### **Chart 1**

**CC:** Lower abdominal pain, bloating

**History of Present Illness:**33-year-old male with 3-week history of intermittent lower abdominal pain and bloating. Pain is dull, 4/10 in severity, worse after meals and partially relieved by passing gas. Denies constipation but notes stools are softer than usual, 1–2/day. Denies blood in stool. No recent illness or travel. No fevers or weight loss.

**Review of Systems:**Negative for fever, chills, vomiting, hematochezia, melena, dysphagia, night sweats, rash, or urinary symptoms.

**Past Medical History:**None.

**Medications:**None.

**Allergies:**No known drug allergies.

**Family History:**No family history of IBD, colorectal cancer, or celiac disease.

**Social History:**Occasional alcohol use (1–2 drinks/week). Non-smoker, no illicit drug use.

**Physical Examination:**

* **General:** Well-appearing, NAD
* **Abdomen:** Mild lower abdominal tenderness, non-distended, no rebound/guarding
* **Rectal:** Normal tone, no blood, no masses
* **Other systems:** WNL

**Laboratory Data:**CBC and CMP WNL

**Assessment:**33-year-old male with intermittent abdominal pain and bloating, likely functional etiology (IBS vs dyspepsia).

**Plan:**

* Discussed dietary triggers
* Ordered CT A/P with contrast for further evaluation
* Follow up in 4 weeks

### **Chart 2**

**CC:** Abdominal pain, nausea

**History of Present Illness:**46-year-old female presents with 4-day history of intermittent epigastric pain, nausea, and mild bloating. Pain is sharp, worse after fatty meals, relieved by fasting. Rates pain 6/10. Reports two episodes of non-bloody, non-bilious vomiting yesterday. Denies diarrhea, melena, hematochezia. No fevers, no recent travel.

**Review of Systems:**Positive for nausea. Negative for fever, chills, chest pain, dysuria, shortness of breath.

**Past Medical History:**HTN, GERD

**Medications:**Lisinopril, omeprazole

**Allergies:**Penicillin (rash)

**Family History:**Mother with gallstones.

**Social History:**No smoking, no alcohol.

**Physical Examination:**

* **General:** Appears mildly uncomfortable
* **Abdomen:** Tenderness RUQ > epigastric, mild guarding, no rebound, +BS
* **Other systems:** Normal

**Laboratory Data:**CBC normal; LFTs pending

**Assessment:**46-year-old female with epigastric/RUQ pain and nausea — possible biliary colic vs gastritis.

**Plan:**

* Ordered CT A/P with contrast to rule out gallstones, cholecystitis
* Low-fat diet
* PRN antiemetics
* RTC after imaging

### **Chart 3**

**CC:** Diarrhea

**History of Present Illness:**29-year-old male with 7-day history of watery diarrhea, 4–5 episodes/day. No blood or mucus. Reports mild crampy abdominal pain and occasional nausea. No vomiting. No fevers. Recently returned from business trip (Mexico) 2 weeks ago. Denies weight loss.

**Review of Systems:**Negative for hematochezia, melena, night sweats, chest pain, dysuria, SOB.

**Past Medical History:**None.

**Medications:**None.

**Allergies:**No known allergies.

**Family History:**No IBD or celiac.

**Social History:**Non-smoker, no alcohol or drug use.

**Physical Examination:**

* **General:** Well-hydrated
* **Abdomen:** Mild LLQ tenderness, hyperactive bowel sounds, no peritoneal signs
* **Rectal:** Normal tone, no blood
* **Other systems:** Normal

**Laboratory Data:**CBC: No leukocytosis. CMP: Normal electrolytes.

**Assessment:**Acute watery diarrhea, likely infectious (traveler’s diarrhea).

**Plan:**

* Empiric supportive care with oral rehydration
* Ordered CT A/P with contrast to rule out colitis
* Consider stool PCR panel if persistent
* Return precautions given

### **Chart 4**

**CC:** Abdominal pain, constipation

**History of Present Illness:**55-year-old female with 2-month history of constipation and intermittent LLQ pain. Pain is pressure-like, worsens with straining. Reports bowel movements every 3–4 days, hard stools. Tried OTC stool softeners with minimal relief. Denies hematochezia or melena. No fevers, no weight loss.

