**Identifying Data:**

Full Name: R.R.

Sex: Male

DOB: XX/XX/2007

Race/Nationality: Caucasian

Primary Language: English

Address: Queens, NY

Date & Time: 01:00PM 04/18/22

Location: Queens Hospital Center

Source of Information: Self & Father

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** blood in urine x3 days

**HPI:**

15 y/o male with no significant PMHx presents with blood in the urine and intermittent non-radiating right flank pain x3 days rated 5/10 in severity. Reports being hospitalized in Ireland 2 months prior for one week due to kidney infection, treated with IV Abx. Pt is unsure if he had kidney stone at that time. No associated aggravating or relieving factors. Reports taking Tylenol once daily without relief. Admits to intermittent nausea and dysuria with frequency and urgency. Denies fever/chills/vomiting/diarrhea, headache, SOB, CP, DOE, penile discharge/swelling/bleeding, testicular pain, foreign body urethral insertion, numbness, tingling, weakness, or sexual activity.

**Past Medical History:**

* No reported PMHx

*Immunizations*

* Up-to-date on immunization schedule
  + Influenza (annually)
  + SARS-CoV-2 x2 doses

**Past Surgical History:**

* No reported PSHx

**Prior Hospitalizations:**

* Kidney infection – Feb 2022 in Ireland

**Current Medications:**

* No reported prescription or OTC medications

**Allergies:**

* NKDA or environmental/food allergies

**Family History:**

* Mother – living & healthy per pt
* Father – living & healthy per pt
* Grandmother - unknown
* Grandfather – unknown
* Siblings – living & healthy

**Social History:**

* Habits – Denies alcohol, tobacco, and illicit drug use.
* Travel – Moved to U.S. from Ireland last month
* Occupation – Student
* Marital History – Single
* Diet – No dietary restrictions. Following American diet.
* Sleep – Sleeps well throughout the night.
* Exercise – No exercise routine but states he plays soccer with his siblings several times per week.
* Sexual History – Denies current or prior sexual activity

**Review of Systems:**

* General
  + Denies generalized weakness/fatigue, weight loss, loss of appetite**,** fever/chills/night sweats
* Skin, hair, nails
  + Denies rash, pruritis, excessive sweating, pigmentations, moles, change in hair distribution.
* Head
  + Denies headache, vertigo, or new head trauma
* Eyes
  + Denies visual disturbances or photophobia.
* Ears
  + Denies, pain, discharge, tinnitus, hearing loss, or feeling of fullness
* Nose/Sinuses
  + Denies epistaxis, congestion, or discharge
* Mouth and Throat
  + Denies bleeding gums, sore tongue/throat, mouth ulcers, voice changes. Last dental exam unknown
* Neck
  + Denies swelling/lumps, stiffness, or decreased ROM
* Pulmonary System
  + Denies wheezing, cough, hemoptysis, cyanosis, orthopnea, or PND
* Cardiovascular System
  + Denies chest pain, known murmur, palpitations, irregular heartbeat, or syncope
* Gastrointestinal System
  + Denies decreased appetite, intolerance to specific foods, N/V/Constipation, mild abdominal pain,diarrhea, dysphagia, pyrosis, flatulence, jaundice, changes in bowel habits, hemorrhoids, rectal bleeding/blood in stool.
* Genitourinary System
  + **Admits to blood in urine, increased frequency, right flank pain, and dysuria**
  + Denies incontinence, nocturia, oliguria, polyuria,
  + Sexual History – refer to Social Hx
* Nervous System
  + Denies generalized weakness, loss of strength, change in cognition/mental status, changes in memory, seizures, headache, loss of consciousness, & ataxia
* Musculoskeletal System
  + Denies deformity, swelling, redness, pain
* Peripheral Vascular System
  + Denies intermittent claudication, coldness/trophic changes, varicose, or color change
* Hematologic System
  + No Hx of DVT/PE, anemia, or lymph node enlargement
* Endocrine System
  + Denies polyuria/polydipsia/polyphagia, heat/cold intolerance, excessive sweating, inability to sweat, or hirsutism
* Psychiatric
  + Denies Hx of anxiety, depression, obsessive/compulsive disorder, or other psychiatric illnesses

**PHYSICAL EXAM**

Vital Signs:

BP: 110/67mmHg – sitting, L arm RR: 18 breaths/min Pulse: 70 bpm

T: 98.1.F (oral) SpO2: 99% on room air

Height: 6’0 inches Weight: 125 lbs BMI: 17.0 kg/m2

General Appearance: Alert & Oriented x3. No acute distress. Not diaphoretic. Appears reported age and well groomed. Appropriate body habitus.

Head: normocephalic, atraumatic.

Eyes: No ptosis or miosis. PERRLA. No strabismus/exophthalmos. Sclera white, cornea clear, conjunctiva pink. No erythema of lacrimal sack.

Ear: Appropriate in size. No lesions/masses/trauma visualized on external ear.

Nose: Symmetrical, no external masses/lesions/deformities/trauma/discharge.

Mouth & Throat:

Lips: Pink and moist. No cyanosis, lesions, or ulcerations

Oral Mucosa: Pink &Moist. No masses/lesions noted. No leukoplakia.

