

## Gastroenterology & Hepatology Scenarios

### Scenario 1 of 6:

**Reason for Visit:** Follow up H. pylori

**HPI:** Patient is a 42-year-old female who presents for follow up of PUD complaining of continued mild nausea and a bloating sensation after eating. No vomiting, no change in stools. No bleeding. She completed initial course of treatment 10 weeks ago after an EGD found a peptic ulcer which was positive for H. pylori. She denies NSAID use or alcohol. Symptoms are not relieved with OTC meds.

**Past Medical History:** Completed 14 day regimen of PPI, clarithromycin, amoxicillin.

**Review of Systems:** As above.

**Physical Exam:** BP= 122/72, P= 65, RR= 12. Physical exam is unremarkable except for mild epigastric tenderness without guarding or rebound.

Lab: Positive stool H. pylori antigen, positive urea breath test

**Assessment and Plan:** Persistent H. pylori infection, initiate salvage protocol.

**Scenario 2 of 6:**

**Reason for Visit:** Ulcerative colitis follow up

**HPI:** Patient is a 41-year-old male with a two year history of ulcerative colitis, previously controlled, who was given a steroid taper dose for an acute exacerbation one month ago. Now he returns complaining of continued cramping abdominal pain, tenesmus and bloody diarrhea after the additional steroids were completed. No fever, no nausea or vomiting.

**Past Medical History:** Ulcerative colitis, on prednisone, 5-ASA.

**Review of Systems:** As above.

**Physical Exam:** BP= 128/84, P= 72, RR= 14. Physical exam is unremarkable except for mild abdominal pain without guarding, rebound or focal findings. Lab: Stool studies are positive for blood but negative for any infective agent.

**Assessment and Plan:** Corticosteroid resistant/dependent ulcerative colitis, start immunomodulator therapy, schedule colonoscopy.

**Scenario 3 of 6:**

**Reason for Visit:** Ulcerative colitis follow up

**HPI:** Patient is a 41-year-old male with a two year history of ulcerative colitis, presents to the office without new complaints. He has been on immunomodulator therapy with rare colitis symptoms. No fevers, no weight loss. Colonoscopy last year showed no disease progression.

**Past Medical History:** Ulcerative colitis with pancolitis, rectal bleeding at diagnosis.

**Review of Systems:** As above.

**Physical Exam:** Exam is unremarkable. Labs: CBC and chemistry panels are WNL, no evidence of hematologic abnormalities or liver, kidney toxicity.

**Assessment and Plan:** Ulcerative colitis, continue current therapy, repeat colonoscopy per surveillance protocol unless symptoms change.

**Scenario 4 of 6:****Reason for Visit:** Malaise

**HPI:** Patient is a 33-year-old female who presents to the office complaining of fatigue, scattered joint pain, muscle aches, loss of appetite and generalized malaise for three weeks. No fever or night sweats. There is no joint swelling or adenopathy. There is no history of drug or alcohol abuse and no recent travel. She is not currently sexually active.

**Past Medical History:** As above. She takes no medications.

**Review of Systems:** As above.

**Physical Exam:** Afebrile, BP= 110/72, P= 68, RR= 14. Exam is significant for scleral icteris and hepatomegaly 2 cm below the costal border. No evidence of ascites. Cardiovascular and respiratory exams are normal. No edema. Labs: elevated serum aminotransferases (ALT>AST), hyperbilirubinemia, positive antinuclear and anti-smooth muscle antibodies, elevated IgG and IgM.

**Assessment and Plan:** Autoimmune hepatitis, start steroids.

**Scenario 5 of 6:****Reason for Visit:** Chest pain

**HPI:** Patient is a 55-year-old male with a history of HTN who presents with complaints of chest pain. Pain is burning, substernal, nonradiating and worse after eating. It is also worse at night or if he is lying down, at which time the burning sensation and liquid material can reach the back of his throat. Symptoms have been occurring intermittently “for years” but progressively worse in the last 6 months. There is no SOB or diaphoresis. He denies a change in his exercise tolerance.

**Past Medical History:** HTN, controlled on meds. Non smoker, rare alcohol consumption

**ROS:** No change in bowel habits.

**Physical Exam:** BP= 132/78, P= 70, RR= 12, afebrile. Moderately obese middle aged male. Physical exam is unremarkable. EKG shows a NSR without ST changes, unchanged from a year ago. All laboratory studies are WNL.

**Assessment and Plan:** GERD disease, counsel reflux diet and precautions, start PPI, schedule EGD for further evaluation.

**Scenario 6 of 6:**  
**Emergency Department Services**

**HPI:** A 70-year-old female is brought to the ER by her family after vomiting for several hours, now with bright red blood. Patient has “not felt well all day”, has not eaten since tea at breakfast which was twelve hours ago. She complains of feeling weak and dizzy. A non-radiating epigastric pain has been present for the last hour. No diaphoresis or SOB.

**Past Medical History:** HTN, on meds which she did not take today.

**Review of Systems:** As above.

**Physical Exam:** Afebrile, BP= 90/65, P= 122, RR= 18. Pale and vomiting coffee ground emesis, some bright red streaks. There is a rapid regular rate without murmurs on cardiovascular exam, pulses are equal, lungs are clear. Abdominal exam is nonfocal, mild tenderness without guarding or rebound. Lab: Hb= 8.2, EKG has sinus tachycardia without ST changes.

**ED Course:** Fluid resuscitation, PPI, nausea meds, type and cross.

**Clinical Impression:** Upper GI bleed

**Disposition:** Admit ICU, emergent EGD, continue resuscitation and PPI.