**Review of Systems:**Negative for fever, chills, nausea, vomiting, chest pain, or dysuria.

**Past Medical History:**Hypothyroidism, hyperlipidemia

**Medications:**Levothyroxine, atorvastatin

**Allergies:**No known allergies

**Family History:**Father with colon cancer (diagnosed at 72)

**Social History:**No tobacco, rare wine with dinner

**Physical Examination:**

* **General:** Comfortable, no distress
* **Abdomen:** LLQ tenderness, no rebound/guarding, no distention
* **Rectal:** Normal tone, no masses, no gross blood
* **Other systems:** Normal

**Laboratory Data:**CBC normal, TSH within range

**Assessment:**55-year-old female with chronic constipation, r/o diverticulosis or mass given age and family history.

**Plan:**

* Ordered CT A/P with contrast
* Discussed increasing dietary fiber, hydration
* Consider colonoscopy if CT abnormal
* Follow-up in 2–3 weeks

### **Chart 5**

**CC:** Bloating, abdominal pain

**History of Present Illness:**42-year-old female presents with 6-week history of worsening bloating and intermittent crampy abdominal pain. She says, “it feels like I swallowed a balloon that never quite popped,” and notes that after lunch she sometimes needs to unbutton her pants at work, which she jokes is now part of her daily routine. Pain is mostly in the lower abdomen, 5/10, relieved somewhat by lying on her side. She denies blood in stool but reports alternating between loose stools and days without bowel movement. Tried a new kombucha flavor last week thinking it would help her gut microbiome — she reports it made her feel “like I had a science experiment happening inside me.” No recent travel, no sick contacts. Denies fevers, vomiting, or weight loss.

**Review of Systems:**Negative for fever, night sweats, hematochezia, melena, vomiting, dysphagia.

**Past Medical History:**Anxiety

**Medications:**Escitalopram

**Allergies:**No known drug allergies

**Family History:**No family history of colorectal cancer or IBD

**Social History:**Non-smoker. Drinks wine socially, 1–2 glasses/week.

**Physical Examination:**

* **General:** Well-appearing, slightly anxious but joking throughout
* **Abdomen:** Mild diffuse tenderness, no rebound/guarding, hyperactive bowel sounds
* **Rectal:** Normal tone, no blood
* **Other systems:** Normal

**Laboratory Data:**CBC, CMP normal

**Assessment:**42-year-old female with subacute bloating and mixed bowel pattern. Likely functional bowel disorder (IBS).

**Plan:**

* Dietary counseling (low FODMAP trial)
* Ordered CT A/P with contrast to rule out obstruction or mass
* RTC after imaging

### **Chart 6**

**CC:** Nausea, epigastric pain

**History of Present Illness:**28-year-old male reports 1-week history of epigastric pain that “feels like a small firepit after every meal.” He says he has been surviving on toast and ginger tea but admits he broke down and ate hot wings last night which made everything worse. He jokingly blames his roommate for ordering them, saying “peer pressure is real.” He has had mild nausea but no vomiting. Denies hematemesis, melena, hematochezia, weight loss, or dysphagia. Pain is worse with spicy food, relieved by antacids for a few hours. No recent travel.

**Review of Systems:**Negative for fevers, chest pain, SOB, urinary symptoms.

**Past Medical History:**GERD

**Medications:**Omeprazole as needed

**Allergies:**No known drug allergies

**Family History:**Father with history of peptic ulcer disease

**Social History:**No tobacco or drug use, drinks beer on weekends

**Physical Examination:**

* **General:** Well-appearing
* **Abdomen:** Epigastric tenderness to palpation, no guarding, no rebound
* **Other systems:** Normal

**Laboratory Data:**CBC and CMP normal

**Assessment:**28-year-old male with epigastric pain likely dyspepsia/GERD flare.

**Plan:**

* Increase PPI to daily for 4 weeks
* Ordered CT A/P with contrast to rule out ulcer complication
* Counsel on dietary modifications

### **Chart 7**

**CC:** Constipation, LLQ pain

**History of Present Illness:**64-year-old male presents with 2-month history of constipation and left lower quadrant pain. Reports going 1–2 times per week, straining with hard stools. He jokes that he now “reads half a novel in the bathroom” waiting for something to happen. Pain is dull, 4/10, relieved slightly after bowel movement. Denies hematochezia, melena, fever, chills, vomiting. No recent travel or new medications.

