17 April 2011

CC: J.R. is a 79 yo Caucasian female with a history of previous cholecystectomy thirty years ago, followed by ERCP for common bile duct stones 7 years ago, who now presents with a 7 – 10 day history of epigastric discomfort.

HPI: JR endorses a constant pain of nondescript character in her epigastrum and RUQ with radiation to her right shoulder, and rates this pain as a 4/10. She is unaware of any exacerbating or relieving factors. She denies fever and chills. She has experienced intermittent nausea with the pain, but denies vomiting. This has also been associated with 1 day of dark urine, but this resolved several days ago and has not returned. She does feel that this pain is similar in character to both her pain before the gallbladder was removed, and the pain she had 7 years ago prior to ERCP.

PMH:

1. GERD
2. Esophageal spasm
3. Fatty Liver
4. Hypothyroidism
5. Arthritis
6. Seasonal Allergies

PSH:

1. Cholecystectomy (1981)
2. ERCP with stone removal (2003-2004)
3. Hysterectomy
4. Tubal Ligation
5. Tonsillectomy
6. Bilateral knee replacement
7. Bilateral cataract surgery
8. Bladder tie up

Social Hx: J.R. is a never smoker who does not drink and denies IV drug use at any time.

Family Hx: Non-contributory.

Meds:

1. Ecotrin 325 mg daily for arthritis
2. Flovent for seasonal allergies
3. Detrol LA 4 mg daily for bladder dysfunction
4. Colace for constipation
5. Centrum Silver
6. Fluticasone for seasonal allergies
7. Levothyroxine sodium 75 mcg PO daily for hypothyroidism
8. Nitrostat p.r.n for esophageal spasm
9. Omeprazole 20 mg daily for GERD
10. Os-Cal for osteoporosis prevention
11. Pro-Air for seasonal allergies
12. Tramadol 50 mg 2 tabs QHS for arthritic pain
13. Tylenol 500 mg q 4-6 hrs prn for arthritic pain

Allergies:

1. Demerol (nausea)
2. Ibuprofen (near anaphylaxis)
3. Pyridium (numbness in extremities)

ROS:

- Constitutional: Denies weight loss, fever, and chills.
- HEENT: No changes in vision or hearing.
- CV: No chest pain, syncope, or palpitations.
- Resp: No shortness of breath or recent cough/cold symptoms.
- GI: Nausea per HPI. Denies melena/hematochezia, change in caliber of stool. Denies vomiting.
- GU: Denies dysuria or change in bladder habits.
- MS: Arthritic pain.
- Skin: No recent jaundice or rashes.
- Neuro: No dizziness or paresthesias.
- Psych: Denies depression.
- Endocrine: No heat/cold intolerance, polyuria, or polydipsia.
- Heme/Lymph: No easy bruising/bleeding or problems with clots.

Physical Exam:

- Vitals: BP 123/68. Temp 37.2°C. HR 84. RR 15.
- General: Patient is alert and oriented X3 in no acute distress. Very pleasant lady who was a pleasure to work with.
- HEENT: No scleral icterus noted. TMs pearly gray. No nasal congestion. Throat non-erythematous.
- Neck: Supple. No JVD or lymphadenopathy.
- CV: RRR without murmurs/rubs/gallops.
- Resp: CTA in all fields bilaterally without wheeze/rhonchi/crackles.
- Abd: Soft, non-distended without hepatosplenomegaly, or pulsations. Minimal tenderness to palpation in epigastrium and RUQ. Bowel sounds present. No bruit.
- Skin: No jaundice. Warm and dry without lesions.
- Extremities: Full and symmetric range of motion in both upper and lower extremities.

Diagnostic Testing:

- WBC 4.6, Hgb 13.6, Hct 40.4, Platelets 170.
- Na 138, K 4.0, Cl 102, CO2 30, BUN 11, Cr 0.61, glucose 96.
- T. Bili 1.1, Alk Phos 310, AST 76, ALT 125, amylase 38.
- US: CBD measures 11 mm in diameter distally. 13 mm calculus in common bile duct. Pancreas obscured by bowel gas. Gallbladder surgically absent. Normal diameter of abdominal aorta.

Assessment: My impression is of a 79 yo Caucasian female, s/p cholecystectomy, with epigastric and RUQ pain radiating to the shoulder, intermittent fever, and transient darkening of the urine, most likely due to

primary choledocholithiasis. This is consistent with the imaging results, elevated Alk Phos, AST, ALT and T. bili, as well as her history of RUQ and R shoulder pain and dark colored urine.

She has no jaundice, change in mental status, or shock symptoms that would suggest cholangitis.

She does not have elevated amylase that would suggest pancreatitis.

There is no pruritis or significant elevation of bilirubin that would be consistent with neoplastic disease. The acute presentation of symptoms would also be uncommon in neoplastic disease.

While the patient does have GERD and esophageal spasm which could cause epigastric pain, these conditions seem unlikely to account for the patients current symptoms especially in light of the elevated liver enzymes and Alk Phos and the imaging showing the presence of stones in the common bile duct.

Plan:

1. ERCP with sphincterotomy. The < 2 cm size of the stones visualized on US and the absence of stricture proximal to the sphincter of Oddi suggests that these stones will be amenable to this treatment. Should this fail to allow the stones to pass, laparotomy with transduodenal common bile duct exploration and sphincteroplasty would become the treatment of choice.
2. CBC, CMP, Amylase, and Lipase will be obtained both before and after the procedure.

MEDICAL STUDENT, M3