

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, road bumps while travelling. Relieved on lying still, gets little bit better with Panadol/Nurofen.
- Feeling hot and cold at times. No chills/rigors.
- Associated with nausea and 4–5 episodes of vomiting. Vomits yellow in colour. Unable to tolerate food.
- 2–3 episodes of loose stool, yellowish-brown in colour, not watery, no blood.
- Denies dysuria/increase in frequency of micturition or hematuria.
- Denies PV bleeding/abnormal PV discharge.
- Last menstrual period 4–5 weeks ago.
- Has been well till onset of symptoms. Denies history of similar symptoms in the past.

Past medical history

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

Allergies and regular medications

- No allergies.
- Does not take regular medications.

Social history

- Lives with partner.
- Relatively active lifestyle.
- Smokes approx. 6–8 cigarettes/week.
- Drinks on the weekends.

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.

HR130/min, BP: 108/65mmHg.

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.

Provisional diagnosis

Likely appendicitis, need to rule out ectopic pregnancy.

Treatment

1. IV cannula inserted and bloods sent for FBC/EUC/LFT/CRP.
2. Urine pregnancy test.
3. Analgesia.
4. IV fluids.
5. For surgical review.

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↑

Urine

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

Start antibiotics as discussed with ED senior.

Awaiting surgical registrar review.

Dr ABC