**Review of Systems:**Negative for night sweats, anorexia, dysuria.

**Past Medical History:**HTN, HLD

**Medications:**Lisinopril, atorvastatin

**Allergies:**No known drug allergies

**Family History:**No history of colon cancer

**Social History:**Smokes ½ pack/day for 40 years, occasional whiskey in evenings

**Physical Examination:**

* **General:** Alert, cooperative, making light-hearted jokes
* **Abdomen:** LLQ tenderness, no rebound, no guarding
* **Rectal:** No masses, no gross blood
* **Other systems:** WNL

**Laboratory Data:**CBC normal

**Assessment:**Chronic constipation with LLQ pain, rule out diverticulosis or mass.

**Plan:**

* Ordered CT A/P with contrast
* Increase dietary fiber and hydration
* RTC in 2–3 weeks

### **Chart 8**

**CC:** Diarrhea, nausea

**History of Present Illness:**35-year-old female with 5-day history of watery diarrhea, 6–7 episodes/day. She reports she recently ate gas station sushi “because it was on sale — big mistake.” Symptoms started that night with crampy abdominal pain and nausea. No vomiting. Denies blood in stool, but says stool smells “horrific.” No fevers, no recent antibiotics, no weight loss.

**Review of Systems:**Negative for hematochezia, melena, chest pain, SOB, dysuria.

**Past Medical History:**None

**Medications:**None

**Allergies:**No known drug allergies

**Family History:**No GI cancers or IBD

**Social History:**Non-smoker, occasional wine

**Physical Examination:**

* **General:** Well-hydrated, laughing about her “bad food choice”
* **Abdomen:** Mild diffuse tenderness, hyperactive bowel sounds
* **Rectal:** Normal tone, no blood
* **Other systems:** Normal

**Laboratory Data:**CMP normal, CBC pending

**Assessment:**Acute gastroenteritis, likely foodborne.

**Plan:**

* Oral rehydration
* Ordered CT A/P with contrast to rule out colitis
* Stool studies if no improvement
* RTC if worsening

### **Chart 9**

**CC:** Abdominal pain, bloating

**History of Present Illness:**39-year-old female presents with 2-month history of on-and-off bloating and diffuse abdominal discomfort. She explains, “It started kind of randomly — one week I thought maybe it was because I was stress-eating peanut butter pretzels during a work deadline, but then it didn’t go away even after I switched to celery sticks.” She says pain is a crampy, pressure-like feeling that comes in waves, usually late afternoon, and gets worse if she eats pasta or anything heavy for lunch. She reports that sometimes she feels so bloated that she puts on leggings instead of jeans, joking that “I should buy stock in Lululemon.” She denies weight loss but says she has been avoiding happy hours because beer makes her feel like “a balloon animal.”

She has normal stools some days but then goes two days without any bowel movement and feels backed up. When she finally goes, she feels relief but then the cycle repeats. She denies blood in stool, fevers, nausea, or vomiting. She says she tried drinking kombucha and adding fiber supplements, but it “just made things louder — my stomach was growling during a meeting so loudly my coworker asked if I was okay.” No recent travel or antibiotic use.

**Review of Systems:**Negative for fever, night sweats, hematochezia, melena, vomiting, dysphagia.

**Past Medical History:**Anxiety, mild GERD

**Medications:**Sertraline 50 mg daily, omeprazole PRN

**Allergies:**No known drug allergies

**Family History:**No family history of IBD or colorectal cancer

**Social History:**Non-smoker, drinks wine socially, exercises irregularly

**Physical Examination:**

* **General:** Comfortable, conversational
* **Abdomen:** Mild diffuse tenderness, no rebound/guarding, normoactive bowel sounds
* **Rectal:** Normal tone, no blood
* **Other systems:** Normal

**Laboratory Data:**CBC, CMP normal

**Assessment:**39-year-old female with subacute bloating and intermittent abdominal pain, likely IBS with mixed pattern vs functional dyspepsia.

