Setting: Emergency Room

Patient Profile: 30 year old woman presenting with abdominal pain.

She was well until this morning when she woke with abdominal pain. She tried to stool to see if that would help. She found that it hurt a lot walking to the bathroom. She was unable to defecate. She did urinate a good amount that was clear.

The pain was in the right lower quadrant. She also felt the pain in her right thigh (top part of thigh). It began about 2 hours ago and was quite severe (It started severe and remains severe). She prefers to remain curled up. Moving makes it worse. The pain is crampy but does not go away. Her husband got her some water and she drank about 1 oz. She did not want to eat anything.

She vomited 2-3 times. It was clear.

She is sexually active with her husband.

There was no diarrhea, fever, or cough. Last stool was two days ago which was a normal stool. She denies constipation. Denies urinary symptoms (dysuria, blood, etc.)

Last menstrual period was 2-3 weeks ago. It was a normal period. She has not missed any periods.

This kind of pain has never happened before.

PMH: Type I diabetes. The diabetes is well controlled with HbA1C's of 6.8. She gets low reactions a couple of times per month consisting of extreme hunger, weakness, and occasionally light headed. She takes 4 oz of orange juice and a couple of peanut butter crackers. She was hospitalized at the time of diagnosis at the age of 9. Since then she has not been hospitalized.

Meds: Insulin by continuous infusion (pump). Humalog insulin with a basal rate and boluses for meals.

Allergies: None

FH: Father had MI at age 48. Had CABG and is doing well now. Maternal aunt and cousin have diabetes which was diagnosed in adolescence.

SH: Lives with husband and two school children ages 10 and 7. All are doing well.

30 year old female with acute onset of RLQ pain.

HPI:	Location/radiation	RLQ (if asked: radiating down right thigh).
	Severity	Severe. Curled up. Almost crying.
	Quality	Crampy. Gets worse at times but never goes away.
	Chronology	Began 2 hours ago. It started abruptly not slowly.
	Associated symptoms	Vomited x 2-3. No blood or bile.
	Aggravating/Alleviating	Worse with movement.
	Context	If asked: Insulin dependent diabetes.
	Diabetes:	• Well controlled. • This AM sugar was 210 without ketones.
LMP:		2 weeks ago. Normal.
PMH:		Insulin dependent diabetes.
Meds:		Insulin pump
Allergies:		None
FH:		Negative
SH:		• Lives with husband and 2 school kids ages 10 & 7 • Sex, only with husband.

PE: Miserable, uncomfortable 30 year old woman, curled up on table who does not want to move. She can answer questions but prefers to be left alone.

Vital signs: T 99^{1} P 128 RR 24 BP 110/64

Height: 75th percentile. Weight: > 90th percentile.

HEENT: All normal. Mucous membranes are moist. No erythema or sores.

Neck: Supple without adenopathy.

Lungs: Clear with excellent air exchange. No grunting, flaring, retractions, wheezing or rales.

Heart: Normal. Without murmurs.

Abdomen: 1+ bowel sounds. Soft throughout. Tender throughout but mild in all quadrants except RLQ. Positive Rovsing sign (when you palpate her mid lower quadrant it hurts in the RLQ). Pushing down on her abdomen hurts, as does letting go. Positive obturator and psoas signs.

Musculoskeletal: FROM of right hip but hyperextension increases the abdominal pain. Back is non tender.

Labs:

Lytes: Na 135 K 4.8 Cl 102 HCO3 23 Glucose 336 BUN 8 Cr 0.7

CBC with diff: WBC 10.8; HCT 40; Plt 376K; S77/L16

UA/cx: Large glucose. Negative ketones. Rest of dip – negative.