Student Note ID: 368

# Chief Complaint

Pancreatitis; abdominal pain

# History of Presenting Illness

Pt is a 28 y/o male with a PMH of alcoholic pancreatitis, DM, and alcohol abuse disorder who initially presented to a hospital in Roswell, NM on 07/07/22 for abdominal pain, nausea and vomiting, fever and chills, and diaphoresis. He was found to have acute pancreatitis and was treated there for five days, and transferred to UMC for surgery on 07/12/22 after an ultrasound showed a 9mm dilation of the common bile duct with transaminitis and elevated T Bilirubin. The patient currently denies fever, chills, nausea, and vomiting. His abdominal pain is still present and he describes it as a constant epigastric pain that radiates to the sides and back. The patient has a history of alcohol abuse, and reports drinking >6 drinks a day. He admits to occasional cocaine use and previous history of recreational marijuana use. His past surgical history includes a history of pancreatic resection of a necrotic pancreatic tail.

# Review of Systems

Constitutional: Denies fever and chills, no sweats, mild weakness.  
  
Eye: no recent visual problems, no icterus, no discharge, no blurry vision, no double vision, no visual disturbances.  
  
Skin: no jaundice, no rash, no petechiae, no bruising present  
  
Respiratory: Denies shortness of breath, no cough, no orthopnea, no wheezing.  
  
Cardiovascular: no chest pain, no palpitations, no edema  
  
Gastrointestinal: no nausea, denies nausea, denies vomiting, denies hematemesis, no melena, no diarrhea or constipation, no abdominal pain, no GI bleeding.  
  
Genitourinary: no dysuria, no hematuria, no discharge, no pain.  
  
Hema/Lymph: no bruising tendency, no bleeding tendency, no swollen glands.   
  
Integumentary: no rash, no pruritus, no abrasions, no breakdown, no burns, no dryness, no petechiae, no skin lesion.  
  
Neurologic: no headache, no dizziness, no numbness, mild weakness.  
  
Psychiatric: no sleeping problems, no irritability, no mood swings/depression.   
  
Additional ROS info: Except as noted in the Review of Symptoms above and in the history of Present Illness, all other systems have been reviewed and are negative or noncontributory.

# History

## Past Medical History

Alcoholic Pancreatitis  
  
Two previous episodes of acute pancreatitis  
  
DM

## Past Surgical History

Pancreatic Tail Resection of Necrotic Area (8 years ago)

## Medications

Insulin (Patient reports not taking any of his medications in 5 months)  
  
Metformin

## Allergies

None

## Family History

Hypertension: Father  
  
Diabetes: Grandparents

## Social History

Tobacco use: used to smoke; denies current use  
  
Alcohol: Daily use; >6 24oz beers daily  
  
Drugs: Reports previous marijuana use, denies current use; admits to cocaine use on weekends

# Physical Exam

## Vitals

Heart Rate: 57, Blood Pressure: 120/78  
 Respiratory Rate: 18, O2 Sat: 100%  
 Weight: 79.3, Height:

## Exam

Constitutional: awake, alert, in no acute distress  
  
Head: normocephalic, atraumatic  
  
Eyes: PERRL, EOMI, no conjunctival pallor  
  
Neck: supple, full range of motion  
  
Cardiovascular: regular rate and rhythm, Normal S1, S2. Radial pulses 2+ bilaterally.  
  
Pulmonary: Lungs clear to auscultation bilaterally, non-labored respirations.  
  
Abdomen: Bowel sounds active in all 4 quadrants. Abdomen soft, tender to palpation in RUQ, RLQ, and epigastric region, and non-distended.   
  
Skin: No lesions, ecchymoses, or rashes. Warm, dry, slightly jaundiced.  
  
Musculoskeletal: Good range of motion, no gross deformity present.   
  
Neurological: Awake and oriented x 3, moving all extremities.   
  
Psychiatric: Mood and affect appropriate.

# Data

CMP  
  
CBC  
  
Lipase  
  
Liver Enzymes   
  
HA1C  
  
Abdominal Ultrasound  
  
CT  
  
MRI  
  
Urine chemistry  
  
C Reactive Protein

# Assessment and Plan

## Summary Statement

This is a 28 year old male, who is presenting today for Episode of Acute pancreatitis with possible choledocholithiasis, and surgery consultation  
 The patient has a pertinent history of Alcoholic Pancreatitis  
  
Alcohol Abuse  
  
DM  
  
Previous Pancreatic tail resection due to necrosis  
 Patient's exam is remarkable for Tenderness to palpation in RUQ, RLQ, and epigastric region; mild jaundice  
 Patient's data is remarkable for Labs:  
  
Liver Enzymes: Total bilirubin: 7; ALT: 178; AST: 244; Alk P:511; Lipase: 28  
  
Glucose: 232; HA1c: 12.8; Urine chemistry negative for drugs  
  
  
  
Abdominal US showed an 8.5 mm dilated CBD, a sludge-filled gallbladder with moderate wall thickness, but no presence of stones.   
  
MRI showed CBD dilatation with no discernable calculus or choledocholithiasis; A possible pancreatic head lesion.  
  
CT showed an ill-defined lesion in the head of the pancreas, possibly an abscess or pseudocyst; mild fat stranding seen with acute pancreatitis; atrophy of the body and tail of the pancreas

### Problem 1

Abdominal Pain

### Differential DX}

Acute Pancreatitis  
  
Choledocholithiasis   
  
Cholecystitis  
  
Pancreatic Carcinoma  
  
Pancreatic abscess

### Diagnostic Plan

Perform labs (CBC, CMP, Liver Enzyme Studies, Lipase). Perform an abdominal ultrasound to confirm common bile duct dilatation, and look at MRI imaging for the presence of stones in the gallbladder.   
  
If no calculus or choledocholithiasis is observed, proceed with CT to look for pancreatic lesions that may be causing obstruction of the common bile duct.

### Treatment Plan

Pain management.   
  
Counseling on alcohol abuse.   
  
Start him back on his diabetes medications.   
  
Set up with social work.   
  
Follow-up appointment with GI 4-6 weeks to perform Endoscopic Ultrasound when pancreatitis resolves.

### Problem 2

Hyperglycemia: Give insulin SSI during his hospital stay, and counsel the patient on the importance of taking insulin. Also, set him up with social work to make sure he has access to medications.

### Differential DX}

### Diagnostic Plan

### Treatment Plan