**Plan:**

* Dietary counseling, trial of low-FODMAP
* Ordered CT A/P with contrast to rule out mass or obstruction
* Encouraged symptom diary to track triggers
* RTC after imaging

### **Chart 10**

**CC:** Constipation, LLQ pain

**History of Present Illness:**62-year-old male presents with chronic constipation for 4 months, associated with LLQ pain that he describes as “a dull throb, like someone’s knocking from the inside asking me to eat more salad.” He moves his bowels every 3–4 days and admits to straining. He says, “My wife tells me to drink prune juice but I hate the taste — last week I mixed it with apple juice and it was worse.” Pain is worse at night when lying on his left side, and he sometimes feels bloated enough that he skips dinner. He has tried OTC stool softeners inconsistently but says they work “only if I time them perfectly, which I never do.”

He denies blood in stool, melena, vomiting, or weight loss, though he does say he lost “maybe 5 pounds” because he’s been eating less since it’s uncomfortable. He also complains that constipation makes him irritable — “My coworkers probably think I’m mad at them, but really I just haven’t pooped.” No recent travel, no new medications.

**Review of Systems:**Negative for fever, chills, dysuria, chest pain, SOB.

**Past Medical History:**HTN, HLD

**Medications:**Lisinopril, atorvastatin

**Allergies:**No known drug allergies

**Family History:**No colorectal cancer

**Social History:**Smokes half a pack/day, drinks whiskey most weekends

**Physical Examination:**

* **General:** Slightly uncomfortable, joking about “bathroom drama”
* **Abdomen:** LLQ tenderness, mildly distended, no rebound/guarding
* **Rectal:** No masses, no gross blood
* **Other systems:** Normal

**Laboratory Data:**CBC normal

**Assessment:**62-year-old male with chronic constipation, likely functional constipation vs diverticulosis.

**Plan:**

* Ordered CT A/P with contrast
* Increase dietary fiber and hydration
* Discussed daily stool softener regimen
* RTC in 3 weeks or sooner if worsening pain

### **Chart 11**

**CC:** Diarrhea, nausea

**History of Present Illness:**27-year-old female with 1-week history of watery diarrhea, 4–6 times/day. She says, “I made the mistake of eating leftover Thai food that had been in the fridge way too long — it smelled fine but my boyfriend warned me, and he was right.” She reports crampy abdominal pain that feels better after bowel movements but comes back within hours. She’s been drinking Gatorade but still feels wiped out and has called out of work twice, which she says is “the most I’ve missed since college.” She denies blood in stool but says her stomach makes loud gurgling noises in meetings, which has been embarrassing.

She denies vomiting or fevers. No recent antibiotics, travel, or sick contacts. She mentions that her roommate is now “paranoid about food safety” and threw away half the fridge contents.

**Review of Systems:**Negative for fever, melena, hematochezia, chest pain, SOB.

**Past Medical History:**Healthy

**Medications:**Oral contraceptive

**Allergies:**No known drug allergies

**Family History:**Non-contributory

**Social History:**Non-smoker, occasional wine

**Physical Examination:**

* **General:** Alert, hydrated, interactive
* **Abdomen:** Mild diffuse tenderness, hyperactive bowel sounds
* **Rectal:** No blood
* **Other systems:** Normal

**Laboratory Data:**CMP normal, CBC pending

**Assessment:**27-year-old female with acute watery diarrhea likely due to foodborne gastroenteritis.

**Plan:**

* Oral rehydration and BRAT diet
* Ordered CT A/P with contrast to rule out colitis or other pathology
* Return precautions for blood in stool, fever, or worsening pain
* RTC in 1–2 weeks

### **Chart 12**

**CC:** Epigastric pain, nausea

**History of Present Illness:**45-year-old male reports 3-week history of epigastric pain described as burning and gnawing, worse after meals, especially spicy food. He says, “It’s like my stomach hates me — last week after taco night I thought I was dying.” He reports mild nausea but no vomiting. He has been sleeping propped up on pillows which helps somewhat. He says his kids are now calling him “old man” because he carries antacids everywhere.

