermenstrual pain, and new bloating are highly suggestive of endometriosis. The dull

pressure-like pain that is only partially responsive to analgesics is common. Transvaginal ultrasound is indicated, with possible diagnostic laparoscopy if symptoms persist.

3. Adenomyosis: The combination of heavy menstrual bleeding, dysmenorrhea, and pelvic pressure with bloating in this 28-year-old obese patient raises concern for adenomyosis. This condition commonly coexists with PCOS. Pain occurring outside of menses further supports this diagnosis. A transvaginal ultrasound or pelvic MRI would be useful for further evaluation.
4. Uterine Fibroids or Endometrial Polyps: Structural causes such as uterine fibroids or endometrial polyps are common in reproductive-age women with heavy menstrual bleeding and pelvic pressure. Obesity and PCOS increase the risk. The patient's report of frequent soaked pads and dull pressure pain makes these important considerations. Pelvic ultrasound is the initial imaging study of choice.

Past Medical History:

- Type 2 Diabetes Mellitus,
- Hypertension,
- Hyperlipidemia,
- Obesity (BMI 37.5),
- Polycystic Ovary Syndrome.

Ob/Gyn:
Menarche: 11
Vaginal deliveries: denies
Pregnancy terminations: denies
Cesarean sections: denies
Spontaneous abortions: denies
Ectopic pregnancies: denies
Menstrual flow: Heavy
Contraception: Oral contraceptive pills and Mirena IUD
Pregnancy: G (0) P (0) A (0) Miscarriage (0) L (0)

LMP: 04/05/2026

Past Surgical History: Mirena IUD insertion (1 year ago)

Medications:

- Metformin 500 mg twice daily
- Amlodipine 5 mg daily
- Atorvastatin 40 mg twice daily

Allergies:

Denies any food, environmental, or drug allergies.

Family History:

Mother - Alive at 46 (HTN, DM2)
Father - Alive at 55 (DM2, HTN, HLD)
Children - none
Grandparents – deceased (unknown medical history and age)
Siblings - none

Social History:
Lives with her boyfriend in an apartment. Patient works as a social worker

Habits –
Cigarette/Substance Use: Smokes marijuana and vapes.
Alcohol: Drinks alcohol occasionally on weekends for special occasions.
Travel – Denies recent travel.
Transfusions- Patient denies any history of transfusions.
Diet – Poor diet consisting of fast food, processed snacks, and sugary drinks.
Exercise – She reports walking approximately 8,000 steps per day but denies engaging in formal exercise.
Safety measures – She wears a seatbelt while in a car.

Sexual Hx – Currently sexually active with one male partner. Reports a history of sexual activity with both men and women. No barrier protection, takes Oral contraceptives, and has an IUD inserted.

Review of Systems:

General: reports headache, dizziness, fatigue, and bloating. Denies weight loss, chills, night sweats, or recent illness.
Skin: Denies rashes, itching, or color changes. No vaginal or perineal skin changes reported.
HEENT: Reports headache. Denies visual changes, ear pain, nasal congestion, sore throat, or oral ulcers.
Pulm: Denies cough, hemoptysis, or shortness of breath.
CV: Denies chest pain, palpitations, orthopnea, or edema.
GI: Endorses abnormal bloating. Denies nausea, vomiting, constipation, diarrhea, blood in stool, appetite changes, or jaundice.
GU: Denies dysuria, hematuria, flank pain, urgency, frequency, incontinence, or dyspareunia. reports excessive bleeding during menstrual cycle, approximately 5-6 pads per day, which were soaked through, with no clotting.
MSK: Denies joint pain, swelling, muscle aches, or back pain.
Neuro: Reports dizziness. Denies numbness, tingling, or balance issues.
Heme: Denies easy bruising, bleeding, or history of blood disorders.
Endo: Denies heat or cold intolerance, polydipsia, or polyuria.
Psych: Denies depression, anxiety, mood changes, or suicidal ideation.

Physical Examination

Vital Signs: T: 97.5 F | HR: 73 bpm | BP: 132/84 mmHg | SpO2: 100% on RA | Wt: 63.3 kg | Ht: 65 in | BMI: 37.5

General: Well-developed, obese female in no acute distress, appears stated age. Mild fatigue noted.

Skin: Warm, dry, intact. Mild pallor of the skin and nail beds was noted. No rashes, bruising, or ulcerations.

Cardiovascular: Regular rate and rhythm. Mild tachycardia present. No murmurs.

Respiratory: Lungs clear to auscultation bilaterally. No wheezes, rales, or rhonchi.

HEENT: Normocephalic, atraumatic. PERRLA, EOMI. Pale conjunctiva noted bilaterally. Oral mucosa moist. No pharyngeal erythema.

Neck: Supple, full range of motion. No thyromegaly.

Lymphatic: No cervical, axillary, or inguinal lymphadenopathy.

Abdomen: Soft, obese, with mild suprapubic tenderness to palpation. No guarding or rebound tenderness. Palpable uterine fundus at the level of the umbilicus. No hepatosplenomegaly.

GU:

Vulva: Normal external genitalia, no lesions, no atrophy.

Vagina: Pink and well-vascularized mucosa, no abnormal discharge.

Cervix: cervical os closed, no cervical motion tenderness, no lesions.

Uterus: Enlarged and irregularly contoured to approximately 12-14 week gestational size, firm, mobile, nontender.

Adnexa: No adnexal masses or tenderness bilaterally.

MSK: Full range of motion. No joint swelling or tenderness.

Neuro: Alert and oriented x3. CN II-XII intact. Strength 5/5 in all extremities. Normal gait.

