Chief Complaint:, Abdominal pain, nausea and vomiting.,History of Present Illness:, A 50-year-old Asian female comes to The Methodist Hospital on January 2, 2001, complaining of a 3-day history of abdominal pain. The pain is described as crampy in the central part of her abdomen, and is associated with nausea and vomiting during the previous 24 hours. The patient denied passing any stool or gas per rectum for the previous 24 hours. She had been admitted recently to the hospital from December 19 to December 23, 2000, with a three-week history of fevers to 101.8, diaphoresis, anorexia, malaise and skin ""lumps"". She described a total of three ""lumps"". The first one started as a pin-sized lesion that grew up and then disappeared, the other two didn't resolve. They were described as ""erythematous nodular lesions on the extensor surface of the left arm."" A punch biopsy was obtained from these skin lesions, showing deep dermis and subcutaneous adipose tissue that contained ""multiple granulomas composed of histiocytes and multinucleated giant cells without caseating necrosis"". However, one granuloma in the deep dermis, showed a hint of central necrosis. Special stains for acid - fast bacilli and fungi were reported as negative. No atypia or malignancy was noted. A CT scan of the chest was obtained on December 19, 2000 and showed numerous masses with spiculated borders bilaterally, predominately in the upper lobes and superior segments of the lower lobes. No cavitary lesions, mediastinal masses or definite hilar adenopathy were reported. The patient underwent bronchoscopy and transbronchial biopsy which

showed fragments of bronchial mucosa and wall with underlying lung parenchyma. Minimal to mild interstitial lymphocytes with a few microfoci of neutrophils were seen. They were also able to appreciate intra-alveolar fibrinous exudates. One of the blood cultures drawn on December 19, 2000 grew Streptococcus mitis.,The patient was discharged on ethambutol 1200 mg po qd, clarithromycin 500 mg po bid, ampicillin 500 mg po q 6h and fluconazole 200 mg po qd.,Past Medical History:,1. Post-streptococcal glomerulonephritis at age 10.,2. End stage renal disease diagnosed in 1994, on peritoneal dialysis until 1996.,3. Cadaveric transplant in October 1996,4. Steroid induced diabetes mellitus,5. Hypertension,Past Surgical History:,1. Total abdominal hysterectomy in January 1996,2. Cesarean section X2 in 1996 and 1997,3. Appendectomy in 1971,4. Insertion of peritoneal dialysis catheter in 1994,5. Cadaveric transplant in October 1996,Social History:,The patient denies a history of smoking, drinking or intravenous drug use. She came to the United States in 1973. She works as a nurse in a newborn nursery. Her hobby is gardening. She traveled to Las Vegas on May 2000 and stayed for 6 months. She denied ill contacts or pets.,Allergies:, Ciprofloxacin and Enteric coated aspirin,Medications:, prednisone 20 mg po qd, enalapril 2.5 mg po qd, clonidine patch TTS 3 1/week, Prograf 5 mg po bid, ranitidine 150 mg po bid, furosemide 40 mg po bid, atorvastatin 10 mg po qd, multivitamins 1 tab po qd, estrogen patch, fluconazole 200 mg po qd, metformin 500 mg po bid, glyburide 10 mg po qd, clarithromycin 500 mg po bid,

ethambutol 1200 mg po qd, ampicillin 500 mg po q 6h.,Family History:, She described a family history of hypertension. Her mother died after a myocardial infarction at age 59. Her father was diagnosed with congestive heart failure and had a pacemaker placed.,Review of systems:, Non-contributory. The patient denied fever, chills, ulcers, liver disease or history of gallstones.,Vaccines: The patient was vaccinated with BCG before starting elementary school in the Philippines.,Physical Examination:, At the time of the examination the patient was alert and oriented times three and in no acute distress. She was well nourished.,BP 106/60 lying down; HR 86; RR 12; T 96.1° F; Hgt. =5' 2""; Wgt. =121 lbs.,SKIN: There was no rash or skin lesions.,HEENT: She had no oral lesions and moist mucous membranes. No icterus was noted.,NECK: Her neck was supple without lymphadenopathy or thyromegaly.,LUNGS: Crackles at the right lower base with normal respiratory excursion and no dullness to percussion.,HEART: IV/VI crescendo - decrescendo systolic murmur was heard at the second intercostal space with radiation to the neck.,ABDOMEN: The abdomen was distended. Bowel sounds were normal. No hepatosplenomegaly, tenderness or rebound tenderness could be detected during the examination.,EXTREMITIES: No cyanosis, clubbing or edema was noted.,RECTAL: Normal rectal exam. Guaiac negative.,NEUROLOGIC: Normal and non-focal.,Hospital Course:, The patient was admitted and a nasogastric tube was placed. IV fluids were started. A KUB was obtained showing an abnormal bowel gas pattern.

Multiple loops of distended bowel were noted in the mid abdomen. Air and feces were noted within the colon in the right side. An Abdominal CT scan was obtained. There was a small amount of perihepatic fluid noted. The liver and spleen were normal. The kidneys were atrophic. The gallbladder was moderately distended. There was marked dilatation of the small bowel proximally and distally. There was gas and contrast material in the colon. A diagnostic procedure was performed.