Borderline acceptable

CC: Vomiting

HPI: Mr. D is a 39 y.o. AAM who presented to the ED with a history of vomiting that began the previous afternoon and continued through the morning. He says that it was normal to start with; but soon developed into dark coffee-like vomit. He has RUQ and epigastric pain that started as a 10/10 at admission and is now a 7/10. He states that the pain radiated around to his back. While he was vomiting he did have sharp substernal chest pain. He denies any diarrhea; constipation; or hematochezia. He has had melanotic stools since his admission to the hospital; but not prior. He has had a recent loss of appetite and headaches that he did not feel led to his vomiting. He says that he had a similar episode at the beginning of this year. He was admitted to the hospital for about a week for what he called acid reflux. He denies any change in food habits since his discharge from SHANDS on 08/06/06.

HPI: Decent organization, misses some key pertinent history but acceptable

PMH:
1. Gastric Ulcers/ Peptic Ulcer Disease
2. GERD
3. Stage 3 Chronic Kidney Disease secondary to DM
4. HTN
5. Diabetes Mellitus
6. Peripheral vascular disease

PSH: Cholecystectomy (6/06); Appendectomy (1993); Left BKA (1996)

FHx: Mother: Renal failure; DM; HTN; bad heart
Father: Renal failure; DM; HTN

SHx: Denies EtOH; tobacco and illicit drug use. He stated that he did try cocaine a few years ago. He lives in Gainesville with his girlfriend. He is unemployed.

Allergies: NKDA

Medications: He has not taken any of these medications. He did not fill his Rx.
1. Amlodipine 10mg po daily
2. Lipitor 10mg po daily
3. Erythromycin ethyl succinate 300mg with meals and at bedtime
4. Labetalol 600mg twice daily
5. Oramorph 15mg twice daily
6. Oxybutynin 5mg twice daily
7. Docusate 100mg twice daily
8. Glipizide 5mg daily

ROS: As stated above. He denies any fever; chills; rashes; oral ulcerations; palpitations; SOB; cough; dysuria; myalgias; or numbness or tingling in his extremities.

Other history: basics are all present didn't really try to explore much detail

Physical Exam:
Vitals: BP 182/114 PR 103 RR 16 Temp 37C O2 Sat 100 on Room air

General: Obese man lying on his back continually rubbing his abdomen. He was drowsy from the pain medication yesterday afternoon; he was more awake this morning.
HEENT: Sclera anicteric. EOM intact. PERRLA. No facial tenderness. Moist mucous membranes with no ulcerations. Thyroid was non-palpable.
Lymph Nodes: No head; neck; or axillary LAD.
Cardiovascular: Regular rate and rhythm; S1 and S2; no S3 or S4. I was not able to appreciate any murmurs; rubs; or gallops.
Pulses: Carotids +2/3 BL. Radial +3/3 BL. DP/PT +2/3 on right.
Lungs: Tympanic to percussion. CTAB. No crackles; rales or wheezes.
Abdomen: Bowel sounds are present. He has scars from his appendectomy and cholecystectomy. He was having severe pain; so I did not examine his abdomen.
Extremities: Normal peripheral perfusion; no cyanosis; clubbing; or edema. He does have what looks to be a healing wound on his right foot.

PE: Started out good with clear documentation but didn't exam abdomen, though provided reason. If patient declined, this would be acceptable otherwise, not.

Labs:
KUB was ordered last night.
Lipase 14
eGFR: 48.4

BMP: Na 131/ K 4.7/ Cl 110/ HCO3 19/ BUN 21/ Cr 2/ Glucose 170/ Ca 9.1
CBC: WBC 9.3/ Hb 11.1/ Hct 35/ Plts 374
LFTs: Total Protein 7.8/ Albumin 4.1/ Total Bilirubin 0.7/ Direct Bilirubin 0.1/ ALP 134/ AST 23/ ALT 20

Lab data: Unclear whether KUB pending or if no official read, in which case student is expected to make attempt to read.

Problem list missing

Assessment: Mr. D is a 39 y.o AAM with a PMH significant for GERD and prior PUD who presented to the ED with complaints of hematemesis. This is concerning for a number of upper GI pathologies including; recurrent PUD; esophageal varices; Mallory Weiss tears; arterial-venous malformations or possible neoplastic etiologies.

Good concise summary but lacks working diagnosis. Differential is good but lacks any discussion of the thought processes of how likely or how the evaluation will be prioritized.

Plan:
1. Hematemesis: Endoscopy; IV Lansoprazole 80mg bolus with 8mg/hr infusion; NG lavage prior to the endoscopy; erythromycin ethyl succinate to facilitate gastric emptying; Type and Screen in case there is a need to tranfuse.
2. DM: Insulin Aspart sliding scale for correction of high blood glucose. Insulin Aspart 30 units 15 minutes before breakfast and 20 units at bedtime.
3. HTN: Continue on Amlodipine and Labetalol.
4. Low Bicarbonate: Obtain an ABG to check for metabolic acidosis.
5. Hyperkalemia: Repeat BMP to account for the hemolysis on the last sample. If the potassium continues to be elevated; consider using Kayexalate to decrease. Since he is using insulin; this may be achieved without out needing Kayexalate.
6. Pain: Oramorph
7. Full Code

Good specifics on some of the drug doses, would encourage this degree of specificity about transfusion and other drugs. Missing a plan regarding IV access and IVF, which a third year should know.

Overall, this is a student whose write-ups could rapidly become good with feedback. I would rate this as barely acceptable for the first half of the year and unacceptable for second half. If the student had committed to a working diagnosis and even give one sentence of why, it would be acceptable.