Identification:

Full name: [redacted]

Sex: Female

Race: White

Language: English

Religion: N/A

Date of Birth & Age: [redacted], 41 YO

Marital status: single

Date and time: 9/16/25, 9:30AM

Location: NY Presbyterian Queens Hospital

Source of history: self

Reliability: reliable

Referral source: self

Chief of complaint: "I have this really bad lower stomach pain" x 1day

History of present Illness:

[redacted] is a 41-year-old female with a past medical history of IBS, hypothyroidism, and CLL who presents to the ER with abdominal pain for the past day**.** She reports the pain began yesterday morning and gradually worsened throughout the day, then dissipated around 3 AM. Initially, the pain was diffuse, later localizing to the right lower quadrant. She describes the localized pain as "sharp" and "fist-like," rated 7/10, and exacerbated by standing or bending forward. She took four doses of Pepto Bismol and three doses of over-the-counter ibuprofen, with the last doses approximately 10 hours ago. She notes this pain is different from her usual IBS episodes and has never occurred before. Currently, she reports no abdominal pain in the ER. She admits to constipation and bloating on Saturday, with her last bowel movement yesterday afternoon, described as normal. She admits to loss of appetite due to the pain, with her last oral intake last night. She denies fever, weight loss, trauma, oral ulcers, dysphagia, chest pain, palpitations, SOB, nausea/vomiting, skin changes, hematochezia, hematuria, history of kidney stones, dysuria, or dysmenorrhea. Last menstrual period was July 31.

Past medical history:

IBS

Hypothyroidism

Chronic lymphocytic leukemia

Vaccination up to date (specifics unknown to patient)

No history of colonoscopy or mammogram screening

Past surgical history:

Pancreatic pseudocyst drainage (2022)

Denies blood transfusions

Medications:

Clonazepam PO for IBS (dosage specific unknown)

Pepto Bismol PO chewable (525mg)

Ibuprofen PO (200mg)

Levothyroxine sodium (PO) (25mcg)

Allergies:

Sulfa drugs
- Reaction: rash

Family history:

- Mother: Alive, PMHx of ovarian cyst, Hashimoto's
- Father: Deceased, cause of death from CAD, PMHX of HLD
- Siblings: N/A
- Grandparents: PMHx specifics of maternal and paternal grandparents unknown to patient
- No children

Social history:

- Habits: No smoking, alcohol, or illicit drug use.
- Travel: No recent travels
- Marital history: Single
- Living: Living alone, no pets
- Occupational history: Employed – publisher
  Diet: Usually 2-3 meals per day. Morning usually consists of eggs, toast and herbal tea. Lunch usually is either a turkey or chicken sandwich. Dinner usually consists of protein (salmon, chicken), rice, and vegetables (green beans, carrots, bell peppers). Patient states she had no appetite for dinner last night because of the abdominal pain.
- Sleep patterns: Average 7-8 hours, denies taking medication for sleep. Patient states she was unable to sleep last night because of the abdominal pain.
- Exercise: Patient sometimes go on 15-30 minutes walks around local park. No shortness of breath or exercise intolerance.
- Safety measures: Admits to wearing seatbelts and helmets
- Sexual history: Heterosexual female. Not currently sexually active. Denies history of STDs and use of OCPs

Review of systems:

General: Admits to loss of appetite last night due to severe abdominal pain. Denies recent weight loss/gain, fatigue, fever, chills and night sweats

Skin, hair, nails: Reports dry hair texture. Denies skin dryness, discolorations, pigmentation, moles, rashes, pruritus, change in hair distribution, nail pitting.

Head: Denies headache, vertigo, or head trauma.

Eyes: Denies use of glasses, blurring, diplopia, scotomas, halos, lacrimation, photophobia, pruritus. Last known eye exam specifics unknown to patient.

Ears: Denies hearing loss, tinnitus, pain and discharge from ear or use of hearing aids

Nose/Sinuses: Denies discharge, epistaxis and obstruction

Mouth and throat: Denies bleeding gums, sore tongue, mouth ulcers and voice changes. Last dental exam was 1 year ago, specifics unknown to patient. Denies use of dentures.

Neck: Denies localized swelling, lumps, stiffness or decreased range of motion

Breast: Denies nipple discharge, pain, swelling, breast lumps. Denies history of mammogram screening

Pulmonary: Denies dyspnea, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular: Denies chest pain, HTN, palpations, irregular heartbeats, murmurs, syncope, edema, leg swelling.

GI: Admits diffused pain for the past day which later localized to a “sharp” and “fist-like” right lower abdominal pain. Currently present with no pain in ER. Admits to constipation and bloating last Saturday. Last bowel movement was yesterday afternoon, described as normal. Denies nausea, vomiting, dysphagia, diarrhea, jaundice, hemorrhoids, rectal bleeding, blood in stool. No history of colonoscopy or stool exam.

