Case notes

Name: A.P.
Gender: M ☐ F ☒
Date of birth: 20/1/1980
Date of admission: 28/1/2014

1412

Presenting complaint

Right-sided abdominal pain for the past 2–3 days.

History of presenting complaint

- Right-sided lower abdominal pain started 2–3 days ago, initially dull aching, now sharp, present all the time (i.e continuous) with increase in severity at times, radiating to the left side sometimes. Exacerbated on coughing, opening bowel, travelling over road bumps. Relieved on lying still, gets little bit better with Panadol/Nurofen.
- Feeling hot and cold at times. No chills/rigors. No recorded temperatures.
- Associated with nausea and 4–5 episodes of vomiting. Vomits yellow in colour without blood, at times with food particles in it.
- Vomiting started after the onset of pain. Loss of appetite.
- 2–3 episodes of loose stool, yellowish-brown in colour, not watery, no blood, associated with transient worsening of abdominal pain.
- Denies PV bleeding/abnormal PV discharge. In a stable relationship with a single partner for the last 4–5 months. 3–4 episodes of unprotected sexual intercourse {without barrier contraception}. Denies using any other methods of contraception
- Denies dysuria/increase in frequency of micturition or haematuria.
- Has been well till onset of symptoms. Denies history of similar symptoms in the past.

Menstrual/obstetric history

- Last menstrual period 4–5 weeks ago.
- Periods normally irregular, onset at 30–40 days, last for 3–4 days, requires approx. 5 pads per day.
- Last menstrual period was normal. No history of previous pregnancies.

Past medical conditions

- No history of chronic medical conditions.
- Denies history of previous surgical procedures.

Allergies and regular medications

- No allergies.
- Does not take any regular medications. Takes multivitamins occasionally.

Social history

- Lives with partner, works as a store manager at a local store.
- Relatively active lifestyle.
- Smokes approx. 6–8 cigarettes/week for the past 10 years.
- Drinks on the weekends 6–8 beers/weekend.
- Denies history of recreational drug use.

On examination

A (Airway): own patent/protected

B (Breathing): Chest: Good bilateral air entry. No adventitious sounds heard.

RR 22/min, Sats: 98% room air.

C (Circulation): Heart sounds are dual, no murmurs heard.

HR 130/min, BP 108/65 mmHg. Capillary refill < 2sec

D (Disability): GCS 15/15, pupils equal and reacting to light. No focal neurological deficits noted.

E: Temp: 37.9 Abdomen soft. Tenderness noted in the right iliac fossa, guarding and rebound tenderness positive. No obvious hernias noted.

Per speculum exam: No blood or discharge noted. Os closed. Swabs done.

Provisional diagnosis

Likely appendicitis, need to rule out ectopic pregnancy.

Differentials considered.

1. Ruptured ovarian cyst/torsion.
2. Pelvic inflammatory disease.
3. Renal colic/UTI.

Treatment

1. IV cannula inserted and bloods sent for FBC/EUC/LFT/CRP/Serum B-HCG. Venous blood gas done.
2. Urine: Dipstick and sent the sample off for urine MCS and Urine PCR for chlamydia and gonorrhoea.
3. Analgesia: Panadol/Nurofen, IV morphine 1–2mg every 5–10 mins prn.
4. IV fluids.
5. ECG.
6. Swabs for chlamydia and gonorrhoea done.
7. Keep patient Nil by Mouth till further review.
8. Will consider abdominal USS post discussion with ED senior.

1500

Investigations

Blood

VBG: pH: 7.33, pco2: 38, pO2: 38, Hb: 118, K: 3.5, Na: 136, Lac: 1.8, HCO3: 20 Glu: 5.1
FBC: WBC: 18⇧/Hb 115/Neut 12⇧/ Plt: 456⇧
EUC: Na 134/ K 3.6/ Urea 6.4/ Creat 100/ GFR >90
LFT: Bili 10/ AST18/ ALT 16/ GGT 26/ Alk phos: 32
CRP: 234⇧
Serum B-HCG: <5

Urine

Dipstick: no leucocytes/ no nitrites. Specific gravity indicates dehydration.
Formal MSU: awaited
Urinary B-HCG: negative

Pelvic USS with a look at the appendix, if seen. Booked for 1545, full bladder.

Impression: Likely appendicitis

1. Antibiotics (ampicillin/metronidazole/gentamycin).
2. Await imaging/chase results.
3. Referred the patient to the surgical team for review. Surg reg will review shortly.

Dr ABC