Farhana Chowdhury

Date & Time: January 5th, 2021

**Chief Complaint:** Right upper quadrant abdominal pain for the past three days

**History of Present Illness:**

A 37 year old female with no significant past medical hx present to the ER complaining of RUQ abdominal pain for the past 3 days. Patient has been experiencing similar pain for the past 15 years but the pain was milder. However, patients have not sought medical care in the past. Patient describes the discomfort as intermittent, sharp, 9/10 epigastric non-radiating pain. The pain worse with food and reports mild relief with maalox and tums. Patient reports three episodes of vomiting non bilious non bloody with constant nausea, feeling feverish and chills. Denies diarrhea, constipation, chest pain, SOB, headache, dizziness, LOC, skin changes or urinary complaint.

**Past Medical History:** none

**Past Surgical History:** none

**Allergies:** NKDA

**FHx**: Unremarkable

**SHx**: denies alcohol, smoking or recreational drug use.

**Home meds**: none

**Review of Systems:**

**Constitutional**: reports fever, chills, fatigue but denies recent weight loss or gain.

**Head** –Denies headaches, vertigo or head trauma.

**Pulmonary system** – denies dyspnea, dyspnea on exertion, cough, hemoptysis, cyanosis,

orthopnea, or paroxysmal nocturnal dyspnea (PND).

**Cardiovascular system** – Denies chest pain, palpitations, irregular heartbeat, edema/swelling of ankles or feet. syncope or known heart murmur

**Gastrointestinal:** reports epigastric abdominal pain, nausea and vomiting. Denies abdominal distention, anal bleeding, blood in stool, diarrhea, dysphagia, flatulence.

**Genitourinary system** – denies urinary frequency, polyuria urgency, nocturia, oliguria, dysuria, incontinence, or flank pain.

**Physical Exam**

**General:** pt appears well-developed and well-nourished, oriented to person, place, and time. Non-toxic appearance. Pt seems to have a moderate distress.

**Vitals**

**BP:** 110/72 Left arm, lying

**Pulse:** 99

**RR:** 17

**SpO2:** 96%RA

**Temp:** 100.3 °F

**Height**: 57 inches

**Weight**: 124LB

**BMI**: 28.82

**Physical Exam**

**Nails:** no sign of clubbing, cyanosis, koilonychia, paronychia. capillary refill <2 seconds

throughout.

**Skin:** warm, moist and smooth to touch, good turgor. Nonicteric, no evidence of hypo or

hyper pigmentation, erythema, mass, lesions, scars or tattoos.

**Head:** normocephalic and atraumatic

**Eyes:** Pupils are equal, round, and reactive to light.

**Neck**:Trachea midline. Neck supple.

**Heart:** Regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4,

splitting of heart sounds, friction rubs or other extra sounds.

**Lungs**: Clear to auscultation and no evidence of adventitious sounds.

**Abdomen**: Flat / symmetrical / no evidence of scars, striae. Bowel sounds present in all four quadrants; Soft, tender to palpation in RUQ. Murphy sign positive; no masses, no organomegaly, rebound, guarding, or rigidity.

**Musculoskeletal:**  Normal range of motion. He exhibits no edema, tenderness or deformity.

**Neurological:** She is alert and oriented to person, place, and time.

**Lab Data:**

UA- Appearance: yellow / turbid, pH: 7.5, glucose: negative, protein: negative, ketones: 15, Trace of leukocytes

WBC: 15.76 / Hb: 10.1 (MCV: 93.1) / Hct: 31.0 / Plt: 302

 -- Diff: N:89.2% L:6.5% Mo:3.6% Eo:0.00%

Alb: 5.1 / Bili: 1.1 / ALT:14 / AST: 16 / AlkPhos: 75 / Lip: 13 /Amylase: 60

 137 | 97 | 12

 -----------------< 128 Ca: 10.3 Anion Gap: 13

 4.1 | 20 | .67

T&S, PT:11.9/ aPTT:29.8/ INR:1.01

**Imaging:**

 **CT Abdomen/Pelvis with IV**

Impression:

1. The gallbladder is distended. Mild gallbladder wall edema is present. There is no biliary ductal dilatation.
2. An approximately 1.9 cm lobulated septated right renal cystic lesion is demonstrated

**Ultrasound:**

Impression:

1. There is cholelithiasis. The wall of the gallbladder measures to be approximately 0.2 cm in thickness.
2. There is no significant dilatation of the intrahepatic or of the extrahepatic bile ducts. The gallbladder is distended

**Assessment**

37 years old female present to ED c/o RUQ abdominal pain for past 3 days. Patient clinical presentation of RUQ pain, murphy sign, nausea, vomiting, fever, chills and the imaging suggest there is high suspicion for acute cholecystitis.

**Differential Diagnosis:**

1. Acute cholecystitis
2. Chronic cholecystitis
3. Cholelithiasis
4. Cholangitis
5. Biliary colic
6. Pancreatitis

**Plan:**

1. Patient will be admitted to the surgical floor for further stabilization and monitoring
2. The benefits and drawbacks of laparoscopic cholecystectomy was discussed with the patient and a consent was sign to perform laparoscopic cholecystectomy tomorrow (1/06/21)
3. NPO
4. IV fluids
5. Pain management: Motrin 400mg every 6 hours
6. Zofran
7. Cefoxitin
8. DVT prophylaxis Lovenox 40 mg daily
9. Spirometry
10. Preoperative labs in the morning