Palate: Pink. No visible lesions/masses/scars.

Teeth: Intact without visible dental carries. All teeth have appropriate shape.

Gingivae: No hypertrophy or recession. Unremarkable

Tongue: Pink, well papillated. Frenulum intact. Appropriate shape/size. No masses/lesions/deviation.

Oropharynx: Hydrated, no exudate/masses/lesions/erythema/postnasal drip/foreign bodies noted. Grade 2 tonsils. Uvula pink, midline with no lesions or edema.

Neck: No palpable goiter.Trachea midline. No lesions/pulsations noted. No stridor noted. No cervical adenopathy. No carotid pulses/thrills/bruits heard on auscultation.

Cardiovascular: PMI located at the 5th ICS in midclavicular line. Carotid pulses are 2+ bilaterally without bruits. RRR. No murmurs. Normal S1 & S2. No splitting of S2 or friction rubs appreciated.

Abdominal: Abdomen flat and soft. Normoactive bowl sounds in all four quadrants. No rigidity/guarding. Liver and spleen WNL. No aortic bruits. **No abdominal tenderness. No CVA tenderness.**

Pulmonary: Chest symmetrical with no deformities or trauma. Lat/AP diameter 2:1. Normal chest expansion and diaphragmatic excursion. No adventitious breath sounds.

Skin: Warm and moist**.** Non-icteric. No tattoos noted. No visible moles.

Hair: Average quality, quantity, & distribution. No seborrhea/lice/dandruff noted

Nails: Capillary refill <2 seconds in bilateral upper and left lower extremities. Appropriate color, shape, and thickness.

Musculoskeletal: No erythema / ecchymosis / atrophy or deformities in bilateral upper and lower extremities.

Peripheral Vascular: Warm to touch bilaterally. Radial pulse 2+ b/l. No edema or ulcerations. Calves equal in circumference. No palpable cords bilaterally.

Genitourinary: **Pt and father declined GU Exam**

**Labs:**

|  |  |  |
| --- | --- | --- |
| *Urinalysis*  pH 7.5  Color: red  Appearance: Turbid  Glucose: negative  Bilirubin: Small  Ketones: Negative  Gravity: 1.021  Blood: moderate  Protein: 30  Urobilirubin: 0.2  Nitrites: positive  Leukocyte esterase: large  WBC: 750  RBC: 21-50  Bacteria: few  Squamous epithelial: 0-4  Yeast: present  Hyaline Cast: 0-4  Pathological casts: Not present  *Urine Culture*  Multiple organisms. Specimen likely contaminated. | *CBC*  WBC: 9.86 ↑  RBC: 5.49 ↑  Hgb: 15.8 ↑  Hct: 48.1 ↑  MCV: 87.6 ↑  MCH: 28.8  MCHC: 32.8 ↓  MPV: 12.1 ↑  RDW: 13.0  PLT: 246K  Neutrophil%: 62.4  Lymphocyte%: 27.3  Monocyte%: 8.2 ↑  Eosinophil%: 1.4  Basophil%: 0.5  Immature granulocyte%: 0.2  Neutrophil Abs: 2.69  Mono Abs: 0.81  Eosinophil Abs: 0.14  Basophil Abs: 0.05  Immature Granulo Abs: 0.02  NRBC Abs: 0.001  NRBC%: 0.0 | *BMP*  Na 141  Cl 102  BUN 13  K 4.5  HCO3 27  Ca 0.93  Glucose 93  Anion Gap 12 |

**Imaging Findings:**

*US Renal/Pelvis*

Hx: R/o kidney stone vs hydronephrosis

Comparison: none

Technique: Transabdominal gray scale and color US of the kidneys.

Findings: Right kidney measures 8.6 x 3.3 x 3.8 cm. Left kidney measures 10 x 4.1 x 4.8 cm. No Hydronephrosis or definite renal mass. Color doppler seen within both kidneys. Bilateral renal parenchymal echogenicity is WNL.

Impression: No hydronephrosis or definite renal mass. Apparent small right kidney may reflect technique. Please correlate and follow up with additional imaging if warranted.

**Assessment:**

15 y/o M no PMHx presents for hematuria x3 days w/ intermittent R flank pain. Hospitalized for kidney infection 2 months prior. Denies sexual activity, foreign body insertion into urethra. Physical Exam unremarkable.

Impression: R flank pain with dysuria and hematuria.

-R/O Nephrolithiasis vs Pyelonephritis

-Probable stone passage as pt no longer tender

-Nontender abdomen, no CVA tenderness, appears comfortable

**Differential Diagnosis:**

1. Nephrolithiasis
2. Pyelonephritis
3. Foreign Body insertion
4. STI
5. Glomerulonephritis

**Plan:**

* + #Cystitis with hematuria
    - CBC, BMP, Urinalysis
    - Ultrasound of renal/pelvis
    - IV Fluids
    - Reassess
    - Dispo: Discharge home with urgent Urology referral for further workup. Ciprofloxacin 500mg q12h x7 days & Ibuprofen 400mg q6h PRN.