- Blood cultures
- Iron studies
- Zofran PRN
- Consult GI
- Will attempt to obtain OSH records regarding previous work-up

Anion gap metabolic acidosis: With elevated ketones and lactic acid at presentation. Concern for possibly DKA as well as mesenteric ischemia. Have subsequently improved with IVF and insulin. Evaluated by surgery and after review of the images, unlikely to have mesenteric ischemia.
- Management of DM as below

DM with hyperglycemia: Poorly controlled on two oral agents with fasting blood sugars of 260s and A1C of 10. Was previously on insulin but discontinued it. Followed by endocrinology at UIC.
- SSI
- Diabetic diet

HTN: Normotensive at presentation, but on lisinopril 40mg daily at home.
- Will resume lisinopril if hypertensive

F: No IVF
E: Replete PRN
N: Diabetic diet

Dispo: Pending further evaluation for abdominal pain, nausea and vomiting

RISK LEVEL
See Attending attestation for assessment of risk level.

Nathan Schoettler
PGY-1
Pager 1420

ATTENDING PHYSICIAN ATTESTATION

I saw and physically examined the patient on 6/23/2013 with **high** level of risk based on abdominal pain, jejunal inflammation, hyperglycemia. I agree with the assessment and plan of Dr. Schoettler as documented with the following comments: .

Pt with a 3 year history of relapsing/remitting abdominal pain s/p multiple workups including exploratory laporatomy, presenting with acute onset of abdominal pain and evidence of jejunal inflammation on CT scan. Will obtain previous records and discuss with GI regarding additional workup given previous concern for inflammatory bowel disease. Empiric antibiotics while awaiting cultures/stool studies and further diagnostic workup.

University of Chicago Medical Center 5841 S Maryland Chicago, IL 60637

Author:		Service:	GENERAL MEDICINE	Author Type:	ATTENDING
Filed:	1401	Note Time:		Note Type:	H&P

PGY-1 H&P

Medical Records Reviewed: **UCMC ER records**

CARE TEAM
Primary Care Physician:
Other physician provider(s):

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

Abdominal pain

HISTORY OF PRESENT ILLNESS
Patient is a 47Yrs female presenting with abdominal pain.
Abdominal Pain
Associated symptoms include nausea and vomiting. Pertinent negatives include fever, diarrhea, constipation and myalgias.

is a 47 year old female with a history of HTN, DM (A1C last week was 10) and chronic abdominal pain who presents with nausea, vomiting and abdominal pain. The patient states that at approximately 3PM the day prior to presentation, she developed acute-onset of colicky, epigastric abdominal pain that was 8/10 at presentation but has subsequently decreased to 2/10. After the onset of the abdominal pain, she developed nausea and four episodes of clear emesis. She says that during this time she has been having loose stools but no diarrhea and no blood in her stool. Shortly before the onset of her symptoms, Ms says that she ate some chicken salad at a lunch event, but says that nobody else, including her three children who at the same food, were having nausea or vomiting. She denies fevers, chills, weight loss, rash, joint pain, joint swelling or recent travel.

The patient reports that her current symptoms are identical to the symptoms that she has experienced over the last two years with three different hospitalizations and extensive evaluation without a confirmed diagnosis. She says that she has never been on prednisone or immunosuppression. Specifically she reports the following:
-10/2010: Presented to and underwent serial CT imaging with concern for inflammation.
-7/2012: Hospitalized at and taken for emergent exploratory laparotomy, reportedly with inflammed small bowel intraoperatively, no evidence of ischemia, no appendicitis and nothing that was surgically resected. Subsequent EGD and colonoscopy without diagnostic abnormality, but patient was told that she may have Crohn's disease.
-10/2012: Hospitalized at Again had serial imaging with small bowel abnormalities. Was told that she would need capsule endoscopy at the U of Chicago but she subsequently had improvement in her symptoms and never followed-up.

PAST MEDICAL HISTORY
Past Medical History

Diagnosis	Date
• HTN (hypertension)	
• Diabetes	

- Abdominal pain, chronic, epigastric

Past Surgical History

Procedure	Date
• Abdominal surgery	

History

Social History

- Marital Status: Married
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: None
- Alcohol Use: No
- Drug Use: No
- Sexually Active:

Other Topics	Concern
• None	

Social History Narrative

- None

Family History

Problem	Relation	Age of Onset
• Cancer - Gastric	Father	
• Renal Cell Carcinoma	Mother	

PRIOR TO ADMISSION MEDICATIONS

Prior to Admission Medications

Medication	Last Dose	Informant	Patient Reported?	Taking?
glimepiride (AMARYL) 4 mg Oral Tab 4 mg by Oral route every morning.			Yes	Yes
lisinopril (PRINIVIL) 40 mg Oral Tab tablet 40 mg by Oral route daily.			Yes	Yes
metFORMIN (GLUCOPHAGE) 1,000 mg Oral Tab tablet 1,000 mg by Oral route twice daily.			Yes	Yes

ALLERGIES AND DRUG REACTIONS

Allergies

Allergen	Reactions
• Penicillins	

CURRENT MEDICATIONS

Current IV Drips

• sodium chloride 0.9%	1,000 mL	Intravenous	CONTINUOUS

Current Scheduled Medications

• ciprofloxacin (CIPRO) 400 mg in D5W - 200 mL IVPB	400 mg	Intravenous	Q12H (09,21)
• enoxaparin	40 mg	Subcutaneous	Q24H
• insulin aspart	1-5 Units	Subcutaneous	Q6H
• lisinopril	40 mg	Oral	DAILY
• metronidazole (FLAGYL) 500 mg in 100 mL IVPB	500 mg	Intravenous	Q8H (05,13,21)

