Name: Abd-Manaaf Bakere
Rotation 5: OBGYN

Chief Complaint: “left lower quadrant and suprapubic pain x one day”

History of Present Illness:

A 21y/o female G2P1, with LMP: 5/22, EGA 6+ weeks, with no significant PMHx present Emergency room complaining of left lower quadrant and suprapubic pain x one day. Pain rated 7/10, described as constant and associated with nausea, vomiting, and headache. She admits using Tylenol without much relieve and changing position does not reduce the pain. Reports three episodes of nonbloody, nonbilious (NBNB) emesis. Patient states this is not a wanted pregnancy. Denies fever, chills, Shortness of breath, chest pain, palpitations, dizziness or shoulder pain, changes in bowel habits, diarrhea and constipation.

Past Medical History
No significant PMHx
Surgical History
No significant PSHx
Family History
Live with parents
Social History
Never smoked.
Never used smokeless tobacco.
Denies currently use drugs.
Denies alcohol use.
Sexually Active

Allergies:
NKDA

OB/GYN: Denies Hx of STI’s
Review of Systems
General: Denies weight changes, fevers, weakness, fatigue, night sweats, chills, body aches.
• Skin: denies rash, sores, lumps, itching, color changes, hair, nails
• Head: **Admits nausea, vomiting, headache**, denies trauma,, dizziness.
• Eyes: Denies glasses/contacts, pain, redness, tearing, vision loss, discharge, double/blurred vision, glaucoma
• Ears: denies hearing loss/aid, tinnitus, vertigo, earache, discharge
• Mouth/Throat: denies bleeding gums, dentures, cavities, hoarseness, voice change, sore throat, dry mouth, difficult/painful
• Nose/Sinuses: denies stuffiness, rhinorrhea, sneezing, itching, epistaxis, allergies (perennial, seasonal)
• Neck: denies lumps/masses, goiter, pain, stiffness, swelling
• Breast: denies lumps/masses, skin changes, pain, discharge

• Respiratory: denies chest tightness, shortness of breath and wheezing, cough, hemoptysis, snoring
Cardiac: denies for chest pain, palpitations, lower extremity edema.
• Gl: **Positive for nausea ,vomiting and Left lower abdominal pain**. Denies constipation, and bloating. dysphagia, vomiting, regurgitation, indigestion, changes in bowel habits, diarrhea, bleeding (hemorrhoids, melena, hematemesis, hematochezia), jaundice.
• Urinary: denies frequency, polyuria, nocturia, hesitancy, urgency, dysuria, hematuria, incontinence, reduced caliber of stream.
Genital: Positive light spoting. Denies loss of interest, function,
• Vascular: denies claudication, edema, varicose veins, past clots
• Musculoskeletal: denies muscle or joint pain, stiffness, arthritis, gout, weakness, swelling, redness, instability
• Neurological: **Positive headache** , denies seizures, numbness, tingling, paralysis, paresthesia, fainting, blackouts, burning, tremors
• Hematological: denies anemia, easy bruising/bleeding, petechiae, purpura, ecchymosis, transfusions
• Endocrine: denies heat/cold intolerance, sweating/thirst/hunger
• Psychiatric: denies psychosis, nervousness, mood, anxiety, depression or suicidal ideation.

Physical Exam

Vital sign

BP	105/67
Pulse	78
Temp	98 °F (36.7 °C) (Oral)
Resp	16
Ht	1.448 m (4' 9")
Wt	68.9 kg (152 lb)
LMP	05/22/2024
SpO2	100%
BMI	32.89 kg/m²
BSA	1.6 m²

General: Alert and oriented and cooperative
Heart: Regular rate and rhythm, S1 and S2 appreciated. No gallops.
Lungs: Clear to auscultation bilaterally, symmetrical chest expansion
Abdomen: +LLQ tenderness, soft, non-distended, no rebound, no guarding
Back: No CVA Tenderness
Extremities: Lower extremities symmetrical, and non-tender bilaterally
DVT Evaluation: No evidence of DVT seen on physical exam.
Pelvic exam: minimal blood noted, cervical os closed. Normal external genitalia, vulva, vagina, cervix, uterus and adnexa. Negative Cervical Motion Tenderness
GU: Scant blood at os. Uterus normal size, non-tender

Lab Data:
Data CBC: 06/04/2024

WBC	8.21	3.50 - 11.00 x10(3)/mcL	Final
RBC	4.13	3.80 - 5.20 x10(6)/mcL	Final
HGB	12.3	12.0 - 16.0 g/dL	Final
HCT	37.4	36.0 - 46.0 %	Final
PLT	255	150 - 440 x10(3)/mcL	Final

BhCG 1,073

Imaging
Pelvic ultrasound . Transabdominal [Transvaginal.]

