Sample Type / Medical Specialty: General Medicine

Sample Name: H&P - Nausea & Vomiting

Description: Intractable nausea and vomiting/history of diabetic gastroparesis/multiple endoscopies revealing gastritis and esophagitis.

(Medical Transcription Sample Report)

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CHIEF COMPLAINT: Intractable nausea and vomiting.

HISTORY OF PRESENT ILLNESS: This is a 43-year-old black female who was recently admitted and discharged yesterday for the same complaint. She has a long history of gastroparesis dating back to 2000, diagnosed by gastroscopy. She also has had multiple endoscopies revealing gastritis and esophagitis. She has been noted in the past multiple times to be medically noncompliant with her medication regimen. She also has very poorly controlled hypertension, diabetes mellitus and she also underwent a laparoscopic right adrenalectomy due to an adrenal adenoma in January, 2006. She presents to the emergency room today with elevated blood pressure and extreme nausea and vomiting. She was discharged on Reglan and high-dose PPI yesterday, and was instructed to take all of her medications as prescribed. She states that she has been compliant, but her symptoms have not been controlled. It should be noted that on her hospital admission she would have times where she would feel extremely sick to her stomach, and then soon after she would be witnessed going outside to smoke.

PAST MEDICAL HISTORY:

1. Diabetes mellitus (poorly controlled).

2. Hypertension (poorly controlled).

3. Chronic renal insufficiency.

4. Adrenal mass.

5. Obstructive sleep apnea.

6. Arthritis.

7. Hyperlipidemia.

PAST SURGICAL HISTORY:

1. Removal of ovarian cyst.

2. Hysterectomy.

3. Multiple EGDs with biopsies over the last six years. Her last EGD was in June, 2005, which showed esophagitis and gastritis.

4. Colonoscopy in June, 2005, showing diverticular disease.

5. Cardiac catheterization in February, 2002, showing normal coronary arteries and no evidence of renal artery stenosis.

6. Laparoscopic adrenalectomy in January, 2006.

MEDICATIONS:

1. Reglan 10 mg orally every 6 hours.

2. Nexium 20 mg orally twice a day.

3. Labetalol.

4. Hydralazine.

5. Clonidine.

6. Lantus 20 units at bedtime.

7. Humalog 30 units before meals.

8. Prozac 40 mg orally daily.

SOCIAL HISTORY: She has a 27 pack year smoking history. She denies any alcohol use. She does have a history of chronic marijuana use.

FAMILY HISTORY: Significant for diabetes and hypertension.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

REVIEW OF SYSTEMS:

HEENT: See has had headaches, and some dizziness. She denies any vision changes.

CARDIAC: She denies any chest pain or palpitations.

RESPIRATORY: She denies any shortness of breath.

GI: She has had persistent nausea and vomiting. She denies diarrhea, melena or hematemesis.

NEUROLOGICAL: She denies any neurological deficits.

All other systems were reviewed and were negative unless otherwise mentioned in HPI.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure: 220/130. Heart rate: 113. Respiratory rate: 18. Temperature: 98.

GENERAL: This is a 43-year-old obese African-American female who appears in no acute distress. She has a depressed mood and flat affect, and does not answer questions elaborately. She will simply state that she does not feel well.

HEENT: Normocephalic, atraumatic, anicteric. PERRLA. EOMI. Mucous membranes moist. Oropharynx is clear.

NECK: Supple. No JVD. No lymphadenopathy.

LUNGS: Clear to auscultation bilaterally, nonlabored.

HEART: Regular rate and rhythm. S1 and S2. No murmurs, rubs, or gallops.

ABDOMEN: Obese. Soft. Slight diffuse tenderness. Bowel sounds are present. Unable to properly assess for organomegaly based on the patient's size.

EXTREMITIES: Full range of motion. Acyanotic. No peripheral edema.

NEURO/PSYCH: Cranial nerves 2 through 12 grossly intact. She moves all extremities and has a nonfocal examination. Her cognition is intact. She does express a depressed mood and flat affect.

LABORATORY DATA: White blood cell count: 16.3, hemoglobin 11.2, hematocrit 33.8, platelets 751,000. PT 12.9, INR 0.95, PTT 33. Urinalysis is remarkable for 99 white blood cells, 68 red blood cells, leukocyte esterase positive and moderate amount of bacteria. Glucose is negative in the urine, and she has greater than 300 albumin. Sodium 140, potassium 3.6, chloride 107, CO2 22, BUN 16, creatinine 2.2, glucose 137, calcium 9.1, magnesium 1.9, total protein 7.4, albumin 2.9, AST 23, ALT 50, alkaline phosphatase 181, total bilirubin 0.2. Amylase and lipase are still pending. Her cardiac enzymes are negative times one set. Urine drug screen is positive for cannabis.

Arterial blood gas shows pH 7.42, pCO2 34, PaO2 83, O2 sat 96% on room air.

ASSESSMENT AND PLAN:

1. Intractable nausea and vomiting/history of diabetic gastroparesis/multiple endoscopies revealing gastritis and esophagitis. We will make the patient NPO for now. IV fluids. Give antiemetics as needed. She will be continued on Reglan 10 mg IV every 6 hours and she will be started on erythromycin 250 mg orally 3 times a day to help increase peristalsis. We will consider obtaining a GI consult in the morning. We will also check an abdominal ultrasound to rule out any gallbladder disease or biliary colic.

2. Hypertension. She will be started on labetalol 10 mg IV every 4 hours and will receive hydralazine 10 mg IV every 6 hours as needed. She will also be started on Catapres patch 0.1 mg for 24 hours.

3. Diabetes mellitus. The patient will receive sliding scale insulin of Humalog every 6 hours while NPO. We will restart her Lantus 20 units at bedtime with supplemental sliding scale when she is tolerating a diet.

4. Chronic renal insufficiency. Her creatinine is 2.2, which is right near her baseline of 2. We will continue to hydrate her and monitor her BMP closely.

5. Urinary tract infection/hemorrhagic cystitis. She will be started on Cipro 400 mg IV daily. We will await the report of the abdominal ultrasound. Other things to consider would be pyelonephritis or renal stone.

6. Obstructive sleep apnea. She will be continued on CPAP as previously ordered when she was an inpatient yesterday.

7. Depression. We will consider a psych consult in the morning. She may have a psychological component to her nausea and vomiting.

8. Case management to evaluate medication options. We need to make sure that she can afford all of her medications upon discharge.

This case was presented and thoroughly discussed with the senior resident who agrees with all medications and treatment.