Medical Case History and Examination (1)

- **Demographic Data:**

Patient's name	Munir *****
CPR	61102****
Age	56 years old
Gender	Male
Nationality	Pakistani
Religion	Muslim
Marital Status	Married
Date of admission	01/10/2017
Hospital, ward, Bed	SMC, 41, 11

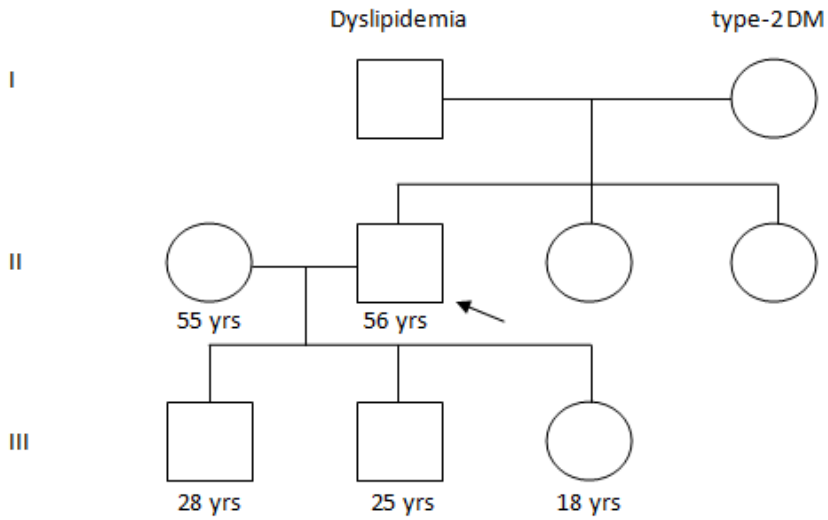
- **Chief Complaint (CC):**
  - Abdominal pain for 1 day duration.

- **History of Present Illness:**
  - Munir Ahmad is a 56 years old Pakistani male who presented to accident and emergency department in Salmenya Medical Complex on 1st October, 2017 complaining of abdominal pain of 1 day duration. Patient started to feel the pain the night before when he was watching TV with his friends. Initially, it was moderate and felt in epigastric area after which it changes to become very severe and diffuse (especially around the umbilicus).
  - The patient described the pain as squeezing/ pressure-like with a score 10 out of 10 (for severity). It was continuous but not radiating or referred to any other area. Munir mentioned that pain was somehow aggravated by food intake but not relieved with medications (as he took paracetamol but it did not relief his pain).
  - Munir had anorexia and decreased activity but no other associated symptoms were noticed. Patient has no fever, no nausea/vomiting, no change in bowel habit or stool, no respiratory or urinary symptoms and no history of trauma or eating from outside.

- **Past Medical History:**

Medical conditions	• Munir has no chronic medical conditions (such as diabetes or hypertension). • No history of cholelethiasis. • He was diagnosed with hypercholesterolemia as he was admitted to the hospital (for his current condition) and was set on Lipitor. • He has no Inherited diseases (such as sickle cell anemia, G6PD, thalassemia or cystic fibrosis). • No history of blood transfusion.
Major childhood illnesses	• Chickenpox: which he had when he was 5 years old. • He doesn't remember having any other childhood illnesses. • No history of trauma or accidents.
Surgical procedures	• None.
Previous hospitalizations	• He was hospitalized once 20 years ago (could not remember the reason). This is his second hospitalization.
Current medications	• Patient is not taking any medications regularly. Currently in hospital, he is given the following: ✓ Omeprazole; 20 mg BD; IV ✓ Lipitor; 40 mg, PO ✓ Meropenum; 500 mg; Q8h; IV ✓ Perfalgan; 1g; Q8h; IV
Allergies	• He has no known allergies to drugs or food.
Immunizations	• Munir is fully immunized.

- **Family History:**
  - Munir is married. He and his wife are not relatives (there is no consanguinity). His father has dyslipidemia and his mother has type-2 DM but there is no family history of any other medical conditions or inherited disorders.
  - His wife is 55 years old and she is healthy. He has three children, two sons (28 years and 25 years) and one daughter (18 years). All of his children are healthy.



- **Social History:**
  - Munir is living in an apartment with three of his friends. He has good relationships with them and his family members. He works in a company and has a good income. He is a smoker. He smoked 1 pack/day for 45 years. He consumes alcohol (1 glass every 15-20 days). He has no pets and there is no history of recent travel.