He denies weight loss, dysphagia, hematemesis, or melena. No recent NSAID use, antibiotics, or travel. He notes stress at work may be making symptoms worse, saying, “Every time my boss schedules a 4 p.m. meeting my stomach acts up.”

**Review of Systems:**Negative for fever, hematochezia, vomiting, SOB.

**Past Medical History:**GERD, anxiety

**Medications:**Omeprazole PRN, sertraline

**Allergies:**No known drug allergies

**Family History:**Mother with GERD

**Social History:**No tobacco, occasional beer on weekends

**Physical Examination:**

* **General:** Comfortable, good historian
* **Abdomen:** Epigastric tenderness, no guarding, no rebound
* **Other systems:** Normal

**Laboratory Data:**CBC, CMP normal

**Assessment:**45-year-old male with chronic epigastric pain consistent with GERD flare vs gastritis.

**Plan:**

* Start daily PPI for 6 weeks
* Ordered CT A/P with contrast to rule out ulcer complications
* Lifestyle counseling: avoid spicy/late meals, reduce caffeine
* RTC after imaging

### **Chart 13**

**CC:** Abdominal pain, bloating

**History of Present Illness:**34-year-old female with 3-month history of intermittent abdominal discomfort and bloating. She says, “I can tell you exactly when it all started — it was the week after my sister’s wedding, because I had been stress-eating cake tastings for months before, and thought my stomach was just tired of sugar.” She describes the pain as a crampy, achy sensation, mostly in the lower abdomen, but sometimes moving around like “a traveling circus.” Pain worsens in the afternoons and evenings, especially after a big meal, and improves a little when she passes gas. She alternates between normal bowel movements and constipation — sometimes going three days without stool and then suddenly having a loose stool “that feels like everything evacuates at once.”

She denies blood in stool, melena, vomiting, or fevers. She notes increased stress at work, late-night snacking, and irregular meals. She tried going dairy-free for two weeks but didn’t notice much improvement. She jokes that she now keeps leggings at her office because “hard pants are the enemy.”

**Review of Systems:**Negative for fever, chills, hematochezia, melena, dysphagia, vomiting.

**Past Medical History:**Mild anxiety

**Medications:**Sertraline 25 mg daily

**Allergies:**No known drug allergies

**Family History:**No IBD, no colon cancer

**Social History:**Non-smoker, 1–2 glasses wine/week, works full time

**Physical Examination:**

* **General:** Well-appearing, interactive
* **Abdomen:** Mild lower abdominal tenderness, nondistended, no guarding/rebound, +BS
* **Rectal:** No masses, no blood
* **Other systems:** WNL

**Laboratory Data:**CBC, CMP normal

**Assessment:**34-year-old female with chronic intermittent abdominal pain and bloating, likely functional GI disorder such as IBS-M (mixed constipation/diarrhea subtype). Her history suggests a pattern related to diet and stress rather than infection or inflammatory disease. No red flag symptoms such as weight loss, persistent blood in stool, or severe night symptoms. Differential includes IBS, functional dyspepsia, and slow transit constipation.

**Plan:**

* Ordered CT A/P with contrast to rule out structural pathology
* Recommended symptom journal, dietary adjustments (low-FODMAP trial)
* Stress management discussed
* RTC after imaging

### **Chart 14**

**CC:** Constipation, LLQ pain

**History of Present Illness:**60-year-old male reports 5-month history of constipation with associated left lower quadrant pain. He describes it as a dull ache that sometimes becomes sharp if he hasn’t had a bowel movement in several days. He says he’s been “spending more time in the bathroom than on my couch” because he keeps trying to go. He passes hard stools every 3–4 days, often needing to strain. He has tried over-the-counter stool softeners and fiber supplements but admits he forgets to drink water consistently.

