Patient Encounter SOAP Note from Week Eight

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GNRS 5569 Adult/Women’s Health
The University of Texas Medical Branch
School of Nursing

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Mr. RB is a 30-year-old Caucasian male who presented to the Magnolia Healthcare clinic March 15, 2013 for stomach pain.

**History of Present Illness & Analysis of Symptom**

Pt reports pain to midepigastric area. Pain began 1 day ago, is described as burning, gnawing, rated as 7/10 at onset, now 1-2/10. Pt relates that pain began after large meal, but not sure if pain related to meal. No previous hx of abdominal pain. No aggravating factors reported. Pain somewhat alleviated by use of ibuprofen and sleeping. No radiation. (+) anorexia. No change in BM. Pt not taking any OTC meds other than ibuprofen. Denies recent trauma.

**Current Health Status**

Pt has no known allergies. He is not currently taking any medication long-term. He last took Advil 400 mg PO this morning.

All immunizations UTD. Pt reports no EtOH, no recreational drugs, no smoking (never smoker), and 2-3 caffeine/day. Last physical exam over 1 year ago. Works out 1-2X/week, more when work schedule permits.

**Past Medical History**

Pt reports being in good general health. Pt denies past major illnesses or injuries. No past surgery. No blood transfusions.

**Social History**

Pt lives alone in own apartment. Pt reports active lifestyle. Pt works full-time as auto mechanic. No previous military service. No religious or cultural considerations. Pt lives in rural community.

**Family History**

Pt’s parents well & healthy. No known family illnesses.

**Review of Systems**

General: Pt denies fatigue, weakness, unintentional weight loss or syncope. CV: No c/o chest pain, dyspnea, dizziness. Resp: Denies dyspnea, SOB, cough. GI: (+) anorexia, No N/V/D/C. Last BM this morning, somewhat softer than usual. No change in bowel habits. No rectal bleeding noted. (+) belching. GU: No c/o dysuria. MSK: No other c/o pain. No numbness or tingling to LE.

**OBJECTIVE**
VS: HR 70 BP 118/78. Ht 70”, Wt 177 lb. BMI 25.4.

- Pt is alert & oriented in no apparent distress. Pt interactive, pleasant.
- Head normocephalic, atraumatic.
- Heart w/ RRR, no gallop or murmur.
- Lungs sounds CTAB. No increased WOB.
- Abdomen non-distended. BS normoactive. Pain localized to L epigastric area. Tympanic to percussion. No tenderness to palpation or percussion. No referred pain. No masses palpable. Liver border 1 cm below L costal margin.

Diagnostic: None available.

ASSESSMENT

Gastroesophageal reflux disease (Kahrilas, 2012)

1. Burning type pain noted after eating
2. No abdominal pain on palpation
3. No N/D/C/D

Differential diagnoses: (Fishman & Aronson, 2013)

- Peptic Ulcer Disease
  1. Pain presentation consistent with PUD, but abrupt onset of pain x 1 day
- Biliary disease: Cholelithiasis, cholecystitis
  1. Abdominal pain poorly localized
  2. Pt eats high-fat diet
  3. But, pain on L side, no N/V/fever
- Dyspepsia
  1. Upper abdominal pain, anorexia
  2. BUT no hx of postprandial pain or early satiety

PLAN

Therapeutic:

1. Acute therapy:
   a. Omeprazole 20 mg PO qday x 2 weeks
2. After 2 weeks, attempt trial off treatment
   a. During trial off treatment, use OTC H2 blocker (ranitidine) or antacids for sx
   b. If recurrence in < 3 months, consider testing for H. pylori or EGD
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Diagnostic Tests:

1. Consider GI referral for endoscopy and/or ambulatory pH testing if symptoms continue (Kahrilas, 2012)
2. Consider stool antigen testing for H. pylori if symptoms continue

Education:

1. Lifestyle modifications: (Kahrilas, 2013)
   a. Elevate head of bed
   b. Avoid laying down for 2 hours after meal
   c. Avoid fatty foods, chocolate, peppermint, EtOH, carbonated drinks, juices, especially at evening meal
   d. Chewing gum after meal may help symptoms
2. Keep diary of pain symptoms, relation to meals and activity, and associated symptoms

Follow-up:

1. Return to clinic in 3 weeks.
2. Call for worsening symptoms