Michael Tan

Woodhull General Surgery

SOAP NOTE # C

Course of illness:

Patient is a 59 y/o female with a PMHx of prediabetes who initially presented to Woodhull ED on 3/2/26 for c/o of periumbilical pain that radiated to the RLQ x 4 days. Patient reported that the pain started last Thursday where she later visited Wycoff Heights Medical Center and was told it was a side effect of her Ozempic medication. She was then discharged from Wycoff without further workup. Afterwards, she reported that her pain got progressively worse and was associated with N/V. She stated that she was also constipated and bloated since last Wednesday. Has not had a bowel movement since then. Reported subjective fever. Denied chest pain, SOB, night sweats, and chills. CT abdomen and pelvis was later done; showed thickening of the appendix, fat stranding, and a 3.3 cm rounded area of fluid attenuation adjacent to the appendix. Patient was then admitted into general surgery for management of acute appendicitis with possible abscess/fluid collection.

Subjective:

March 5th, 2026

59 y/o female with a PMHx of prediabetes admitted to general surgery for management of acute appendicitis and possible abdominal abscess/fluid collection. Seen at bedside this morning. She reports one episode of fever 101.1F overnight; was given Tylenol. No other acute events reported per nursing staff. Patient currently endorses mild pain in the RLQ, but otherwise pain is well controlled with ibuprofen. She is ambulatory and tolerating her general diet. As of this morning, denies fever, chills, nausea, vomiting, chest pain, and SOB.

Objective:

Vital signs:

Temp: 98.4 F

BP: 99/66

HR: 84

RR: 18

O2 sat: 95% RA

Physical exam:

General: Patient is alert and oriented x3 (time/person/place). Well-kept in hospital gown supine on bed.

Cardiovascular: regular rate and rhythm

Lungs: Respiration WNL. Unlabored respiration. No accessory muscle use noted. Lung sounds clear to auscultation bilaterally. Systematical chest rise.

Abdomen: symmetric, soft, non-distended, mild tenderness on RLQ, negative rebound tenderness, negative guarding, no masses noted.

Labs

	3/5/26	**3/4/26**	**3/3/26**
WBC	17.51	17.91	19.99
HGB	11.9	12.5	13.0
HCT	38.5	38.7	41.9
Platelets	373	392	361

	3/5/26	**3/4/26**	**3/3/26**
Na+	134	136	133
K+	3.8	3.9	4.1
Cl-	99	99	95
CO2	23	23	22
BUN	6	10	11
Creatinine	0.84	0.99	0.89
Ca+2	9.2	9.2	9.0

Intake/output (3/4-3/5)

Intake: 1,070 ml

PO: 240 ml

- water

IV: 830 ml

- Zosyn 100 ml (x3)
- Lactated ringer infusion 500 ml
- Sodium chloride 0.9% infusion 30 ml
- Dextrose 5% infusion 30 ml

Output: Unable to quantify

Urine occurrence: x4 times

Stool occurrence: x2 times

Assessment

59 y/o female with a PMHx of prediabetes admitted to general surgery for management of acute appendicitis and possible abdominal abscess/fluid collection. Patient reports mild tenderness on the RLQ. CBC lab shows WBC has been trending down from 19.99 to 17.91 then 17.51. No reports of fever, chills, N/V, chest pain or SOB this morning. Tolerating PO intake. Surgery team suspects fluid collection seen on CT may be an accumulation of residual inflammatory fluid due to inflammation, rather than a true abscess. Patient is hemodynamically stable Plan is to continue conservative management for appendicitis.

Plan:

- Observe and monitor vitals
- Pain control; Ibuprofen or Tylenol PRN
- Continue DVT prophylaxis; Heparin; ambulation as tolerable
- Continue IV Zosyn
- AM labs tomorrow
- Repeat CT imaging if symptoms worsens or up-trend of wbc
- Possible discharge tomorrow if patient is tolerable to PO intake and hemodynamically stable