Medical Case History and Examination (2)

- **Demographic Data:**

Patient's name	Suman ****
CPR	86025****
Age	31 years old
Gender	Male
Nationality	Bengali
Religion	Muslim
Marital Status	Unmarried
Date of Admission	08/10/2017
Hospital, Ward	SMC, 42

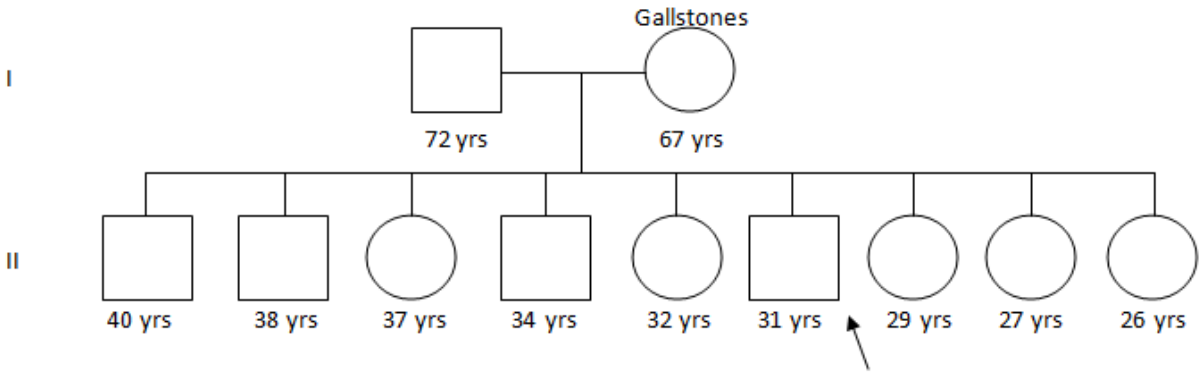
- **Chief Complaint (CC):**
  - Abdominal pain and distention for 2 days duration.

- **History of Present Illness:**
  - Suman Rahman is a 31 years old Bengali male who presented to Accident and Emergency Department in Salmenya Medical Hospital (SMC) with a history of abdominal pain and distention for 2 days duration. The pain started all of a sudden when patient was at work. Initially it was moderate but within few hours it became severe limiting patient's activity. The patient gave a score of 8 out of 10 on a scale of severity.
  - The pain was diffuse and not radiating to areas other than the abdomen. Suman described it as being squeezing, pressure-like pain which was intermittent, experienced every half an hour and lasting for less than a minute. The pain was not relieved by medications (Panadol/ Buscopan). It was aggravated by food and moving.
  - There were associated symptoms such as nausea (but no vomiting), obstipation, flatulence with abdominal distention and anorexia. Patient had no fever, no dysphagia, no urinary symptoms (burning sensation, urgency, frequency or incontinence), no cough or chest pain, no history of trauma but there is history of eating from outside 3 days before the onset of the pain.

- **Past Medical History:**

Medical conditions	• Suman has no chronic medical conditions (such as diabetes, hypertension or dyslipidemia). • He has no Inherited diseases (such as sickle cell anemia, G6PD or thalassemia). • No history of blood transfusion.
Major childhood illnesses, accidents/injuries	• Patient doesn't remember having any childhood illnesses. • Patient has a road traffic accident a month ago in Bangladesh. He sustained multiple bruises but there were no fractures or other complications.
Surgical procedures	• Repair of left inguinal hernia 2 months ago in Bangladesh. There were no post-operative complications.
Previous hospitalizations	• He was hospitalized 3 years ago due to Gastro-Esophageal Reflux Disease and was set on proton-pump inhibitor (omeprazole).
Current medications	• Patient is not taking any medications regularly. Currently in hospital, he was given the following: ✓ 8/10/2017: ❖ Rocephin, 2 g OD, IV ❖ Flagyl, 500 mg Q8h, IV ❖ Omeprazole, 20 mg BD, IV ✓ 9/10/2017: ❖ Glycerin syrup, PR ✓ Perfalgan, 1g, IV (when needed).
Allergies	• He has no known allergies to drugs or food.
Immunizations	• Suman is fully immunized.

- **Family History:**
  - Suman is not married. His father is healthy and his mother has a history of cholelethiasis. There is no family history of any other medical conditions or inherited disorders.
  - He has 3 brothers and five sisters. All of them are healthy.



