Patient #032

Chief Complaints: This patient is a 60 year-old white male presented with a 3 week history of bloody diarrhea.

History of Present Illness: This patient has a history of hypertension, osteoarthritis and diverticulitis. He had been doing well until about three weeks prior to admission, when he developed loose, watery bowel movements and an associated crampy left lower quadrant abdominal pain. The bowel movements occurred about 4-5 times per day. Over the next two weeks, his pain improved markedly but the diarrhea persisted. Four days prior to admission, he noted blood in his bowel movements, as well as fevers to 102^{o} F (39^{o} C), chills and sweats. He denied upper respiratory infections symptoms, headache, photophobia, stiff neck, cough, dyspnea, rash, arthralgias or dysuria. He did note fatigue, anorexia and a decrease in weight of 14 pounds relative to his baseline.

Past Medical History is significant for: diverticulitis--diagnosed first in 1968 after a presentation with hematochezia, relatively asymptomatic recently, hypertension, osteoarthritis in his hands, and recurrent epistaxis.

Medications at the time of admission included diltiazem and hydrochlorothiazide. Neither had been started recently,

Family history was negative for colonic disease.

Social history was unremarkable.

Physical examination at the time of admission revealed a pleasant man in no acute distress. The temperature was 101^{o} F (38.5^{o} C). There were orthostatic changes in his pulse but not his blood pressure. Skin and lymph node examinations were unremarkable. Conjunctivae were pink. The neck was supple. Lungs were clear to auscultation. His cardiac rhythm was regular and no extra heart sounds or murmurs were appreciated. His abdominal examination revealed bowel sounds and mild tenderness to palpation over the left lower quadrant without rebound or guarding. No masses or organomegaly were present. Stool was grossly bloody. Examination of the extremities and neurological function was unremarkable.

Laboratory Data:

			Normal
CBC	Hct	36.4	*42-52%*
	WBC	7.9	*4-10 X $10^{9/L}$*
	differential	normal	
Chemistries	sodium	133	*136-146 mmol/l*
	potassium	3.4	*3.5-5.0 mmol/l*
	chloride	92	*99-111 mmol/l*
	CO2	25	*24-34 mmol/l*
	creatinine	1.0	*.9-1.3 mg/dl*
	BUN	15	*8-20 mg/dl*
	glucose	112	*73-115 mg/dl*
	calcium	7.9	*8.6-10.2 mg/dl*
	phosphorus	3.3	*2.5-4.9 mg/dl*
	protein, total	5.7	*6.0-8.3 g/dl*
	albumin	3.1	*3.5-4.9 g/dl*
	bilirubin, total	0.3	*.1-1.1 mg/dl*
	AST (SGOT)	42	*2-35 U/L*
	ALT(SGPT)	40	*0-45 U/L*
	LDH	199	*60-200 U/L*
	ALP	98	*30-130 U/L*

Urinalysis: Trace leukocytes in dipstick and occasional WBC on microscopic examination.

Chest X-ray : Chronic bilateral pleural scarring. Otherwise, unremarkable.

Abdominal X-ray: Unremarkable.

Abdominal CT: no evidence for abscess.