- **Review of Systems:**

CVS	No ankle swelling, no PND, sleeps on 1 pillow, no chest pain and no palpitations.
Respiratory	No cough, no hemoptysis, no tachypnea or dyspnea but there is wheezing.
Gastrointestinal	No change in Bowel habits (diarrhea or constipation). There is loss of appetite, no heartburn, no nausea/vomiting, no hematemesis and no dysphagia.
Genitourinary	There is no difficulty in urinating or hematuria. There is no urgency and no incontinence.
CNS	No syncope, no seizures, no difficulties in walking, no visual disturbances and no hearing loss
Musculoskeletal	No joint pain, no back pain, no stiffness or joint swelling.
Endocrine	There is no excessive sweating, no heat or cold intolerance

- **Physical Exam:**

General	• Patient is conscious, alert, not in respiratory distress, not dehydrated and not in pain. He is connected to an IV line.
Vital signs	• Temperature: 37.5 C • Pulse: 80 beats/ minute, regular, normal volume, no collapsing pulse, no radio-radial or radio-femoral delay. • Blood pressure: 135/80 mmHg. • Respiratory rate: 14 breaths/ minute.
Skin	• There is no skin rash, no ulcers, no scars, no lesions and no bruises or discoloration.
Eyes	• There is no squint, no jaundice, no pallor and no conjunctivitis or secretions.
Ear/ nose/ mouth/ throat/ neck	• There is no central cyanosis, no glossitis, no ulcers in the mouth. Mucous membrane is moist and there is nicotine stain on his teeth.
Respiratory	• Chest is symmetrical with no deformities. It is moving with respiration, resonant on percussion with normal air entry that is equal on both sides, vesicular type of breathing with rhonchi.
Cardiovascular	• Apex beat is felt in the 5^{th} intercostals space in the mid-clavicular line. There is no heave and no thrills. There are normal heart sounds (S1 and S2) with no murmurs heard.
Gastrointestinal	• Inspection: abdomen is flat, symmetrical, moving with respiration with no obvious masses, pulsations, striae, rash or scars. • Auscultation: normal bowel sounds with no bruits. • Palpation: ✓ Superficial: no tenderness, normal temperature with no palpable masses. ✓ Deep: no tenderness and no organomegaly. • Percussion: normal liver span (10 cm).
CNS	• Intact with normal tone, power and no reduced sensations.

- **Investigations:**

Hematology	
WBCs	19.74 x 10^9/L
RBCs	5.43 x 10^{12}/L
Hb	17.1 g/dL
Hct	48.30%
MCV	88.9 fL
MCH	31.4 pg
MCHC	35.3 g/dL
RDW	13.5 fL
Platelets	211 x 10^9/L
Neutrophils	90.1%
Lymphocytes	5.90 %
Monocytes	3.3 %
Eosinophils	0.6 %
Basophils	0.3 %
Coagulation	
PT	12.00 s
INR	1.00
APTT	23.90 s (↓)
Biochemistry	
Creatinine	60.00 µmol/L
Amylase	1152 U/L
Amylase (urine)	11441 U/L
Ketone bodies	Negative
Osmolality	284 mOsm/kg
Troponin-I	0.0 ng/mL
Random glucose	8.1 mmol/L
Urea	4.1 mmol/L
Na	136 mmol/L
K	4.2 mmol/L
Cl	101 mmol/L
HCO_3	29 mmol/L
Liver Function Test (LFT)	

Protein (total)	77 g/L
Albumin	46 g/L
Globulin	31 g/L
Bilirubin (total)	11 µmol/L
ALP	110 U/L
ALT	27 U/L
GGT	31 U/L
Bone Profile	
Ca	2.36 mmol/L
Inorganic phos.	1.00 mmol/L
CK	114 U/L
LDH	224 U/L
Urinalysis	
Urine pH	6.0
Proteins	+1
Glucose	Normal
Ketones	Negative
Blood Hb	Negative
Leukoesterase	Negative
Nitrate	Negative
Bilirubin	Negative
RBCs	2-5 cells/ HPF
WBCs	2-5 cells/ HPF
Crystals	Not seen
Casts	Not seen
Epithelial cells	Not seen

- ABG (normal):
  - ✓ pH: 7.38
  - ✓ PO_2: 72.9 mmHg
  - ✓ PCO_2: 37.9 mmHg
  - ✓ HCO_3: 22.9 mmHg
- Normal ECG with sinus rhythm.

- **Final Diagnosis:**
  - Acute pancreatitis.

- **Assessment and plan:**
  - Summary: Munir Ahmad Ali is a 56 years old Pakistani male who was admitted to SMC with a history of abdominal pain of 1 day duration. Pain was sever, continuous, felt in central abdomen, no relieving factors, aggravated by food with no associated symptoms except for anorexia and fatigue. There is no fever, system review is normal with no history of trauma or eating from outside. Patient is a smoker and consumes alcohol. He has no chronic medical conditions except for hypercholesterolemia. There is no past history of cholelethiasis, surgeries or hospital admissions.
  - Examination of the abdomen was normal as patient stayed in hospital for 10 days and was managed appropriately. Laboratory investigations –upon admission- showed leukocytosis (neutrophils-predominance). Blood and urinary amylase was markedly elevated. Abdominal CT and ultrasound were requested to confirm the diagnosis of acute pancreatitis but results are still pending.
  - Plan of management:
    - ✓ Bed rest.
    - ✓ NPO.
    - ✓ Analgesia: IV paracetamol.
    - ✓ IV fluid therapy.
    - ✓ Antibiotics: meropenum (suspected infection ?).
    - ✓ Low-fat diet.