GU: Denies urinary frequency/urgency, nocturia, oliguria, polyuria, blood in urine, dysuria, incontinence, flank pain, awakening at night to urinate.

Menstrual: Menarche 15y/o. LMP July 31st. Denies active pregnancy or previous pregnancies. Denies history of STDs and OCPs use. Currently, not sexually active. Denies dysmenorrhea, metrorrhagia, vaginal discharge.

Nervous system: Denies seizures, headache, loss of consciousness, sensory disturbances, changes in cognition/memory, ataxia, loss of strength or weakness

Musculoskeletal: Denies muscle/joint pain, muscle or done deformity, swelling, redness, arthritis or straining.

Peripheral vascular system: Denies varicose veins, color change of lower extremities, claudication, coldness of lower extremities or peripheral edema, peripheral edema

Hematologic system: Denies anemia, easy bruising/bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE

Endocrine system: Admits to cold intolerance. Denies changes in facial of body hair, excessive hair growth.

Psychiatric: Denies depression, anxiety, suicidal ideations, feeling of helplessness, difficulty concentrating, mood changes, use of psychiatric medication or history of seeing a mental health professional

Physical

General: [redacted] is a middle-aged white female of average stature who appears well groomed. Her general appearance is consistent with her stated age. She is A&Ox3 awake, alert and oriented.

Vitals:

Blood pressure	Left	Right
Seated	120/70	124/72 (done on family)
Supine	126/74 (done on family)	122/70 (done on family)

HR: 72 beats/min, strong and regular

RR: 18 breathes/min, unlabored and regular

Temp: 97.4 °F, (thermometer)

SpO2: 99% room air

Height: 5 ft 10 in. Weight: 142 BMI: 20.4

Head: Normocephalic, atraumatic with no signs of contusions, ecchymoses, hematomas or lacerations. Nontender to palpation.

Hair: Smooth hair texture. No lice, lesions, moles, scaliness or male pattern baldness noted.

Skin: warm, moist, good turgor. No lesions, moles or scars noted.

Nails: No clubbing, pitting, spooning, cyanosis, lesions. Cap refill < 2 secs upper & lower extremities.

Eyes: symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink. No palpebral lesions, erythema or edema. No swelling or tenderness of lacrimal apparatus.

Visual acuity:

Uncorrected – 20/30 OS, 20/30 OD, 20/30 OU

Visual fields - full OU. PERRLA, EOMs intact with no nystagmus

Fundoscopy: Red reflex present OU. Cup to disk ratio <0.5 OU. Negative AV nicking, copper wiring, cotton-wool spots, hemorrhages, exudates, or neovascularization OU

Ears: symmetrical and appropriate in size. No external discoloration, lesions, masses, or evidence of trauma. No discharge or foreign bodies in external auditory canals AU. TMs are pearly white and intact with cone of light reflex in good position AU. No perforation, swelling, effusions of TMs AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne reveals AC>BC AU

Nose: Symmetrical. No deformities, redness, lesions, swelling. Nasal bridge midline. No external trauma. Nares patent bilaterally. Nasal mucosa pink and well-hydrated. Septum midline with no lesions, deformities, perforation. No foreign bodies noted. No discharge noted on rhinoscopy.

Sinuses: Nontender to palpation and percussion over bilateral frontal, maxillary and ethmoid sinuses. Sinuses clear upon trans-illumination.

Mouth and pharynx

Lips – Pink, moist, no cyanosis or lesions. No tenderness to palpation

Oral Mucosa – Pink, well-hydrated. No masses or lesions or leukoplakia noted. Nontender to palpation

Palate – Pink and well-hydrated. Normal rise of soft palate. No apparent lesions or masses noted. Nontender to palpation and intact

Teeth – Good dentition. No dental caries noted.

Gingivae – Pink and moist. No hyperplasia, masses, discharge, bleeding, erythema or lesions noted. Nontender to palpation.

Tongue – Pink, well- hydrated. Well papillated. No masses, lesions or deviation. Nontender to palpation

Oropharynx – Well-hydrated. No exudates, masses, lesions or erythema. Tonsils are present (grade 2) with no erythema, exudates, masses or lesions Uvula is midline with no lesions, masses. Gag reflex present.

Neck – Trachea midline. No obvious lesions, masses, scars. Supple and nontender to palpation. Full range of motion. No palpable adenopathy noted.

Thyroid – Non tender to palpation. No palpable nodules. No bruits noted. Thyroid swallowing test normal.

Thorax & Lungs: Normal regular unlabored breathing rate. Lat: AP diameter is 2:1. No apparent chest lesions, deformities, trauma, or accessory muscle use. Trachea midline. Vesicular lung sounds. Clear to auscultation bilaterally. Chest expansion symmetrical. NO adventitious sounds bilaterally. Tactile fremitus symmetric throughout. Non- tender to palpations.