Psych: Mood and affect appropriate. No acute distress.

Labs

CBC with Differential

- WBC: 7.9 $\times 10^3$/uL
- RBC: 4.18 $\times 10^6$/uL
- Hemoglobin: 10.9 g/dL (low)
- Hematocrit: 31.2% (low)
- MCV: 72 fL (low)
- MCH: 23 pg (low)
- RDW: 16.8% (high)
- Platelets: 368 $\times 10^3$/uL

Iron Studies

- Ferritin: 8 ng/mL (low)
- Serum Iron: 28 µg/dL (low)
- TIBC: 452 ug/dL (high)
- Transferrin Saturation: 6% (low)

Comprehensive Metabolic Panel (CMP)

- Sodium: 138 mEq/L
- Potassium: 4.0 mEq/L
- Chloride: 102 mEq/L
- Bicarbonate: 24 mEq/L
- BUN: 13 mg/dL
- Creatinine: 0.9 mg/dL
- Glucose: 146 mg/dL (elevated)
- Calcium: 9.2 mg/dL
- AST: 20 U/L
- ALT: 24 U/L
- Alkaline phosphatase: 76 U/L
- Total bilirubin: 0.5 mg/dL

Hemoglobin A1c : 7.4%

Thyroid Studies : TSH: 2.1

Pregnancy Test: Serum beta-hCG: Negative

Coagulation Panel

- PT: 11.8 sec
- INR: 1.0

- aPTT: 30 sec

STI Screening

- Gonorrhea/Chlamydia NAAT: Negative
- HIV Ag/Ab: Negative
- RPR: Nonreactive

Imaging

Transabdominal and transvaginal pelvic ultrasound:

Findings: The uterus is enlarged and measures 14.1 x 8.9 x 9.4 cm. Uterine contour is lobulated and heterogeneous due to multiple fibroids.

- Dominant posterior intramural fibroid measuring 6.3 x 5.7 x 5.2 cm
- Anterior submucosal fibroid measuring 3.4 x 3.1 x 2.9 cm, causing distortion of the endometrial cavity
- Fundal subserosal fibroid measuring 2.7 x 2.4 x 2.5 cm

Impressions

Enlarged fibroid uterus with multiple leiomyomas, including a submucosal fibroid distorting the endometrial cavity. Findings likely contribute to heavy menstrual bleeding and pelvic pressure symptoms. Mirena IUD remains within the uterine cavity in the expected position. Bilateral ovarian morphology compatible with PCOS.

Assessment:

28-year-old G0P0 female presents with 3 months of progressively worsening heavy menstrual bleeding, dysmenorrhea, pelvic pressure, and bloating in the clinical setting of obesity, PCOS, and known Mirena IUD use. Associated symptoms include fatigue, dizziness, and headaches. Examination is notable for pallor, mild tachycardia, suprapubic tenderness, and an irregularly enlarged uterus approximately 14 weeks in size. Laboratory studies reveal microcytic iron deficiency anemia secondary to chronic blood loss. Pelvic ultrasound demonstrates an enlarged fibroid uterus with multiple leiomyomas, including a submucosal fibroid distorting the endometrial cavity. Based on clinical history, physical findings, and imaging results, there is a strong suspicion of symptomatic uterine fibroids causing abnormal uterine bleeding, dysmenorrhea, and secondary iron deficiency anemia.

Plan

#Symptomatic Uterine Fibroids with Abnormal Uterine Bleeding

- Gynecology referral for management of symptomatic fibroids
- Discuss uterine-sparing vs procedural options, including:
    - Hysteroscopic myomectomy (submucosal fibroid)

    - Uterine artery embolization
- Referral for pelvic MRI for surgical planning and fibroid mapping
- Continue Mirena IUD (correctly positioned) for endometrial suppression

Iron Deficiency Anemia (secondary to chronic blood loss)

- Start oral iron supplementation (ferrous sulfate 325 mg PO every other day or daily as tolerated)
- Start vitamin C supplements to enhance absorption
- Counsel on constipation prevention (fiber, stool softeners PRN)
- Repeat CBC and iron studies in 2-3 weeks

Abnormal Uterine Bleeding (Symptomatic Management)

- NSAIDs (e.g., ibuprofen during menses) for pain and prostaglandin reduction
- Continue supportive measures (heating pads, hydration)
- Monitor bleeding severity
- Return precautions: soaking >1 pad/hour, syncope, worsening dizziness

#Type 2 Diabetes Mellitus

- Continue metformin 500 mg BID; consider titration as tolerated
- Discuss dietary modification (low-carbohydrate, reduced sugary beverages)
- Continue home glucose monitoring
- Discuss the Goal of A1c <7%

Hypertension

- Continue amlodipine 5 mg daily
- Encourage home blood pressure monitoring
- Lifestyle modification with a structured weight loss program, including diet and resistance training
- Re-evaluate Blood pressure 4-6 months and determine if Blood pressure remains elevated, add a second Anti-hypertensive medication, i.e., HCTZ

Hyperlipidemia

- Encourage a diet low in saturated fats and high in fiber
- Encourage regular physical activity
- Repeat lipid panel in 3–6 months

Obesity (BMI 37.5) with PCOS

- Lifestyle modification with a structured weight loss program, including diet and resistance training
- Continue metformin for insulin resistance and PCOS-related metabolic benefit

- Refer for bariatric surgery evaluation for gastric bypass consideration, given the patient has a BMI >35 with multiple comorbidities (T2DM, HTN, HLD, PCOS).