Chief Complaint:, Chronic abdominal pain.,History of Present Illness:, 23-year-old Hispanic male who presented for evaluation of chronic abdominal pain. Patient described the pain as dull, achy, constant and located at the epigastric area with some radiation to the back. There are also occasional episodes of stabbing epigastric pain unrelated to meals lasting only minutes. Patient noted that the pain started approximately six months prior to this presentation. He self medicated ""with over the counter"" antacids and obtained some relief so he did not seek medical attention at that time.,Two months prior to current presentation, he had worsening of his pain as well as occasional nausea and vomiting. At this time the patient was found to be H. pylori positive by serology and was treated with triple therapy for two weeks and continued on omeprazole without relief of his pain.,The patient felt he had experienced a twenty-pound weight loss since his symptoms began but he also admitted to poor appetite. He stated that he had two to three loose bowel movements a day but denied melena or bright red blood per rectum. Patient denied NSAID use, ethanol abuse or hematemesis. Position did not affect the quality of the pain. Patient denied fever or flushing. He stated he was a very active and healthy individual prior to these recent problems.,Past Medical History:, No significant past medical history.,Past Surgical History:, No prior surgeries.,Allergies:, No known drug allergies.,Medications:, Omeprazole 40 mg once a day. Denies herbal medications.,Family History:, Mother, father and siblings were alive and well.,Social

History:, He is employed as a United States Marine officer, artillery repair specialist. He was a social drinker in the past but quit altogether two years ago. He never used tobacco products or illicit/intravenous drugs.,Physical Examination:, The patient was a thin male in no apparent distress. His oral temperature was 98.2 Fahrenheit, blood pressure was 114/67 mmHg, pulse rate of 91 beats per minute and regular, respiratory rate was 14 and his pulse oximetry on room air was 98%. Patient was 52 kg in weight and 173 cm height.,SKIN: No skin rashes, lesions or jaundice. He had one tattoo on each upper arm.,HEENT: Head was normocephalic and atraumatic. Pupils were equal, round and reactive. Anicteric sclerae. Tympanic membranes had a normal appearance. Normal funduscopic examination. Oral mucosa was moist and pink. Oral/pharynx was clear.,NECK: No lymphadenopathy. No carotid bruits. Trachea midline. Thyroid non-palpable. No jugular venous distension.,CHEST: Lungs were clear bilaterally with good air movement.,HEART: Regular rate and rhythm. Normal S1 and S2 with no murmurs, gallops or rubs. PMI was non-displaced.,ABDOMEN: Abdomen was flat. Normal active bowel sounds. Liver span percussed sixteen centimeters, six centimeters below R costal margin with irregular border that was mildly tender to palpation. Slightly tender to palpation in epigastric area. There was no splenomegaly. No abdominal masses were appreciated. No CVA tenderness was noted.,RECTAL: No perirectal lesions were found. Normal sphincter tone and no rectal masses. Prostate size was normal without nodules.

Guaiac positive.,GENITALIA: Testes descended bilaterally, no penile lesions or discharge.,EXTREMITIES: No clubbing, cyanosis, or edema. No peripheral lymphadenopathy was noted.,NEUROLOGIC: Alert and oriented times three. Cranial nerves II to XII appeared intact. No muscle weakness or sensory deficits. DTRs equal and normal.,Radiology/Studies: 2 view CXR: Mild elevation right diaphragm.,CT of abdomen and pelvis: Too numerous to count bilobar liver masses up to about 8 cm. Extensive mass in the pancreatic body and tail, peripancreatic region and invading the anterior aspect of the left kidney. Question of vague splenic masses. No definite abnormality of the moderately distended gallbladder, bile ducts, right kidney, poorly seen adrenals, bowel or bladder. Evaluation of the retroperitoneum limited by paucity of fat.,Patient underwent several diagnostic procedures and soon after he was transferred to Houston Veterans Administration Medical Center to be near family and to continue work-up and treatment. At the HVAMC these diagnostic procedures were reviewed.