Ling Yi Mei

Rotation 3: Surgery

Note: exams in light grey shade are NOT performed

**Identification:**

Patient’s name: CM

Age: 71

Gender: female

Race: African American

Location: Queens Hospital Center, Jamaica NY

Date: Apr 1st, 2019

**Informant**: self, reliable

**CC:** “abdominal pain” x 3 days

**HPI:**

71 y/o female with significant PMHx of recently diagnosed advanced rectal cancer presents to the ED with generalized abdominal pain x 3 days. Pt reports abdominal discomfort and rumbling since the last dose of chemoradiation about 5 days ago. States that her stools are getting thinner, but she attributes this to her decreased appetite. Her last bowel movement was on 3 days ago and it was small mucoid material. Admits to not having a normal bowel movement for several weeks, and not passing gas for 5 days. Also admits to nausea and several episodes of non-bilious non-bloody vomiting. Denies fever, chills, chest pain, palpitation, SOB, urinary symptoms.

**PMH:**

Rectal Cancer, diagnosed on Jan, 2019

**Past Surgical History:**

None

**Medications:**

Current outpatient medications include:

Colace 100mg capsule PO, BID

Ferrous sulfate tablet 325mg PO, BID

Zofran 4mg tablet, 1 tablet PO q8h PRN

**Allergies:**

None

**Family History:**

Not able to obtain from patient

**Social History:**

Denies use of alcohol, smoking, and illicit drug.

**ROS:**

General: Patient denies generalized weakness, fatigue, fever, chill or night sweats

**Positive: weight loss >40lbs, decrease appetite**

Skin, Hair, Nails: Patient denies any changes of texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, or changes in hair condition

Head: Patient denies headache, vertigo, head trauma, or fracture

Eyes: Patient denies visual disturbance, lacrimation, photophobia, pruritus, or last eye exam

Ears: Patient denies deafness, pain, discharge, tinnitus

Nose/Sinuses: Patient denies discharge, epistaxis, or obstruction

Mouth and throat: Patient denies bleeding gums, sore tongue, sore throat, mouth ulcers or last dental exam

Neck: Patient denies localized swelling or lumps, stiffness or decreased range of motion

Breast: Patient denies lumps, nipple discharge, pain, or last mammogram

Pulmonary System: Patient denies SOB, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular System: Patient denies chest pain, palpitations, edema, syncope, or known heart murmur

Gastrointestinal System: see HPI

Genitourinary System: Patient denies changes in frequency, nocturia, urgency, oliguria, polyuria, dysuria, change in color of urine, incontinence, awakening at night to urinate, or pain

Menstrual and Obstetrical: unable to obtain from patient

Nervous System: Patient denies seizures, headache, loss of consciousness, sensory disturbances, numbness, paresthesia, dysesthesias, ataxia, loss of strength, change in cognition, mental status, memory, or weakness

Musculoskeletal System: Patient denies muscle or joint pain, deformity or swelling, redness, arthritis

Peripheral System: patient denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes

Hematological System: Patient denies anemia, easy bruising or bleeding, or lymph node enlargement

Endocrine System: Patient denies polyuria, polydipsia, polyphagia, heat or cold intolerance or goiter

Psychiatric: Patient denies depression, sadness, feeling of helplessness, hopelessness, lack of interest in usual activities, anxiety, obsessive or compulsive disorder, seen a mental health professional, or use medications

**Physical Examination:**

General: A/Ox3. Well dressed and doesn’t appear to be distressed. Pt seems cachexic and thin. Looks older than her stated age.

Vital Signs:

BP (supine): 130/70 mmHg

HR: 102 bmp, regular rhythm, slightly tachycardia

RR: 18 breath per min, not labored

Temp: 97.5F oral

O2 sat: 99 room air

Height/weight/BMI: unable to obtain from patient

Skin: Warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair: Average quantity and distribution

Nails: No clubbing, capillary refill <2 seconds throughout.