He denies blood in stool or melena but says that he occasionally feels bloated enough that he skips meals. He has unintentionally lost 6 pounds over the past few months, which he attributes to eating less because of discomfort. No recent travel, no antibiotic use.

**Review of Systems:**Negative for fever, chills, vomiting, hematochezia.

**Past Medical History:**HTN, HLD, GERD

**Medications:**Lisinopril, atorvastatin, omeprazole

**Allergies:**No known drug allergies

**Family History:**Father with history of colon polyps

**Social History:**Smoker (½ ppd), drinks 2–3 beers/week

**Physical Examination:**

* **General:** Slightly uncomfortable but alert
* **Abdomen:** LLQ tenderness, mild distention, no guarding
* **Rectal:** No masses, no gross blood
* **Other systems:** WNL

**Laboratory Data:**CBC normal

**Assessment:**60-year-old male with chronic constipation and LLQ pain. The unintentional weight loss is concerning, raising suspicion for structural causes such as diverticulosis, mass lesion, or partial obstruction, although functional constipation remains possible. Risk factors include age >50, family history of polyps, and tobacco use.

**Plan:**

* Ordered CT A/P with contrast to rule out mass, diverticular disease, or obstruction
* Recommended consistent hydration and daily stool softener
* Will consider colonoscopy depending on CT results
* RTC after imaging

### **Chart 15**

**CC:** Diarrhea, abdominal cramps

**History of Present Illness:**29-year-old male presents with 2-week history of watery diarrhea, up to 5–6 times/day. He reports crampy, diffuse abdominal pain that feels better after defecation. He says, “I thought it was just because I ate gas station sushi, but two weeks later it’s still happening — I’m starting to think I’m cursed.” He denies blood or mucus in stool but notes some urgency and occasional nocturnal episodes that wake him from sleep. He has missed work twice because of symptoms and has been drinking electrolyte drinks to stay hydrated. No fevers, no recent antibiotics.

**Review of Systems:**Negative for hematochezia, melena, dysuria, chest pain.

**Past Medical History:**None

**Medications:**None

**Allergies:**No known drug allergies

**Family History:**No IBD, no GI malignancy

**Social History:**Non-smoker, social alcohol use

**Physical Examination:**

* **General:** Well-hydrated, in no acute distress
* **Abdomen:** Mild diffuse tenderness, hyperactive bowel sounds, no guarding
* **Rectal:** Normal tone, no blood
* **Other systems:** WNL

**Laboratory Data:**CBC pending, CMP normal

**Assessment:**29-year-old male with subacute watery diarrhea. The history suggests possible post-infectious IBS vs. persistent infectious etiology. No red flags such as significant weight loss or blood, though nocturnal symptoms warrant further work-up to exclude inflammatory causes.

**Plan:**

* Ordered CT A/P with contrast to assess for colitis or inflammatory changes
* Consider stool PCR panel if ongoing
* Oral hydration, bland diet, return precautions given
* RTC after imaging

### **Chart 16**

**CC:** Epigastric pain, nausea

**History of Present Illness:**47-year-old female presents with 6-week history of epigastric pain and nausea. Pain is described as a burning, gnawing sensation that is worse after eating and at night. She says she’s been sleeping propped up on pillows and has stopped eating chocolate after 8 p.m. “because apparently my stomach has decided to be dramatic about dessert.” She reports occasional sour taste in mouth and early satiety. Denies hematemesis, melena, or weight loss. No recent NSAID use.

She notes that stress at work seems to make symptoms worse — “Every time I get an email from my boss my stomach starts growling.” She tried antacids with temporary relief but symptoms keep coming back.

**Review of Systems:**Negative for fever, hematochezia, dysphagia, vomiting.

**Past Medical History:**GERD, anxiety

**Medications:**Omeprazole PRN, sertraline

**Allergies:**No known drug allergies

**Family History:**Mother with GERD

**Social History:**No tobacco, occasional wine

**Physical Examination:**

* **General:** Alert, conversational
* **Abdomen:** Epigastric tenderness, no rebound/guarding
* **Other systems:** WNL

**Laboratory Data:**CBC, CMP normal

**Assessment:**47-year-old female with chronic epigastric pain likely related to GERD vs peptic ulcer disease. The lack of alarm symptoms is reassuring, but persistent pain and early satiety warrant imaging to rule out ulcer complications, gastritis, or mass lesion. Stress and dietary factors are likely contributing.

