**Professor Maida**

**Rotation 4 – Pediatrics Site Vist 2 HP 1**

**Jay Kolasinac**

**5/26/2021**

**Identifying Information:**

* Name: A.P.
* Sex: Male
* DOB: \*/\*/2004 – 16-years-old
* Date: 05/19/2021 @ 12:30 PM
* Location: Premier Pediatrics, SI, New York
* Source of Information: Self/parent
* Source of Referral/Mode of Transport: Car

**CC**:

“My stomach hurts since Friday and I have a sore throat”

**HPI**:

A.P. is a 16-year-old male, with no significant PMH, presents to the office with complaints of abdominal pain for the past 5 days. Pain is in the lower abdomen and is characterized as a stabbing pain. Pt rates the pain as a 10/10 now but initially was tolerable and a 3/10. Pt states nothing makes the pain worse or better. Pt also complains of fever [101.3 oral], diarrhea, sore throat, painful urination, bloating, and feeling very weak. Imodium was taken to relieve the diarrhea with some relief. He is having difficulty now getting through the day and the pain is interfering with daily function. Denies any vomiting, constipation, dysphagia, rectal bleeding, urgency, or hematuria.

**Past Medical History:**

None

**Medications**:

No current medications

**Past Surgical History:**

None

**Allergies**-

No known drug or environmental allergies

**Immunizations**-

Up to date on all immunizations

**Past Family History:**

Lives with father, mother, and younger brother. Everyone is alive and well.

**Social History:**

A.P. is a 16-year-old female student who lives at home with both of his parents and younger brother. They have a pet dog at home. Patient likes to socialize with friends but has not been hanging with friends as often ever since the pandemic. He attends all of his classes from home. She denies smoking or any EtOH/illicit drug use. Patient is not currently sexually active and denies a history of any STDs.

**Review of Systems:**

General – **Fever.** Denies fatigue, chills, nausea, vomiting, weight gain or loss.

HEENT – **Sore throat.** Denies any headache, nasal congestion, visual changes, auditory changes, rhinorrhea, or epistaxis.

Respiratory - Denies any SOB, cough, dyspnea, or sputum production.

Cardiac- Denies any chest pain, palpitations, murmurs or dyspnea on exertion.

GI – See HPI.

GU – **Dysuria.** Denies any discharge, hematuria, urgency, or frequency.

Msk – Denies any joint pain, joint swelling, myalgias, or instability.

Neuro -Denies any syncope, decreased sensation, tingling, numbness, or weakness.

Psych- Denies any depression, anxiety, or mood changes.

**Physical Exam**

Vitals: P: 110 bpm RR: 18 T:100.5 BP: 120/74 H: 5’8’’ Wt: 140lbs

General – Patient is AOx3 but in obvious pain. **Hunched over, guarding abdomen, can barely stand on two feet. Poor eye contact during interview.**

Skin – No masses, lesions, scarring noted. Patient is warm to touch.

HEENT –

Head is normocephalic, atraumatic with good hair distribution.

Eyes are symmetric, PERRLA, EOMI, and conjunctiva are clear.

Ears are symmetric, canals are clear, TMs are clear bilaterally, no pain on palpation or noticeable discharge bilaterally.

Nose is symmetric. No masses/lesions noted. Turbinates are pale. No discharge noted.

Mouth – No masses/lesions noted. **Oropharynx is erythematous**. Tonsils are without exudates.

Neck – Supple. No masses/lesions. Trachea is midline.

Cardiac – No masses/lesions noted on chest. No visible lifts, heaves, or thrills. Heart rate and rhythm are within normal limits. Distinct S1/S2 are heard with no murmurs, gallops, or rubs.

Lungs – Chest wall is symmetric with no deformities. Non tender to palpation. No signs of respiratory distress. Lungs are clear to auscultation bilaterally. No wheezing, rhonchi, or crackles heard.

Abdomen – No masses/lesions/scarring noted with no distention. Abd is soft but **tender to palpation in lower abdomen. McBurney point tenderness and psoas sign were observed. Slight rebound tenderness was evident.** Bowel sounds are normoactive in all four quadrants. No hepatosplenomegaly appreciated.

GU – A circumcised male with no masses/lesions/scarring noted on penis or testicles. No hernias were appreciated. Testes were within normal limits of size and non-tender. No discharge was noted.

**Assessment**:

16-year-old male with no PMH presents with complaints of abd pain, fever, sore throat, painful urination, diarrhea, and weakness.

DDx:

1. Appendicitis
2. UTI
3. Viral gastroenteritis
4. Streptococcal pharyngitis
5. COVID 19
6. Acute Infectious mononucleosis

**Plan:**

1. CBC w/ differential
2. UA
3. Rapid strep test
4. COVID-19 test rapid/PCR
5. Monospot/IgM/IgG

Results:

CBC – Wbc – 18.6, Hgb/Hct – 15.7/48, Plt – 185

LY – 7.9 L, GR 81.0 H

U/A – Color – yellow, Clarity – clear, BLO small , Leu/Nit/Glu/Ket – negative,

Rapid strep test – Negative

Following CBC results – did not even do Covid or Monospot – Rushed to ER for possible appendicitis.

He has perforated appendicitis which he then developed an abscess. Required IR drainage and was in hospital for 5 days. Had a drain placed in and put on abx.

He will then require a laparoscopic interval appendectomy one month later.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7869969/>

We reviewed records of all children younger than 18 years old treated for acute appendicitis across 3 large academic medical centers in the NYC metropolitan region during 2 discrete time periods: a control period from January 1, 2014 through June 1, 2019; and a COVID-19 era between March 1, 2020 and May 7, 2020.

During the 10-week COVID-19 study period, we identified 55 patients with acute appendicitis across 3 institutions. Fifty of these children (91%) underwent surgical appendectomy. All 5 patients treated nonoperatively involved cases of perforated appendicitis: 3 patients had large intra-abdominal abscesses managed with percutaneous image-guided drainage and intravenous antibiotics; 1 child was managed nonoperatively based on strong family preference for medical management; the fifth patient was a teenager who developed concomitant severe COVID-19 systemic illness, prompting a decision to avoid general anesthesia.

Findings from this investigation suggest surgeons should proactively anticipate delayed presentations of acute disease

Children in the epicenter of the COVID-19 outbreak demonstrated higher rates of perforated appendicitis compared to historical controls. Preoperative detection of SARS-CoV-2 was not associated with inferior outcomes. Although children likely avoid much of the morbidity directly linked to COVID-19, disruption to local healthcare delivery systems may negatively impact other aspects of pediatric surgical disease.