I’ve been feeling this pain in my stomach after I eat. It seems like it’s getting a little worse all the time.

Module 5 - Gastrointestinal

For “at least a month,” Tina has been experiencing pain in her upper stomach after eating, which she describes as “kind of like heartburn, but sharper.” She notices it a little every day, but 3-4 times a week it is very painful (5/10 on pain scale). She also notices burping after she eats. She denies cough, hoarseness, sore throat, dysphagia, and chest pain.

Timeframe: 6 months after establishing primary care (Age: 28.5)
Reason for visit: Patient presents complaining of recent recurrent stomach pain.

Learning Objectives

Develop strong communication skills
- Interview the patient to elicit subjective health information about her health and health history
- Ask relevant follow-up questions to evaluate patient condition
- Demonstrate empathy for patient perspectives, feelings, and sociocultural background
- Identify opportunities to educate the patient

Document accurately and appropriately
- Document subjective data using professional terminology
- Organize appropriate documentation in the EHR

Demonstrate clinical reasoning skills
- Organize all components of an interview
- Assess risk for disease, infection, injury, and complications

After completing the assessment, you will reflect on personal strengths, limitations, beliefs, prejudices, and values.

Module Features

- Student Performance Index - This style of rubric contains subjective and objective data categories. Subjective data categories include interview questions and patient data. Objective data categories include examination and patient data.

Underlying ICD-10 Diagnoses

K21.9, gastroesophageal reflux disease without esophagitis
History of Present Illness

Ms. Jones is a pleasant 28-year-old African American woman who presented to the clinic with complaints of upper stomach pain after eating. She noticed the pain about a month ago. She states that she experiences pain daily, but notes it to be worse 3-4 times per week. Pain is a 5/10 and is located in her upper stomach. She describes it “kind of like heartburn” but states that it can be sharper. She notes it to increase with consumption of food and specifically fast food and spicy food make pain worse. She does notice that she has increased burping after meals. She states that time generally makes the pain better, but notes that she does treat the pain “every few days” with an over the counter antacid with some relief.

Subjective and Objective Model Documentation

Printable “Answer Key” available within the Shadow Health DCE.

Vitals

- Weight (kg) - 85
- BMI - 29.4
- Heart Rate (HR) - 80
- Respiratory Rate (RR) - 15
- Pulse Oximetry - 98%
- Blood Pressure (BP) - 138/80
- Blood Glucose - 131
- Temperature (F) - 99.6

Medications

1. OTC antacid prn, last taken yesterday • Fluticasone propionate, 110 mcg 2 puffs BID (last use: this morning)
2. Albuterol 90 mcg/spray MDI 2 puffs Q4H prn (last use: “a few months ago”)
3. Acetaminophen 5001000 mg PO prn (headaches)
4. Ibuprofen 600 mg PO TID prn (menstrual cramps: last taken a month ago)

Review of Systems

- General: Denies changes in weight and general fatigue. She denies fevers, chills, and night sweats.
- Cardiac: Denies a diagnosis of hypertension, but states that she has been told her blood pressure was high in the past. She denies known history of murmurs, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, or edema.
- Respiratory: She denies shortness of breath, wheezing, cough, sputum, hemoptysis, pneumonia, bronchitis, emphysema, tuberculosis. She has a history of asthma, last hospitalization was age 16, last chest XR was age 16
- Gastrointestinal: States that in general her appetite is unchanged, although she does note that she will occasionally experience loss of appetite in anticipation of the pain associated with eating. Denies nausea, vomiting, diarrhea, and constipation. Bowel movements are daily and generally brown in color. Denies any change in stool color, consistency, or frequency. Denies blood in stool, dark stools, or maroon stools. No blood in emesis. No known jaundice, problems with liver or spleen.

Chief Complaint

- Symptoms - Recurrent stomach pain
- Diagnosis - GERD
Abnormal Findings

Subjective (Reported by Tina)
- Reports daily occurring stomach pain, with 3 to 4 episodes a week that are more severe
- Pain begins right after finishing a meal and lasts a few hours
- Describes the pain as similar to heartburn, located in center of upper stomach
- Pain worsens with larger or spicy meals, and with supine body position
- Decreased appetite and increased burping

Objective (Found by the student performing physical exam)
- Abdominal exam results are normal (inspection, auscultation, percussion, and palpation), which allows students to eliminate differential diagnoses such as appendicitis or cholecystitis.

Assessment

Gastroesophageal reflux disease without evidence of esophagitis

Plan

1. Educate on lifestyle changes including weight loss, engagement in daily physical activity, and limitation of foods that may aggravate symptoms including chocolate, citrus, fruits, mints, coffee, alcohol, and spicy foods.
2. Ms. Jones may elevate the head of her bed or sleep on a wedge-shaped bolster for comfort or symptom reduction.
3. Encourage to eat smaller meals and to avoid eating 2-3 hours before bedtime.
4. Educate on dietary reduction in fat to decrease symptoms.
5. Trial of ranitidine 150 mg by mouth daily for two weeks. If reduction in symptoms, Ms. Jones may continue therapy. If symptoms persist, consider testing for helicobacter pylori, trial of a proton pump inhibitor, or upper endoscopy.
6. Educate on when to seek emergent care including signs and symptoms of upper and lower gastrointestinal bleed, weight loss, and chest pain.
7. Return to clinic in two weeks for evaluation and follow up.