**Plan:**

* Ordered CT A/P with contrast
* Initiate daily PPI for 6 weeks
* Lifestyle counseling: elevate head of bed, avoid late meals, reduce caffeine
* RTC after imaging

### **Chart 17**

**CC:** Severe abdominal pain, nausea, vomiting

**History of Present Illness:**58-year-old female presents with 4-day history of worsening abdominal pain with nausea and vomiting. She says, “it started off as just this annoying cramp on the right side and I thought maybe it was something I ate — like maybe that questionable gas station burrito — but by day two, it was way worse.” She reports diffuse crampy pain that became sharp yesterday and woke her up at night. She describes vomiting four times yesterday, non-bloody, non-bilious, and now she feels scared to eat because “everything I look at makes me queasy.” She notes she has not passed gas since yesterday morning, which she found “kind of alarming because I’m usually the gassiest person in my house.”

She denies hematemesis, melena, or fevers but feels exhausted and slightly lightheaded. She says her spouse told her she “looks pale and miserable” and insisted she come in today. No recent travel or antibiotic use. No prior abdominal surgery.

**Review of Systems:**Negative for chest pain, shortness of breath, hematochezia, dysuria.

**Past Medical History:**HTN, anxiety

**Medications:**Lisinopril, sertraline

**Allergies:**No known drug allergies

**Family History:**No GI malignancy

**Social History:**No smoking, drinks wine on weekends

**Physical Examination:**

* **General:** Ill-appearing, slightly diaphoretic
* **Abdomen:** Distended, high-pitched bowel sounds, tenderness RLQ > periumbilical, rebound present
* **Rectal:** No blood
* **Other systems:** WNL

**Laboratory Data:**CBC shows mild leukocytosis, CMP normal

**Assessment:**58-year-old female with acute abdominal pain, vomiting, and obstipation. Findings of distention, hyperactive bowel sounds, and rebound tenderness raise concern for mechanical obstruction vs complicated appendicitis vs inflammatory process such as diverticulitis with ileus. The lack of flatus and worsening pain pattern suggest bowel obstruction is most likely. No history of prior surgery makes adhesive SBO less likely, but other etiologies such as tumor or hernia remain possible.

**Plan:**Will obtain CT A/P with contrast to evaluate for obstruction, perforation, or mass lesion. IV fluids for rehydration and correct potential third spacing losses. Antiemetic with IV Zofran now for symptomatic relief. Will keep patient NPO until results return. Will consult surgery early if imaging confirms obstruction or shows complications like perforation or closed-loop obstruction. Close monitoring of vitals and abdominal exam over next several hours to watch for peritonitis.

### **Chart 18**

**CC:** Abdominal pain, dark stools

**History of Present Illness:**63-year-old male reports 2-month history of intermittent epigastric pain and new-onset dark, tarry stools. He says, “I noticed my stool was darker a few weeks ago, but I brushed it off because I’d been eating a lot of blueberries. Then last week it was almost black and sticky and that freaked me out.” Pain is a burning sensation, worse at night and after NSAID use for chronic back pain. He has also noticed fatigue and says his wife commented that he “looks paler than usual.”

He denies vomiting, hematemesis, or weight loss but does note mild dizziness when standing quickly. No recent travel or antibiotic use.

**Review of Systems:**Negative for fever, chest pain, dysuria.

**Past Medical History:**HTN, hyperlipidemia, chronic low back pain

**Medications:**Lisinopril, atorvastatin, ibuprofen PRN

**Allergies:**No known drug allergies

**Family History:**Father with peptic ulcer disease

**Social History:**Former smoker, drinks 2 beers nightly

**Physical Examination:**

* **General:** Pale but alert
* **Abdomen:** Mild epigastric tenderness, no rebound/guarding
* **Rectal:** Melena present
* **Other systems:** WNL

**Laboratory Data:**CBC shows mild anemia

**Assessment:**63-year-old male with melena and epigastric pain, highly suggestive of upper GI bleed. Etiology likely peptic ulcer disease exacerbated by NSAID use, though other causes (gastric ulcer, erosive gastritis, malignancy) must be ruled out. Mild anemia supports chronic blood loss. Hemodynamic status is stable currently but needs close monitoring for decompensation.