Head: Normocephalic, atraumatic, non-tender to palpation throughout

Eyes: Symmetrical OU; no strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity with glasses 20/20 OS, 20/20 OD, 20/20 OU. Visual fields full OU. PERRLA (old people do not accommodate), EOMs full with no nystagmus. Fundoscopy - Red reflex intact OU. Cup:Disk < 0.5 OU, no AV nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU

Ears: Symmetrical and normal size. No lesions, masses, trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TM's pearly white, cone of light at 4 o’clock in right ear, 7 o’clock in the left ear. Auditory acuity intact to whispered voice AU. Weber midline, and Rinne reveals AC>BC AU

Nose: Symmetrical with no masses, lesions, deformities, or trauma. Nasal mucosa pink, no discharge or foreign bodies. Anterior septum deviated to left, no lesions, deformities, injection perforation

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses

Lips: Pink, dry, no cyanosis or lesions

Mucosa: Light pink, dry, no masses, lesions, or leukoplakia

Palate: Pink, hydrated. Palate intact with no lesions, masses, scars, nontender to palpation, continuity intact

Gingivae: Pink, no hyperplasia, masses, lesions, erythema, or discharge

Tongue: Pink, no masses, lesions, or deviations noted

Oropharynx: Hydrated, no injection, exudate, masses, lesions, or foreign body. Tonsil present with no injection or extrudate, uvula light pink, no edema or lesions

Neck: No masses, lesions or scars. Trachea midline, pulsation noted. Supple nontender to palpation. 2+ carotid pulses, no thrills, bruits bilaterally. No palatable adenopathy

Thyroid: Nontender, no palpable masses, no thyromegaly, no bruits

Chest: Symmetrical, lat to AP diameter 2:1, no deformities, no trauma. Respirations unlabored. Nontender to palpation

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No wheezing, crackles, rales

Heart: S1, S2 without murmur, no gallops, S3 or S4. RRR. No JVD. Carotid pulse are 2+ bilaterally without bruits

Abdomen: Mildly elevated abdomen, symmetrical, no scars, striae, caput medusae or abnormal pulsations. Distended, hyperactive bowel sounds. No bruits. Tympany to percussion throughout. Nontender to percussion or to light and deep palpation. No organomegaly, guarding, or rebound tenderness. No CVAT bilaterally. No peritoneal sign.

Female genitalia: External - normal pubic hair pattern, no erythema, inflammation, ulcerations, lesions or discharge. Bartholins, Urethra, Skenes glands wnl. Vaginal mucosa without inflammation, erythema or discharge. Cervix nulli or multiparous without lesions or discharge. No cervical motion tenderness. Uterus retro-flexed, mobile, non-tender and of normal size, shape, and consistency. Adnexa without masses or tenderness

Rectal: No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. 2cmx 2cm mass felt at junction between sigmoid and rectum. Trace brown stool present in vault. FOB negative

Peripheral vascular: The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted

Neurological:

Mental status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted

Cranial nerve:

I - Intact no anosmia.

II- VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopic + red light reflex OS/OD, discs yellow with sharp margins. No AV nicking, hemorrhages or papilledema noted.

III-IV-VI- PERRLA, EOM intact without nystagmus.

V- Facial sensation intact, strength good. Corneal reflex intact bilaterally.

VII- Facial movements symmetrical and without weakness.

VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.

IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar: Full active and passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No Pronator Drift. Gait normal with no ataxia. Tandem walking and hopping show balance intact. Coordination by RAM and point to point intact bilaterally. Romberg negative

Sensory: Intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally

Reflexes R L R L

Brachioradialis 2+ 2+ Patellar 2+ 2+

Triceps 2+ 2+ Achilles 2+ 2+

Biceps 2+ 2+ Babinski neg neg

Abdominal 2+/2+ 2+/2+ Clonus negative

Meningeal signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Musculoskeletal System:

Upper extremities and lower extremities: No soft tissue swelling, erythema, ecchymosis, atrophy or deformities in bilateral upper and lower extremities. Nontender to palpation, no crepitus noted throughout. Full range of motion of all upper and lower extremities bilaterally. No spinal deformities

Imaging Studies and labs:

CT abdomen/pelvis: Wall thickening in the rectum that likely corresponds to patient’s known neoplasm. This area appears to cause a degree of obstruction as evidenced by proximal colon containing air and stool with abrupt tapering in the rectum. Increase dilation of colon. No free intraperitoneal air.

CBC:

WBC 4.4 dec

HGB 10.7 dec

HCT 33.4 dec

MCH 25.8 dec

MPV 7.0 dec

RDW 17.2 inc

Neutrophil 84.1 inc

Lymphocytes 10.4 dec

BMP:

Chloride 95 dec

Anion gap 19 inc

LFT:

AST 42 inc

**Assessment:**

71 y/o female with above findings presents for evaluation of abdominal pain, most consistent malignant large bowel obstruction secondary to rectal cancer.

**Differential Diagnosis:**

LBO

Sigmoid volvulus

Diverticulitis

Appendicitis

IBS/Constipation

**Plan:**

Admit to general surgery for emergency transverse loop colostomy

NPO, IV fluid with LR 1 L bolus not then 125/ml/hr