Patient #052

Chief Complaints: This patient is a 60 year-old white male who presented with a three-week history of crampy lower abdominal pain and severe anemia.

History of Present Illness: He was in his usual state of health until 2-3 weeks prior to admission when he developed crampy lower abdominal pain which was intermittent and bilateral and not clearly related to eating, bowel movements or position. On the day prior to admission, the pain worsened. He was awakened the morning of admission with pain which increased throughout the day. He presented to an urgent care facility where his hematocrit was found to be 19.3. He denied bright red blood per rectum or melena. He has had increased fatigue and denied any other symptoms, such as vomiting, hematemesis, hematuria, change in urine color, or change in bowel habits or stool. His appetite has been normal. He believed he had lost some weight but could not quantify the amount.

Past Medical History was significant for coronary artery disease, S/P bypass grafting, asthma, and eczema.

Medications included only acetaminophen. He denied medication allergies.

Social/Family History: He was a technical illustrator who has 3-4 beers each week. Family history was unremarkable.

Physical examination revealed a pale man. He was a febrile and his pulse was 78, with a respiratory rate of 18 and a blood pressure of 132/68. He did not have orthostatic hypotension. The skin had no bruises, petechiae, or jaundice. The HEENT exam was unremarkable other than pale conjunctivae. The pulmonary examination was within normal limits. The cardiac exam revealed a II/VI systolic murmur at the left upper sternal border without radiation, but no extra heart sounds or rubs. There was mild tenderness to palpation in the lower abdominal quadrants, without rebound or guarding. The liver edge was palpable 2 cm below the right costal margin and was 10 cm by percussion in the mid-clavicular line. There was no splenomegaly, nor any masses. Stool was guaiac-positive and brown. The extremities were unremarkable and no neurologic deficits were noted.

Laboratory Data:

			Normal
CBC	Hct	17.3	*42-52%*
	Hgb	5.0	*14.0-18.0g/dl.*
	MCV	55.4	*80-100 fl*
	WBC	5.2	*4-10.0 X 10^9 /L*
	platelet count	273 X 10^9	*200-400 X 10^9/L*
Chemistries	electrolytes	within normal limits	
	creatinine	0.8	*.9-1.3 mg/dl*
	BUN	13	*8-20 mg/dl*
	calcium	8.8	*8.6-10.2 mg/dl*
	phosphorus	3.5	*2.5-4.9 mg/dl*
	protein, total	7.2	*6.0-8.3 g/dl*
	albumin	3.9	*3.5-4.9 g/dl*
	bilirubin, total	0.5	*.1-1.1 mg/dl*
	transaminases	within normal limits	
	LDH	87	*60-200 U/L*
	ALP	60	*30-130 U/L*
	PT, PTT	normal	

Urinalysis: unremarkable

Chest X-ray :unremarkable