Breast & Axilla: Symmetric, no dimpling, no masses upon palpation, no tenderness noted on the breast tissue. Nipples symmetrical without discharge, lesions, tenderness on palpation. No palpable axillary nodes noted.

Heart: JVP is 2.5 cm above the sternal angle with the head of the bed inclined at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits or thrills. Regular rate and rhythm noted. Distinct S1 and S2 sounds. No murmurs, gallops noted. No noted S3 or S4.

No splitting S1, S2 or friction rubs appreciated. No tenderness on palpations. No large apparent pulsations with heartbeat.

Abdomen: Symmetric, non-distended. No discomfort or tenderness noted on palpation on all 4 quadrants. Negative tenderness on McBurney point or palpation. No scars, striae, or apparent pulsation noted. Bowel sounds are normoactive in all 4 quadrants. No aortic, renal or femoral bruits. Tympanic throughout, no hepatosplenomegaly to palpation. No CVA tenderness. No rebound tenderness or guarding noted.

Genitalia: Negative erythema or lesions on external genitalia noted. Vaginal mucosa is pink without inflammation or discharge. Cervix is pink, smooth without lesions or discharge. No cervical motion tenderness noted. Uterus is anterior, midline, non-tender and not enlarged. No adnexal tenderness or masses noted. Good vaginal tone.

Rectal: Rectovaginal wall intact. No lesions or masses noted. No external hemorrhoids, skin tags, ulcers, sinus tracts, fissures or erythema noted. Good sphincter tone noted. No tenderness upon palpation. No traces of blood or stool present in the anal canal.

Assessment:

41 y/o female patient with a PMHx of IBS, hypothyroidism and CLL, presenting with acute abdominal pain that initially began diffusely and later localized to the right lower quadrant before spontaneously resolving. Pain is sharp and rated as 7/10, worsened with movement and different from her IBS episodes. Associated symptoms includes loss of appetite, bloating and recent constipation. Denies fever, nausea, vomiting, diarrhea, urinary or gynecological symptoms. Currently, she is pain free in the ER.

DDx:

1. Acute appendicitis

   Rationale: Patient presents with classic migratory pain of appendicitis. Patient states she was constipated 3 days ago which can possibly be the cause of the appendicitis – fecalith obstruction. Although the pain has resolved and physical exam shows negative McBurney point tenderness, this does not exclude appendicitis. Further workup is needed to assess for possible perforation.

   Plan: CBC, ESR+CRP, Abd US

2. Ovarian pathology (ectopic pregnancy, cyst, torsion)

   Rationale: Patient is 41 y/o female who can still be consider in her reproductive age. Her LMP was almost 7 weeks ago, so ectopic pregnancy is a differential that must be rule out. Possible rupture or torsion of the ovaries are differentials as they can presents with sudden, severe pain in the lower abdomen.

   Plan: hCG test, pelvic US, UA

3. Kidney stones

Rationale: RLQ pain can indicate kidney stone in urethral passage. Physical examination and history show no hematuria, dysuria or flank pain. However, kidney stones may have been small enough to pass into the bladder, which spontaneously could have relieved her from the pain. Further workup is needed to exclude it.

Plan: UA with microscopy, US renal/bladder

4. IBS flare

   Rationale: Patient has a history of IBS. IBS often presents with recurrent abdominal pain with altered bowel habits. In this case, the patient reported constipation and bloating several days ago prior to onset of RLQ pain. IBS is usually relieved after defecation. Although patient's last bowel movement was yesterday afternoon and was described as normal, IBS patients can have normal appearing stool between symptomatic episodes. Patient, however, does report that this pain is different from her usual IBS episodes, making IBS a less likely differential but remains as one due to her history, bloating and constipation.

   Plan: diagnosis of exclusion

5. Mesenteric adenitis

   Rationale: Patient has a history of CLL which can cause mesenteric lymphadenopathy. This can mimic appendicitis and present as diffuse pain that localizes to the RLQ.

   Plan: Abd US followed by Abd CT once pregnancy is r/o

Plan

Dx workup:

Labs to order

- CBC → evaluate for leukocytosis and anemia
- CMP → evaluate electrolyte imbalances, liver and renal function
- CRP/ESR
- Serum hCG → rule out pregnancy/ectopic
- UA with microscopy → evaluate for crystals, red blood cells for kidney stones

Imaging

- Abd + pelvic US → assess for ectopic pregnancy, ovarian cyst/torsion/rupture, appendicitis, kidney stones

Management

- NPO
- IV fluids for hydration
- Acetaminophen PO PRN if pain recurs
- Zofran PO PRN if nausea develops

Consult

- General surgery
- OB/GYN
- Urology
- Hematology

Patient education

- If patient is stable and discharged, advise patient for close follow up and RTO if symptoms worsen
- Educate patient about the risk and complication of appendicitis and possible needed for an appendectomy if symptoms worsen.
- If appendicitis confirmed, consult surgery for appendectomy; discuss conservative antibiotics if surgery refused or contraindicated.”