Rotation 9 – Surgery

Site Evaluation 1 HP 1

11/24/21

Jay Kolasinac

Identifying Information:

- Name: I.V
- Sex: Female
- DOB: */*/2015 – 6-years-old
- Date: 11/8/21 @ 10:00 AM
- Location: NYPQ
- Source of Information: Self
- Source of Referral/Mode of Transport: Car

CC:

3 episodes of vomiting x 2 days

HPI:

Patient is a 6-year-old, female, with no significant PMH, with a prior admission in July 2021 for abnormal electrolytes in the setting of vomiting. Patient presents to the ED today complaining of vomiting x 3 episodes. Patient had 2 episodes of vomiting yesterday and one today, non-bloody and non-bilious. She also has not had a bowel movement in 3 days nor has she been able to pass gas. She has tried MiraLAX at home with no improvement. Patient does endorse some achy, non-specific, 8/10 abdominal pain as well where nothing makes the pain better or worse. As per mother, patient with intermittent episodes of vomiting for the last several months associated with constipation. She has not tried any new foods and has not eaten nor drank anything all day. Her last meal was a two slices of pizza yesterday. Patient has been referred to GI but has not been seen by them yet. Patient denies fever, chills, cough, congestion, sore throat, ear pain, diarrhea, chest pain, SOB, diarrhea, or hematochezia. She denies sick contacts or recent travels.

She presented to the ER afebrile and normotensive but in sinus tachycardia to the 120s. Patient initially treated with 1L NS and Zofran 4mg PO. Observed at bedside for initial response to treatment. Surgery was consulted.

Past Medical History:

Denies any medical history

Past Surgical History:

Denies any surgical history

Medications:

MiraLax – 17g PO qd

Allergies-

Denies any known drug/environmental allergies.

Past Family History:

Father – 33. Alive and well. No PMH.

Mother – 29. Alive and well. No PMH.

No siblings

Social History:

I.V. is a 6-year-old, female, who attends 1st grade and lives with her parents. She is an only child and spends most of her day at school or with her mother while the father is at work doing construction. Parents deny their daughter of ever using or being exposed to any cigarettes, EtOH, or illicit drug use.

Review of Systems:

General: (-) fever, fatigue, chills, nausea, weight gain or loss.

HEENT: (-) any headache, sore throat, visual changes, auditory changes, rhinorrhea, or epistaxis.

Respiratory: (-) any SOB, cough, dyspnea, or sputum production.

Cardiac: (-) any chest pain, palpitations, murmurs, or dyspnea on exertion.

GI: SEE HPI

GU: (-) hematuria, dysuria, urgency, frequency, or discharge.

MSK: (-) Bone pain, arthralgia, joint pain, redness, swelling.

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

Psych: (-) Denies any current depression, anxiety, or mood changes.

Physical Exam

Vitals:

T: 37 C Oral

BP: 104/77 mm Hg

HR: 121

RR: 20 unlabored

O2 Sat: 99% on RA

Wt: 22.1 kg

Ht: 121 cm

BMI: 15.1 (42 percentile – healthy weight for age)

General: Patient is AOx3. Appears her stated age. Lying in bed, appears to be uncomfortable due to pain/nausea.

Skin: No masses, lesions, scarring noted. Skin is warm. Good skin turgor. Capillary refill is less than 2 seconds in all extremities.

Head: Normocephalic, atraumatic.

Eyes: Anicteric sclera, normal conjunctiva. PERRLA, EOMI

Ears: Atraumatic. Symmetrical and nontender throughout. TMs clear with no signs of erythema or effusion.

Oral: **Mucosa dry.** No masses/lesions noted.

Neck: Atraumatic in appearance. No visible masses/lesions/scars. Trachea is midline. Non-tender to palpation.

Cardiac: No masses/lesions noted on chest. No visible lifts, heaves, or thrills. Heart rate and rhythm are regular and WNL. Distinct S1/S2 are heard with no obvious murmurs, gallops, or rubs.

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

Abdomen: **Moderately distended** w/ no masses/lesions/scarring. **Bowel sounds are diminished in all four quadrants. Tympanic throughout. Tender to R+L upper quadrants**. No hepatosplenomegaly appreciated. Negative murphy sign. Negative psoas/Rovsing/obturator/McBurney's point tenderness.

