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

[redacted]

Filed: [redacted] Note Time: [redacted] Author Type: ATTENDING

Related Notes: Original Note by: [redacted] filed at [redacted] Note Type: Consult (Initial)

GI Consult Initial Note

GI Consult Note

Date of Service: [redacted]

[redacted] is a 47Yrs Black/African-American female who was admitted on [redacted]

Reason for referral:
Abdominal pain, n/v, abnormal imaging of abdomen

HPI:
47 yo AAF with HTN, poorly controlled DM, multiple past admissions for abdominal pain with extensive w/u at OSH admitted to the general medicine service on [redacted] with c/o nausea/vomiting and abdominal pain x 1 day. Pt reports that on Saturday evening she suddenly developed abdominal discomfort. She describes the pain as intermittent, crampy, w/o any radiation. This was followed by nausea and 4-5 episodes of non bilious non bloody emesis. She reports eating out on Saturday but no sick contacts. She had leukocytosis, elevated lactic acid and an AG of 20 on arrival to the ED. She had a CT a/p with contrast which showed moderate ascites and marked jejunal thickening. She was seen by surgery team in the ED as well. She was managed conservatively and started on empiric antibiotics with resolution of her symptoms. Currently she denies any n/v/abd pain. She had some loose stools during the episode of abd pain but has not had a BM in more than 24 hrs. Passing flatus though.

Pt has been admitted at OSH 3 times in the past for similar complaints with spontaneous resolution of her symptoms at all times. Currently none of these records are available, so information is per pt recall. She was first admitted at OSH in Oct 2010 when a CT a/p showed SB inflammation. Subsequently admitted to [redacted] hospital in July 2012 when she was taken to the OR for exp laparotomy. She says no resection was done, and she was told that she had SB inflammation. She is not sure if any biopsies were taken. She also had an EGD and colonoscopy for concern for Crohn's disease during the same hospitalization, again not sure of the findings or path reports. Her 3rd admission was [redacted] in Oct 2012 when CT a/p showed SB thickening and she was told she would need to be transferred to UCMC for small bowel evaluation but she was discharged home after improvement in her symptoms.
She reports feeling well other than occasional nausea in between these episodes.

Past Medical and Surgical History
Past Medical History
Diagnosis — Date
- HTN (hypertension)
- Diabetes
- Abdominal pain, chronic, epigastric

Past Surgical History
Procedure — Date
- Abdominal surgery

Family History

[redacted]

Family History

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

Personal and Social History
History

Social History

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

Occupational History
- Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Not on file
• Alcohol Use:	No
• Drug Use:	No
• Sexually Active:	

Other Topics	Concern
• Not on file	

Social History Narrative
- No narrative on file

Allergies
Penicillins

Current Medications

Medication	Dose	Frequency
• ciprofloxacin (CIPRO) 400 mg in D5W - 200 mL IVPB	400 mg	Q12H (09,21)
• dextrose injection 25 g	25 g	Q20 MINUTES PRN
• enoxaparin (LOVENOX) injection 40 mg	40 mg	Q24H
• insulin aspart (NOVOLOG) injection 1-5 Units	1-5 Units	Q6H (03,09,15,21)
• lisinopril (PRINIVIL) tablet 40 mg	40 mg	DAILY
• metronidazole (FLAGYL) 500 mg in 100 mL IVPB	500 mg	Q8H (05,13,21)
• morphine syringe 2 mg	2 mg	Q4H PRN
• ondansetron (ZOFRAN) injection 8 mg	8 mg	Q8H PRN
• sodium chloride 0.9% IV 1,000 mL	1,000 mL	CONTINUOUS

[redacted]

ROS
All systems are negative except for the following:
Constitutional: Neg for weight loss, fatigue
Eyes: Neg for vision change
ENT: Neg
Pulmonary: Neg for shortness of breath, cough, sputum
Cardiac: Neg for chest pain
GI: As above
GU: Neg for hematuria
Musculoskeletal: Neg for swelling, redness, pain
Neuro: Neg for seizures, confusion
Psych: Neg for depression, anxiety
Endo: Poorly controlled DM
Skin: Neg for rashes
Heme: Anemia

Physical Examination
Blood pressure 133/77, pulse 83, temperature 36.4 °C (97.5 °F), temperature source Tympanic, resp. rate 18, height [redacted] weight [redacted], last menstrual period 06/08/2013, SpO2 98.00%..

GEN: Well developed, alert, oriented, NAD
EYES: anicteric sclerae, PERRL, EOMI
Head and Neck: Clear oropharynx, supple neck
LUNGS: Clear to ausculation bilaterally
CV: Regular in rate and rhythm, normal S1,S2, no murmur
ABDOMEN: soft, mild epigastric tenderness to deep palpation, well healed surgical scar, No free fluid on exam
EXT: No c/c/e, normal hand grip strength
NEURO: non focal, CNs intact, no asterixis
PSYCH: Normal affect, Denies SI/HI

Recent Labs

Last 24 Hours of Labs	[redacted]452
WBC	7.7
HGB	9.3*
HCT	28.3*
PLT	245
PGRA	Test not performed
GLUC	158*
NA	143
K	3.1*
CHLORIDE	107
CO2	22*
BUN	5*
CREAT	0.8
GFR	77
CALCIUM	7.9*
MAG	1.4*
BILTOTAL	--
TOTPROT	--
ALB	--
ALKPHOS	--
AST	--
ALT	--
PROTIME	--
INR	--

Impression and Recommendations:

[redacted]

47 yo AAF with HTN, poorly controlled DM with repeat episodes of severe abdominal pain, nausea and vomiting. CT imaging with significant thickening of jejunum and small amount of ascites. Possible etiologies include vascular /ischemic (? Vasculitides) vs inflammatory vs infectious. Less likely infiltrative but we are not sure if her imaging is normal when she is asymptomatic.

- currently abdominal exam is benign with resolution of symptoms
- can start CLD if ok with surgery team and advance as tolerated
- would recommend checking ESR, CRP, ANA, ANCA
- also recommend CTA and CTE (can discuss with radiology regarding getting both studies at the same time)
- please obtain OSH records especially operative notes, EGD and colonoscopy reports with path findings.
- if no obvious etiology ound, will consider EGD/push enteroscopy to obtain tissue for diagnosis (CT shows thickening of proximal jejunum which can be reached by push enteroscopy)

Discussed with primary team. Thanks for the consult.

[redacted]

RISK LEVEL
See Attending attestation for assessment of risk level.

I interviewed and examined the patient, and reviewed with [redacted] the history, exam, assessment, and plan with the following comments. See resident/fellow's notes for detail.

Small bowel wall thickening. Differential includes ischemia, inflammatory, infiltrative/malignant versus, less likely, infectious. Review previous records. Rule out large vessel abnormalities with CTA.

Risk level: High
Explanation of high risk: abnormal CT imaging; abdominal pain; nausea/vomiting

[redacted]