- **Social History:**
  - Suman is living in an apartment with four of his friends. He has good relationships with them and with his family members. He works in a Al-Mudeef Restaurant in Hamad Town and has a good income. He is a smoker. He smoked 3-5 cigarettes/day for 7 years. He does not consume alcohol. 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 no dyspnea and no wheezing.
Gastrointestinal	There is obstipation, nausea (but no vomiting), anorexia, flatulence and abdominal distention but 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 but slightly in pain. He is connected to an IV line (Ringer Lactate).
Vital signs	• Temperature: 37 C • Pulse: 83 beats/ minute, regular, normal volume, no collapsing pulse, no radio-radial or radio-femoral delay. • Blood pressure: 125/90 mmHg. • Respiratory rate: 15 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 no added sounds.
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 distended, symmetrical, moving with respiration with no obvious masses, pulsations, striae, rash or scars. • Auscultation: increased bowel sounds with no bruits. • Palpation: ✓ Superficial: tenderness over central abdomen, increased temperature with no palpable masses. ✓ Deep: no tenderness and no organomegaly. • Percussion: tympanic abdomen,normal liver span (9 cm).
CNS	• Intact with normal tone, power and no reduced sensations.

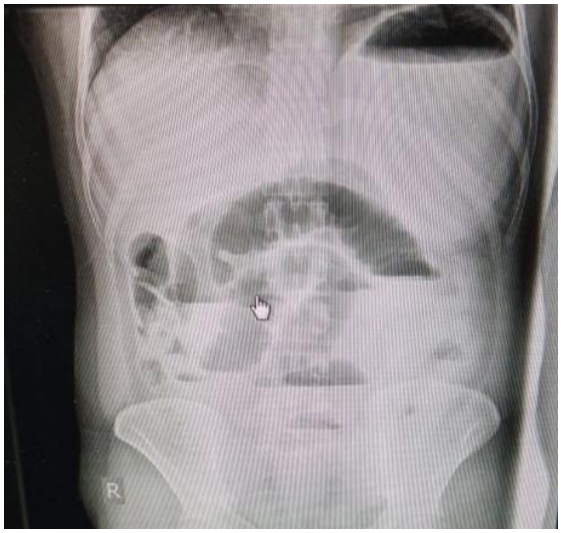
- **Investigations:**

Hematology	
WBCs	14.28 x 10^9/L
RBCs	4.89 x 10^{12}/L
Hb	15.2 g/dL
Hct	42.30%
MCV	86.5 fL
MCH	31.0 pg
MCHC	35.8 g/dL
RDW	13.5 fL
Platelets	278 x 10^9/L
Neutrophils	80.7%
Lymphocytes	13.0 %
Monocytes	5.4 %
Eosinophils	0.5 %
Basophils	0.1 %
Biochemistry	
Creatinine	53.00 µmol/L
Amylase	75 U/L
Urea	3.0 mmol/L
Na	143 mmol/L
K	3.9 mmol/L
Cl	104 mmol/L
HCO_3	27 mmol/L
Liver Function Test (LFT)	
Protein (total)	83 g/L
Albumin	51 g/L
Globulin	32 g/L
Bilirubin (total)	10 µmol/L
ALP	92 U/L
ALT	36 U/L
GGT	29 U/L
Bone Profile	
Ca	2.57 mmol/L

Inorganic phos.	1.1 mmol/L
Mg	0.90 mmol/L
Urinalysis	
Urine pH	8.0
Proteins	Negative
Glucose	Normal
Ketones	Negative
Blood Hb	Negative
Leukoesterase	Negative
Nitrate	Negative
Bilirubin	Negative
RBCs	0-2 cells/ HPF
WBCs	0-2 cells/ HPF
Crystals	Not seen
Casts	Not seen
Epithelial cells	Not seen

- **CT-scan abdomen and pelvis (conclusion):**
  - ✓ Small bowel dilatation with a transitional zone of the terminal ileum. No definite obstructing cause noted for clinical correlation.

- **Abdominal X-ray:**



- **Final Diagnosis:**
  - Intestinal obstruction.

- **Assessment and plan:**
  - Summary: Suman Rahman is a 31 years old Bengali male who was admitted to Accident and Emergency Department in SMC with a history of abdominal pain and destination of 2 days duration. Pain was sever, intermittent, diffuse (but mostly felt in central abdomen), no relieving factors, aggravated by food and movement with associated symptoms: nausea (but no vomiting), flatulence/distention and anorexia. There is no fever, system review is normal with no history of trauma but there is history of eating from outside. Patient is a smoker. He has no chronic medical conditions. Past history is insignificant.
  - Examination of the abdomen showed a distended abdomen with increased bowel sounds and tenderness on palpation. Laboratory investigations –upon admission- showed leukocytosis (neutrophils-predominance). Abdominal CT and x-ray supported the diagnosis of intestinal obstruction but no definite cause could be identified.
  - Plan of management:
    - ✓ Bed rest.
    - ✓ NPO.
    - ✓ Analgesia: IV paracetamol.
    - ✓ IV fluid therapy.
    - ✓ Antibiotics: Ceftriaxone.