

# Case Report

## A 55-Year-Old Woman with Abdominal Pain

**Urgent message:** Noting ‘red flags’ specific to the individual patient is of key importance when details of the presentation do not add up.

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J.W. is a 55-year-old female who presented with abdominal pain. She reported that the pain woke her up the night before and lasted all day long, which prevented her from doing much that day. She described the pain as constant and gnawing, assessing its severity as 6 on a scale of 10.

The pain is located in her lower abdomen diffusely and does not radiate. She denies any fever, chills, nausea or vomiting. In addition, she reports:

- no diarrhea
- no frequency or urgency
- no back pain
- no chest pain or any respiratory complaints

J.W. is drinking fluids without difficulty. There were no alleviating or aggravating factors.

She lives elsewhere and is in town visiting her son and daughter-in-law to help with their baby.

### Observations and Findings

The patient appeared healthy and comfortable, in no distress at presentation.

- *Past medical/surgical history:* hysterectomy
- *Medications:* estrogen
- *Allergies:* sulfa
- *Social history:* social drinker,



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non-smoker

- *Physical:* t-98.5, p 86, r 12, bp 138/84, O<sub>2</sub> sat 98% ra
- *HEENT:* normal
- *Resp:* normal; good air exchange
- *CV:* RRR no m/r/g, equal pulses throughout
- *ABD:* non-distended; BS normal. Soft, diffusely tender to palpation in the lower abdomen and bladder; also:
  - no guarding or rebound
  - negative Murphy’s sign
  - no masses or hernia appreciated
  - no abdominal bruits.
- *Back:* no CVA tenderness
- *Skin:* no rashes; warm and dry
- *Neuro:* non-focal, alert and appropriate
- *Urinalysis:* SG 1.015; ph 6.5; LEU 75; NIT POS; PRO 30; GLU norm; KET 150; UBG norm; BIL neg; BLD 50
- *Chemistry:* glucose 138 (65-110); sodium 130 (135-145); potassium 3.8 (3.5-5.5); chloride 98 (95-107); Bun 10 (5-23); Cr 0.7mg/dL
- *CBC with diff:* WBC 17.3 (4.4-11.3); RBC 4.71 (4.0-5.2); HGB 14.9 (12.0-16.0); HCT 42.8 (36.0-46.0); neutrophil 15.36 (1.2-7.70); lymphocyte 1.12 (1.20-4.80); monocyte 0.80 (0.10-1.00); eosinophil 0.00 (0.00-0.70), basophil 0.02 (0.00-0.10)

### Patient Course and Diagnosis

On discharge from the urgent care, J.W. was given ceftriaxone 1 g IM and sent to the emergency room for an imaging study. An abdominal CAT scan was done, revealing a thickened edematous appendix measuring at least 14 mm in the transverse diameter, consistent with acute appendicitis.

She was taken to the OR later that morning with a preoperative diagnosis of acute appendicitis.

She tolerated the procedure well and was found to have an appendix that was markedly distended and dilated, with fibrinous exudates and omentum tethered to it. Postoperative diagnosis was acute severe appendicitis.

The rest of her hospital course was unremarkable and she was discharged to home on postoperative day 2.

### Discussion

Often in urgent care medicine, patients present in the very early stages of disease processes which have not yet declared themselves. Therefore, it is essential that we are diligent in looking for and paying attention to any “red flags” in the patient’s history and physical findings.

It is also important to not let any one test lead our clinical impression—or, ultimately, our medical decision making—astray if all the information does not add up.

Our patient with non-specific abdominal pain had a few red flags in her history and physical that couldn’t be explained by her urinary tract infection. In particular:

- She reported that the pain woke her up from sleep.
- This pain prevented her from helping out around the house, the reason she was in town in the first place. One would not expect a simple UTI in an otherwise healthy 55-year-old woman to have such an effect.
- And, finally, a WBC of 17. The main reason a CBC was obtained here was to help with our medical decision making. Had her WBC been normal, it may have been appropriate to discharge her to home with antibiotics to treat her UTI and to re-evaluate her non-localizing abdominal pain in 12 hours. However, because of the previously mentioned factors that are inconsistent with a urinary tract infection, she was sent on to an emergency room for an imaging study and, ultimately, found to have acute appendicitis.

While a detailed review of acute appendicitis is not the main focus of our discussion, it should be noted that the typical history and physical findings are present in only

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50% to 60% of cases. Fever and leukocytosis usually follow later in the course of the illness but may remain absent, and the abdominal pain may never localize or may be as subtle as to be described as indigestion, flatulence, and sometimes just a sense of not feeling well.

Further, while most cases occur between the second and third decade, acute appendicitis can present at any age. At the extremes of age, the diagnosis is often missed or delayed secondary to more atypical presentations which predispose these patients to go on to rupture, thereby increasing their morbidity and mortality. In the elderly, pain and tenderness are often blunted. In addition, while a urinary tract infection is in the differential diagnosis, pyuria and microscopic hematuria are not uncommon and may be found in up to one-third of patients because the appendix lies close to the right ureter and bladder.

A lot of urgent care medicine is about triage. How we manage early disease speaks directly to what is our expertise.

We must ask ourselves, is this patient sick? Does he have a high-risk chief complaint such as chest pain, abdominal pain, syncope, etc.? Is she safe to be discharged to home, does she need to be admitted to the hospital (or, alternatively, do we have enough information to answer that question)?

When managing these high-risk patients, it is especially important to be able to fit the history and exam under one working diagnosis. If some critical information does not seem to fit, then we are obligated to pay attention and gather more information.

In this case, I could not reconcile her night pain and her general incapacity, as well as her moderate leukocytosis, with a simple urinary tract infection. The key to managing this typical urgent care case was paying attention to the “red flags” and realizing that not all was adding up. ■