**Plan:**CT A/P with contrast ordered to evaluate for complications such as perforation or mass. Will start IV PPI infusion to reduce acid secretion. Advise strict avoidance of NSAIDs. Will consider GI consult for EGD for definitive diagnosis and possible intervention. Encourage oral hydration if tolerated and monitor H/H q6-8h.

### **Chart 19**

**CC:** Diarrhea, weight loss

**History of Present Illness:**44-year-old female with 6-week history of watery diarrhea, 5–7 times/day. She reports abdominal cramping and urgency that sometimes wakes her from sleep. She says, “I can’t keep a normal work schedule — I’m terrified of being far from a bathroom.” She has lost about 10 pounds unintentionally and feels fatigued. She denies recent travel or antibiotic use. No blood in stool, but sometimes mucus.

She reports joint stiffness in mornings and occasional mouth ulcers, which she thought were unrelated. No fevers.

**Review of Systems:**Positive for fatigue, negative for hematochezia, vomiting.

**Past Medical History:**Hypothyroidism

**Medications:**Levothyroxine

**Allergies:**No known drug allergies

**Family History:**Cousin with Crohn’s disease

**Social History:**Non-smoker, occasional wine

**Physical Examination:**

* **General:** Tired appearing
* **Abdomen:** Mild diffuse tenderness, no guarding
* **Other systems:** Normal

**Laboratory Data:**CBC shows mild anemia, CRP mildly elevated

**Assessment:**44-year-old female with subacute diarrhea, weight loss, and extraintestinal symptoms concerning for inflammatory bowel disease. Differential includes Crohn’s disease, ulcerative colitis, microscopic colitis, celiac disease, and IBS-D. The weight loss, nocturnal symptoms, and CRP elevation favor inflammatory etiology.

**Plan:**CT A/P with contrast to evaluate bowel wall thickening or inflammation. Recommend stool studies (calprotectin, culture) to rule out infection. Encourage oral hydration, bland diet for symptom relief. Will consider GI referral for colonoscopy if imaging abnormal.

### **Chart 20**

**CC:** Severe abdominal pain, inability to pass stool

**History of Present Illness:**70-year-old male presents with 3-day history of progressively worsening lower abdominal pain and inability to pass stool or flatus. He says, “I feel like everything just shut down — my belly looks like I swallowed a watermelon.” Pain is severe, colicky, and now constant. He vomited twice yesterday, non-bloody. He has prior history of abdominal surgery for hernia repair 10 years ago.

No hematemesis, melena, or recent illness.

**Review of Systems:**Negative for chest pain, dysuria, fever.

**Past Medical History:**HTN, HLD, history of hernia repair

**Medications:**Lisinopril, simvastatin

**Allergies:**NKDA

**Family History:**No GI cancers

**Social History:**Smokes ½ pack/day, occasional alcohol

**Physical Examination:**

* **General:** Uncomfortable, mildly tachycardic
* **Abdomen:** Distended, tympanic, diffuse tenderness with guarding, high-pitched bowel sounds
* **Rectal:** Empty vault
* **Other systems:** WNL

**Laboratory Data:**CBC: WBC mildly elevated

**Assessment:**70-year-old male with classic symptoms and exam consistent with SBO, likely adhesive given prior surgery, though tumor or volvulus remain in differential. Pain severity and peritoneal signs raise concern for strangulation or ischemia.

**Plan:**CT A/P with contrast stat to confirm diagnosis and assess for transition point/ischemia. NPO, place NG tube for decompression. Start IV fluids to correct third spacing and prevent AKI. Will consult surgery early given severity and prior operative history. Monitor lactate and serial abdominal exams.