**Emergency Room Report**

Name: Jane Doe  
DoB: 01/01/1954  
MRN: 1234567  
SSN: 305-58-8554  
Medicare Number: 9876543  
  
The patient was seen by me at approximately 4:30 a.m. on the 17th of September 1995.

CHIEF COMPLAINT: The patient complains of chest pain.

HISTORY OF PRESENT ILLNESS: The patient is a 20-year-old male who states that he has had two previous myocardial infarctions related to his use of amphetamines. The patient has not used amphetamines for at least four to five months, according to the patient; however, he had onset of chest pain this evening.

The patient describes the pain as midsternal pain, a burning type sensation that lasted several seconds. The patient took one of his own nitroglycerin tablets without any relief. The patient became concerned and came into the emergency department.

Here in the emergency department, the patient states that his pain is a 1 on a scale of 1 to 10. He feels much more comfortable. He denies any shortness of breath or dizziness, and states that the pain feels unlike the pain of his myocardial infarction. The patient has no other complaints at this time.

PAST MEDICAL HISTORY: The patient's past medical history is significant for status post myocardial infarction in February of 1995 and again in late February of 1995. Both were related to illegal use of amphetamines.

ALLERGIES: None.

CURRENT MEDICATIONS: Include nitroglycerin p.r.n.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 131/76, pulse 50, respirations 18, temperature 96.5.

GENERAL: The patient is a well-developed, well-nourished white male in no acute distress. The patient is alert and oriented x 3 and lying comfortably on the bed.

HEENT: Atraumatic, normocephalic. The pupils are equal, round, and reactive. Extraocular movements are intact.

NECK: Supple with full range of motion. No rigidity or meningismus.

CHEST: Nontender.

LUNGS: Clear to auscultation.

HEART: Regular rate and rhythm. No murmur, S3, or S4.

ABDOMEN: Soft, nondistended, nontender with active bowel sounds. No masses or organomegaly. No costovertebral angle tenderness.

EXTREMITIES: Unremarkable.

NEUROLOGIC: Unremarkable.

EMERGENCY DEPARTMENT LABS: The patient had a CBC, minor chemistry, and cardiac enzymes, all within normal limits. Chest x-ray, as read by me, was normal. Electrocardiogram, as read by me, showed normal sinus rhythm with no acute ST or T-wave segment changes. There were no acute changes seen on the electrocardiogram. O2 saturation, as interpreted by me, is 99%.

EMERGENCY DEPARTMENT COURSE: The patient had a stable, uncomplicated emergency department course. The patient received 45 cc of Mylanta and 10 cc of viscous lidocaine with complete relief of his chest pain. The patient had no further complaints and stated that he felt much better shortly thereafter.

AFTERCARE AND DISPOSITION: The patient was discharged from the emergency department in stable, ambulatory, good condition with instructions to use Mylanta for his abdominal pain and to follow up with his regular doctor in the next one to two days. Otherwise, return to the emergency department as needed for any problem. The patient was given a copy of his labs and his electrocardiogram. The patient was advised to decrease his level of activity until then. The patient left with final diagnosis of:

FINAL DIAGNOSIS:

1. Evaluation of chest pain.   
2. Possible esophageal reflux.

EMERGENCY ROOM REPORT

CHIEF COMPLAINT: Colostomy failure.

HISTORY OF PRESENT ILLNESS: This patient had a colostomy placed 9 days ago after resection of colonic carcinoma. Earlier today, he felt nauseated and stated that his colostomy stopped filling. He also had a sensation of "heartburn." He denies vomiting but has been nauseated. He denies diarrhea. He denies hematochezia, hematemesis, or melena. He denies frank abdominal pain or fever.

PAST MEDICAL HISTORY: As above. Also, hypertension.

ALLERGIES: "Fleet enema."

MEDICATIONS: Accupril and vitamins.

REVIEW OF SYSTEMS: SYSTEMIC: The patient denies fever or chills.  
HEENT: The patient denies blurred vision, headache, or change in hearing. NECK: The patient denies dysphagia, dysphonia, or neck pain. RESPIRATORY: The patient denies shortness of breath, cough, or hemoptysis. CARDIAC: The patient denies history of arrhythmia, swelling of the extremities, palpitations, or chest pain. GASTROINTESTINAL: See above. MUSCULOSKELETAL: The patient denies arthritis, arthralgias, or joint swelling. NEUROLOGIC: The patient denies difficulty with balance, numbness, or paralysis. GENITOURINARY: The patient denies dysuria, flank pain, or hematuria.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 183/108, pulse 76, respirations 16, temperature 98.7.

HEENT: Cranial nerves are grossly intact. There is no scleral icterus.

NECK: No jugular venous distention.

CHEST: Clear to auscultation bilaterally.

CARDIAC: Regular rate and rhythm. No murmurs.

ABDOMEN: Soft, nontender, nondistended. Bowel sounds are decreased and high-pitched. There is a large midline laparotomy scar with staples still in place. There is no evidence of wound infection. Examination of the colostomy port reveals no obvious fecal impaction or site of obstruction. There is no evidence of infection. The mucosa appears normal. There is a small amount of nonbloody stool in the colostomy bag. There are no masses or bruits noted.

EXTREMITIES: There is no cyanosis, clubbing, or edema. Pulses are 2+ and equal bilaterally.

NEUROLOGIC: The patient is alert and awake with no focal motor or sensory deficit noted.

MEDICAL DECISION MAKING: Failure of colostomy to function may repre- sent an impaction; however, I did not appreciate this on physical examination. There may also be an adhesion or proximal impaction which I cannot reach, which may cause a bowel obstruction, failure of the shunt, nausea, and ultimately vomiting.

An abdominal series was obtained, which confirmed this possibility by demonstrating air-fluid levels and dilated bowel.

The CBC showed WBC of 9.4 with normal differential. Hematocrit is 42.6. I interpret this as normal. Amylase is currently pending.

I have discussed this case with Dr. S, the patient's surgeon, who agrees that there is a possibility of bowel obstruction and the patient should be admitted to observation. Because of the patient's insurance status, the patient will actually be admitted to Dr. D on observation. I have discussed the case with Dr. P, who is the doctor on call for Dr. D. Both Dr. S and Dr. P have been informed of the patient's condition and are aware of his situation.

FINAL IMPRESSION: Bowel obstruction, status post colostomy.

DISPOSITION: Admission to observation. The patient's condition is good. He is hemodynamically stable.