Full name: [redacted]

Sex: Female

Race: Hispanic

Language: English

Religion: unspecified

Date of Birth & Age: [redacted], 13 Y/O

Marital status: Single

Date and time: 3/19/26, 9:30AM

Location: Queens Hospital Center

Source of history: Self with Spanish translator, ID 21793

Reliability: reliable

Referral source: self

Chief of complaint: Abdominal pain x 1 day

History of Present Illness:

13 y/o female with no significant self-reported PMHx presents to ED with mother c/o abdominal pain x 1 day. Pain began yesterday morning at lower abdomen with radiation to periumbilicus overnight. She reports she had generalized abdominal pain 2 weeks ago and went to NYP Queens at that time; thought to be a UTI and was started on antibiotics, then called back and told likely viral so medication was discontinued. She took Motrin which alleviated the pain, but it returns after a couple of hours. Pain worsens with bending towards the abdomen. No pain with walking. She reports that it has been constant throughout the yesterday. Currently, she rates the pain 8/10 and describes it as sharp. She reports nausea but no vomiting or diarrhea. Bowel movements has been normal; no blood in stool. Denies fever, chills, weight loss, constipation, chest pain, shortness of breath, dysuria, hematuria, sick contacts or recent travels. Denies ever being sexually active, vaginal discharge or bleeding. She is premenarchal.

Past medical history:

- No self-reported past medical history

Allergies

- NKA

Vaccines: up to date per mother

Past surgical history:

- No past surgical history

Medications:

- Motrin 200 mg

Family history:

- No reported family history

Social history:

Housing situation: Patient lives with mother, father. No exposure to tobacco smoke in home. No pets at home.

Daycare/school: Patient currently attends junior high school 8th grade. No complaints with school.

Travel: No recent travels

Diet: 3 meals per day with 2-3 snacks per day. Consumes balanced diet including fruits, vegetables, protein. No known food allergies or feeding concerns reported. Appetite is good with no recent changes.

Sleep: Average 8-10 hours per mother. Denies difficulty falling asleep.

Tobacco/drug use: Denies tobacco smoking and illicit drug use

Sexual activity: Sexually inactive

Review of systems:

General: Denies fever, chills, weight loss

Skin: Denies mass, moles, rash, skin discoloration

HEENT: Denies HA, dizziness, blurry vision, hearing loss, tinnitus, ear pain, sore throat

Respiratory: Denies cough, shortness of breath, or wheezing

Cardiovascular: Denies chest pain, palpitations, lower extremity edema

GI: Reports nausea and lower abdominal pain rated 8/10 at this time. Denies vomiting, hematochezia, melena, constipation, normal bowel movements and frequency

Genitourinary: Denies hematuria, changes in urine output

Menstrual: Premenarchal. Denies vaginal discharge or bleeding

Musculoskeletal: Denies muscle/bone pain.

Neurological: Denies seizures, loss of consciousness, peripheral weakness, paresthesia

Physical:

- Vital signs

- Temperature (F): 98.2 F oral
- Heart rate: 118
- Respiration rate: 20
- Blood pressure: 108/72
- SpO2%: 99% RA

General: Patient appears her stated age. She is not in acute distress. Normal appearance. Well kempt. She is not toxic appearing.

HENT: Atraumatic and normocephalic. No lice/nits noted on scalp. Tympanic membrane and external ear normal bilaterally. No nasal discharge noted. Nasal passage patent.

Eyes: pupils equal, round and reactive to light. No swelling, erythema, discharge noted.

Mouth: Oral pharynx clear. Mucous membranes moist.

Neck/throat: No lymphadenopathy

Cardiovascular: Regular rate/rhythm. No murmurs. S1/S2 normal

Pulmonary: Lung sounds clear to auscultation bilaterally. No wheezing, rhonchi, crackles. No respiratory distress. No accessory muscle use. No nasal flaring

Abdominal: Soft, non-distended. Symmetric. No guarding, rebound tenderness masses, scars noted. Mild tenderness noted on LLR quadrant.

Neurological: Patient is alert and oriented x3 to person, place and time. No focal deficit noted.

Skin: Warm and dry. Pink-flushed color.

Assessment

13-year-old premenarchal female with no significant past medical history presenting with acute lower abdominal pain for 1 day, described as sharp, constant, and rated 8/10, with associated nausea but no vomiting, diarrhea, urinary symptoms, or systemic complaints. Pain initially localized to the lower abdomen with radiation toward the periumbilical region. Vital signs notable for mild tachycardia, otherwise stable and afebrile. Physical exam demonstrates a soft, non-distended abdomen with mild left lower quadrant tenderness without guarding or rebound. Overall, patient is well-appearing and non-toxic. Given the acute onset of abdominal pain with associated nausea and localized tenderness, the presentation raises concern both gastrointestinal and gynecologic etiologies.

Differential diagnoses

1. **Appendicitis –** appendicitis can present with vague, poorly localized abdominal pain before migrating to the right lower quadrant. Although this patient has left lower quadrant tenderness, early or atypical presentations are common in pediatrics.
2. **Ovarian torsion –** ovarian torsion should be considered in females with acute lower abdominal pain even if premenarchal. It typically presents with sudden, severe unilateral

pian with associated nausea. Although this patient pain is more gradual and less severe in presentation, it is an important diagnosis to rule out due to risk of ovarian loss.

3. **Ovarian cyst –** ovarian cysts can present as unilateral lower abdominal pain. Even though this may be less common in premenarchal patients, there is a likelihood for an atypical occurrence. An important diagnosis to rule out to prevent rupture and hemorrhagic complications
4. **Gastroenteritis –** gastroenteritis, especially in its early stages, can present as abdominal pain with nausea even before vomiting or diarrhea. However, due to the absence of sick contacts, recent travels, diarrhea, systemic symptoms, this is less likely. However, still consider a differential due to increase cases of viral gastroenteritis seen in the ED lately.
5. **Recurrent UTI –** Despite no reports of dysuria, frequency, hematuria, systematic symptoms, UTI is less likely. However, due to history of suspected UTI, a recurrent UTI should still be ruled out with a UA

Plan

- Order labs
    - CBC with differential
    - BMP
    - CRP + ESR
    - POC urinalysis
    - Urine B-hCG test
    - LFTs
    - Prolactin
- Pain management
    - Tylenol
- Nausea management
    - Zofran
- Imaging
    - Transfer ultrasound to Cohen's children medical center