Extremities: Upper and lower extremities are atraumatic in appearance without deformity**.** Muscle strength is 5/5 bilaterally for both upper and lower extremities. Full ROM of all joints. Pulses palpable. Steady gait noted.

Neuro: Alert and oriented, cranial nerves 2-12 grossly intact, gait normal, sensory exam intact.

Labs:

CBC w/ Diff

	11/8/21 1013
WBC	7.08
RBC	5.19
HGB	14.1
CRIT	42.2
MCV	81.3
MCH	27.2
MCHC	33.4
RDW	12.8
PLT	**410***
MPV	9.6
NEUTP	**82.4***
LYMPHP	**12.90***
MONOP	4.2
EOSP	0.10
BASOP	0.30
NEUT	5.83
LYMPH	**0.91***
MONO	**0.30***
EOS	**0.01***
BASO	0.02

BMP

	11/8/21 1013
NA	**135***
K	4.1
CL	**86***
CO2	**20***
BUN	**40.2***

CREATININE	0.71
GLU	70
ANOINGAP	**29***
CA	10.2
MAGNESIUM	**2.9***
PHOS	**7.2***

VBG

Lab	Units	11/8/21 1449
PH (VENOUS)		7.46
PCO2 (VENOUS)	mmHg	**34***
PO2 (VENOUS)	mmHg	Failed iQC
HCO3 (VENOUS)	mmol/L	24.1
BASE EXCESS (VENOUS)	mmol/L	0.70
LACTATE, W/B (BLDV)	mmol/L	1.7

URINALYSIS

	Ref. Range	11/8/2021 10:24
APPEARANCE, URINE	Latest Ref Range: Clear	Clear
COLOR, URINE	Latest Ref Range: Yellow	Yellow
SPECIFIC GRAVITY, URINE, STRIP	Latest Ref Range: 1.010 - 1.030	1.028
PH, URINE	Latest Ref Range: 5 - 8	5.0

PROTEIN, URINE	Latest Ref Range: Negative/Trace	Trace
BLOOD, URINE	Latest Ref Range: Negative	Negative
GLUCOSE, URINE	Latest Ref Range: Negative	Negative
KETONES, URINE	Latest Ref Range: Negative mg/dL	**80 (A)**
BILIRUBIN, URINE TEST STRIP	Latest Ref Range: Negative	Negative
UROBILINOGEN URINE (MCNC)	Latest Ref Range: 0.2 mg/dL	0.2
NITRITE, URINE	Latest Ref Range: Negative	Negative
LEUKOCYTE ESTERASE, URINE	Latest Ref Range: Negative	Negative

Images:

X-ray abdomen: There is an abnormal bowel gas pattern. CT A/P w/ contrast recommended.

CT Abdomen and Pelvis w/ IV and Oral Contrast: There is marked dilatation of the stomach, duodenal bulb and second portion of the duodenum, with clockwise mesenteric swirling of the third portion of the duodenum around the mesenteric vessels. No evidence of free air. All bowel distal to the third portion the duodenum is completely collapsed. **Massively dilated stomach and proximal duodenum with midgut volvulus.**

Assessment & Plan:

I.V. is a 6-year-old, female, who presented to the ER today with 3 episodes of NBNB vomiting and non-specific abdominal pain. CT A/P shows malrotation and midgut volvulus.

DDx:

- ~~Appendicitis~~
- Volvulus
- ~~Obstruction~~
- ~~Gastroenteritis~~
- ~~Food poisoning~~
- ~~Intussusception~~
- ~~Allergy to food/drink vs lactose Intolerance~~

#Case discussed with Pediatric Surgery attending and accepts patient to go to OR emergently for Exploratory Laparotomy & Ladd's Procedure.

#NPO/IVF

NS 0.9% infusion 65mL/hr

#Zofran IV pre OP

#NG Tube will be placed in OR

#Pain control post-op

#Patient Education

Explained the diagnosis to the mother and indications for surgery. Risks of recommended procedure (exploration, Ladd's procedure) include bleeding, infection, bowel ischemia, bowel injury, and bowel obstruction. Mother gave informed consent, using video interpreter.