Current PRN Medications

• dextrose	25 g	Intravenous Push	Q20 MINUTES PRN
• morphine	2 mg	Intravenous Push	Q4H PRN
• ondansetron	8 mg	Intravenous Push	Q8H PRN

REVIEW OF SYSTEMS
Review of Systems
Constitutional: Negative for fever, chills, fatigue and unexpected weight change.
HENT: Negative for congestion.
Cardiovascular: Negative for chest pain, palpitations and leg swelling.
Gastrointestinal: Positive for nausea, vomiting and abdominal pain. Negative for diarrhea, constipation, blood in stool and abdominal distention.
Genitourinary: Negative for urgency and flank pain.
Musculoskeletal: Negative for myalgias and joint swelling.
Skin: Negative for rash.
Neurological: Negative for dizziness and light-headedness.
Psychiatric/Behavioral: Negative for confusion.
Otherwise negative

OBJECTIVE

Admission Height/Weight		***Admission Vitals:***

	LAST RECORDED VALUE (IF AVAILABLE)	24 HOUR RANGE (IF AVAILABLE)
Weight:		
Temperature:	**Temp: 36.1 °C (97 °F) (06/23/13 0904)**	*Temp: [36 °C (96.8 °F)-36.5 °C (97.7 °F)]*
Heart Rate/Pulse:	**Heart Rate/Pulse: 90 (06/23/13 0904)**	*Heart Rate/Pulse: [81-113]*
Blood Pressure:	**BP: 105/63 mmHg (06/23/13 0904)**	*BP: (89-123)/(56-76)*
Patient Resp:	**Resp: 18 (06/23/13 0904)**	Resp: [17-21]
Patient SPO2:	**SpO2: 98 % (06/23/13 0904)**	SpO2: [92 %-100 %]

Physical Exam
Constitutional: She appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Pupils are equal, round, and reactive to light. No scleral icterus.

Cardiovascular: Normal rate and regular rhythm. Exam reveals no gallop and no friction rub.
No murmur heard.
Pulmonary/Chest: Effort normal. She has no wheezes. She has no rales.
Abdominal: Soft. Bowel sounds are normal. She exhibits no distension and no mass. There is tenderness **(diffuse, worse over RUQ)**. There is no rebound and no guarding.
Musculoskeletal: She exhibits no edema and no tenderness.
Lymphadenopathy:
She has no cervical adenopathy.
Skin: No rash noted.
Psychiatric: She has a normal mood and affect.

INTAKE/OUTPUT DATA

Date		06/22/13 1500 - 06/23/13 0659(Not Admitted)			06/23/13 0700 - 06/24/13 0659			
Shift		1500-2259	2300-0659	24 Hour Total	0700-1459	1500-2259	2300-0659	24 Hour Total
INTAKE	IV Piggyback		2300	2300				
	Shift Total		2300	2300				
OUTPUT	Urine (mL/kg/hr)		500 (0.9)	500 (0.3)				
	Shift Total		500	500				
NET			1800	1800				
Weight (kg)		67.1	67.1	67.1	70.1	70.1	70.1	70.1

REVIEW OF LABORATORY DATA
I have reviewed the following:

Lab Component

Component	Value
WBC	17.8*
RBC	5.40*
Hemoglobin	13.6
Hematocrit	41.1
MCV	76.1*
MCH	25.2*
MCHC	33.1
RBC Dist Width	14.7
Platelet Count	350
Mean Platelet Volume	10.9

Lab Component

Component	Value
Glucose, Ser/Plasma	241*
Sodium	138
Potassium, Ser/Plasma	3.6
Chloride	105
Carbon Dioxide	19*
Anion Gap	14
BUN	11
Creatinine	0.8

GFR Estimate (Calc)	77
Calcium	7.3*
Bilirubin, Total	0.2
Total Protein	8.1
Albumin	4.5
Alk Phos, Serum	56
AST (SGOT)	19
ALT (SGPT)	12

Lab Component

Component	Value
PT	12.0
INR	0.9

Lab Component

Component	Value
Color	PALE YELLOW
Clarity	CLEAR
Specific Gravity, Ur	1.030*
pH, Ur	6.0
Leukocyte Esterase, Ur	Negative
Nitrite, Ur	Negative
Protein	2+*
Blood	Negative
Glucose	TRACE*
Reducing Substances	Test not performed
Ketones	2+*
Bilirubin	1+*
Urobilinogen	1.0

Lab Component

Component	Value
Lipase	136*

Lactic acid: 1.7 (down from 3.4)

REVIEW OF STUDIES & IMAGES

I have reviewed the following:

CT abdomen: Diffuse marked bowel wall thickening of the entire jejunum. Moderate generalized ascites. No intramural air or free air. Mesenteric vasculature enhances normally. Main differential diagnostic considerations include infection and ischemia. May be exacerbated by prior surgery in its appearance with lymphatics accounting for the increased ascites which would be atypical for both infection or ischemia.

ASSESSMENT & PLAN

47 year old female with relapsing abdominal pain, nausea and vomiting of unclear etiology.

Abdominal pain, nausea and vomiting: Has had three episodes necessitating hospitalization and extensive evaluation including ex-lap that appear to only be notable for having small bowel inflammation without known diagnosis. Pain had improved when admitted, but also CT with inflammation in jejunum. Also with elevated WBC in ED and concern for inflammatory process (infectious versus autoimmune). Lipase elevated, but not to the extent that would be expected for pancreatitis and no evidence of pancreatitis on CT imaging.

- Surgery consulted with serial exams
- Continue ciprofloxacin and metronidazole
- Fecal leukocytes and stool culture