Clinical history: Right-sided facial, left lower quadrant pain, evaluate for ectopic

Technique: High-resolution grayscale ultrasound performed.Color, Doppler imaging performed.

Findings:
The uterus measures [7.9 cm x 3.4 cm x 5.0 cm].

The endometrium measures [11.5] mm. .[No IUP]
No uterine masses are noted.
The right ovary measures [3.1 cm x 2.3 cm x 3.1 cm]. [A few follicles are noted.]
No ovarian masses are seen.
[Color flow [and spectral] Doppler within normal limits.]
[Right adnexal region is unremarkable.]
The left ovary measures [3.1 cm x 1.6 cm x 3.2 cm]. [A few follicles are noted.]
No ovarian masses are seen.
[Color flow [and spectral] Doppler within normal limits.]
There is a 3.3 cm x 1.6 cm complex cystic lesion seen posterior to the left ovary.
This finding is associated with small amount of free fluid in the pelvis which has some internal echoes which may represent hemorrhagic fluid.
The included images of the urinary bladder are unremarkable.

IMPRESSION:
No IUP.
Endometrial thickness of 11.5 mm.
There is a 3.3 cm x 1.6 cm complex cystic lesion seen posterior to the left ovary.
This finding is associated with small amount of free fluid in the pelvis which has some internal echoes which may represent hemorrhagic fluid.
Imaging findings are consistent with an left-sided ectopic pregnancy.

Differential Diagnoses:
Ectopic Pregnancy:

The patient's positive BhCG, absence of intrauterine pregnancy on ultrasound, and presence of a complex cystic lesion with free fluid, ectopic pregnancy is highly likely. The pain and symptoms align with this diagnosis.

Ovarian Cyst Rupture:

The ultrasound shows a complex cystic lesion which could represent a hemorrhagic ovarian cyst. The symptoms of acute pain and free fluid in the pelvis support this possibility.

Pelvic Inflammatory Disease (PID):

Although the patient denies a history of STIs, PID could present with lower abdominal pain and tenderness. However, the absence of fever, cervical motion tenderness, and discharge makes this less likely.

Appendicitis:

While less likely due to the location of pain and lack of fever, appendicitis should be considered. It can present with lower abdominal pain, nausea, and vomiting, and needs to be ruled out.

Assessment:

A 21-year-old female, G2P1, with a 6+ week gestation presenting with left lower quadrant and suprapubic pain, nausea, vomiting, and headache. Physical examination and pelvic ultrasound findings are consistent with a left-sided ectopic pregnancy, with a complex cystic lesion posterior to the left ovary and associated hemorrhagic free fluid in the pelvis. The absence of an intrauterine pregnancy on ultrasound and a BhCG level of 1,073 further support this diagnosis. Differential diagnoses include ovarian cyst rupture, PID, and appendicitis, but these are less likely given the clinical presentation and imaging findings.

Plan:

Arranged for an urgent OB/GYN consultation to confirm the diagnosis

Management of Ectopic Pregnancy:

Discussed medical management with methotrexate versus surgical intervention (laparoscopy or laparotomy) with the patient. The patient's hemodynamic stability and the absence of severe pain suggest that both options could be considered.

Patient taken to OR for explorative laparoscopy

On laparoscopy, 100cc hemoperitoneum and clots evacuated. Right tube/ovary appeared normal. Following irrigation of left adnexa, tube then appeared normal. Small portion of tissue suspicious for POC's found in cul-de-sac. Pathology results pending

Pain and Symptom Management:

Administer analgesics for pain relief acetaminophen or NSAIDs

Provided antiemetics, ondansetron, Zofran to manage nausea and vomiting.

Monitoring:

Recheck vitals regularly to monitor for signs of hemodynamic instability.

Repeat BhCG levels in 48 hours to assess the trend, which will help in monitoring the response to treatment.

Patient Counseling and Support:

Provided emotional support and counseling regarding the non-wanted pregnancy and treatment options. Discuss potential complications and the importance of follow-up care.

Offered information on contraception and family planning if desired by the patient after stabilization.

Education and Follow-Up:

Educated the patient on signs of complications such as increased pain, heavy bleeding, dizziness, or syncope, and instruct her to return to the hospital/ED immediately if these occur.

Arranged follow-up appointments in ED for monitoring and to ensure complete resolution of the ectopic pregnancy.