Patient Medical Chart

Patient Information

- **Name:** John Doe
- **Date of Birth:** March 22, 1967
- **Age:** 57 years
- **Gender:** Male
- **MRN:** 56789
- **Admission Date:** 02/22/2024
- **Discharge Date:** 04/22/2024

Chief Complaint

- **Reason for Visit:** Severe abdominal pain.

History of Present Illness (HPI)

- The patient presented with acute-onset abdominal pain localized to the lower right quadrant.
- Pain began 24 hours prior to admission, progressively worsening, associated with nausea, loss of appetite, and low-grade fever.
- No history of trauma or prior episodes of similar pain.

Past Medical History (PMH)

- **Hypertension:** Diagnosed 10 years ago, well-controlled with medication (lisinopril 10 mg daily).
- **Hyperlipidemia:** Diagnosed 5 years ago, managed with atorvastatin 20 mg daily.
- **No prior surgeries.**

Past Surgical History (PSH)

- None reported.

Family History

- **Father:** Deceased at 78 (myocardial infarction).
- **Mother:** Alive, 85, with hypertension and Type 2 diabetes.
- **No known family history of malignancy or gastrointestinal disorders.**

Social History

- **Tobacco Use:** Quit 15 years ago, 10 pack-year history.
- **Alcohol Use:** Occasional, 2-3 drinks per month.
- **Illicit Drug Use:** Denied.
- **Employment:** Retired accountant.
- **Physical Activity:** Walks 3-4 times per week.

Allergies

- **Penicillin:** Rash and itching.

Medications

- Lisinopril 10 mg daily
- Atorvastatin 20 mg daily
- Multivitamin once daily

Physical Examination

General Appearance:

- Alert, oriented, and in mild distress due to pain.

Vital Signs:

- Temperature: 100.8°F
- Pulse: 92 bpm
- Respiratory Rate: 18 breaths/min
- Blood Pressure: 138/84 mmHg
- Oxygen Saturation: 98% on room air

Abdominal Examination:

- Inspection: No visible scars, distention, or discoloration.
- Palpation: Tenderness and guarding in the right lower quadrant; positive rebound tenderness.
- Percussion: Dullness in the right lower quadrant.
- Auscultation: Bowel sounds present but diminished.

Other Systemic Examination:

- Cardiovascular: Regular rate and rhythm, no murmurs.
- Respiratory: Clear to auscultation bilaterally.
- Neurological: No focal deficits.

Differential Diagnosis

1. Acute appendicitis
2. Diverticulitis
3. Small bowel obstruction
4. Peptic ulcer disease
5. Mesenteric ischemia

Investigations

1. **Laboratory Tests:**

- CBC: WBC 15,000/µL (elevated), Hemoglobin 13.5 g/dL, Platelets 230,000/µL.
- CRP: Elevated.
- Liver and renal function tests: Normal.

2. **Imaging:**
    - Abdominal ultrasound: Enlarged appendix with wall thickening and periappendiceal fluid.
    - CT abdomen and pelvis: Confirmed acute appendicitis with no perforation or abscess.

Diagnosis

Acute Appendicitis.

Treatment Plan

1. **Pre-operative Management:**
    - NPO (nothing by mouth).
    - IV hydration with normal saline at 100 mL/hour.
    - IV antibiotics (ceftriaxone 1 g and metronidazole 500 mg).
    - Pain management with IV morphine as needed.
2. **Surgical Intervention:**
    - Laparoscopic appendectomy performed on 02/24/2024
    - Operative findings: Inflamed appendix with no perforation.
    - Procedure uneventful with minimal blood loss.

Operative Note

- **Date:** 03/21/2024
- **Surgeon:** Dr. Jane Smith

- **Assistant Surgeon:** Dr. Mark Lee
- **Anesthesia:** General endotracheal anesthesia.

Procedure Summary:

- Three small incisions were made (umbilical, suprapubic, and left lower quadrant).
- Appendix identified, ligated, and removed without complications.
- Irrigation performed with saline.
- Incisions closed with absorbable sutures.

Estimated Blood Loss: <10 mL.
Intraoperative Complications: None.

Post-operative Course

1. **Immediate Recovery:**
    - Patient transferred to PACU in stable condition.
    - Pain managed with IV acetaminophen and PRN hydromorphone.
    - No signs of infection or bleeding.
2. **Day 1 Post-op:**
    - Ambulated with assistance.
    - Tolerated clear liquids, advanced to soft diet.
    - Vital signs stable.
3. **Day 2 Post-op:**
    - Pain controlled with oral medications (acetaminophen 500 mg q6h).
    - No fever, bowel sounds normal, passing flatus.

Discharge Summary

1. **Discharge Date:** 04/22/2024
2. **Condition on Discharge:** Stable.

3. **Medications:**
    - Cephalexin 500 mg PO q6h for 7 days.
    - Acetaminophen 500 mg PO q6h PRN pain.
4. **Instructions:**
    - Follow-up appointment in 1 week with the surgical team.
    - Keep incisions clean and dry.
    - Monitor for signs of infection (redness, swelling, fever).
    - Resume normal activities gradually, avoid heavy lifting for 4-6 weeks.

Follow-Up Plan

- **Primary Care Physician:** Dr. Alan Green
- **Specialist Follow-Up:** Surgical clinic visit scheduled for 06/12/2024.

Summary

John Doe, a 57-year-old male with a history of hypertension and hyperlipidemia, was admitted with acute right lower quadrant abdominal pain. Workup revealed acute appendicitis, and he underwent a successful laparoscopic appendectomy. Post-operative recovery was uneventful, and the patient was discharged in stable condition with appropriate follow-up.