Name: Ms JT
Gender: Female
DOB:
Address:

07-10-03 14:20 (DEM RHH)

Presenting Case

Ms JT, a 71 year-old lady presents with a 3-day history of a painful mass on her umbilical area, associated with nausea and decreased appetite, on a background of hypertension controlled by medication.

History of Presenting Case

Ms JT was working in the garden in the afternoon of 01-10-03 when she noticed a mass protruding from atop her umbilicus. There was no pain associated with the mass, and Ms JT did not attempt to reduce the mass. Ms JT explained she was not performing any excessive activity whilst gardening that day, but it did involve some bending and movement. The mass partially disappeared when she lied down, but it did not change in its shape, size or other characteristics. She reported no other masses in her body. No further symptoms were experienced until 03-10-03, when she noticed a continuous "burning" umbilical pain associated with the lump. Ms JT explained that her lower umbilical area became "extremely red" & tender to the touch. The pain was aggravated by movements, including walking, getting up from the chair, and subsided, but did not completely disappear on rest. The pain was severe enough to interrupt her sleep and it did not radiate anywhere else in the body. Other associated symptoms include nausea, but no vomiting, and loss of appetite. Ms JT did not take any analgesics for the pain and presented to her GP on the morning of 07-10-03, who reviewed her and sent her to DEM at RHH, for attention.

Ms JT suffers from hypertension, but is otherwise well. She continued to have normal bowel movements over the week. Her last motions were this morning. Her urinary habits have been normal. She has not noticed any significant weight change, difficulty in swallowing, heartburn or jaundice.

Ms JT was tired, and was in considerable pain at rest.

Past Medical History

Hypertension for 15 years, well controlled using medication
Varicose veins – right leg, had operation approx. 25 years ago
Thyroidectomy – approx. 20 years ago
"Stroke" (TIA) – 4 years ago
Denies any history of diabetes although BSL is elevated.

Medications

Natrilix SR (Indapamide hemihydrate): 1.5mg, 1 tablet daily
Cartia (Aspirin): 100mg, 1 tablet daily

Allergies
No known drug or food allergies

Family History
Mother – died of heart attack, history of hypertension
Father – died of old age, history if hypertension
Father and mother's side has history of heart disease & hypertension. No family history of diabetes or asthma.

Social History
Lives by herself at home.
Retired and on pension for the past 15 years.
Ex-smoker: 40-pack year history, quit 4 years ago
Alcohol: occasional glass of wine. Last drink was few months ago.

Systems Review

Cardiovascular
Hypertension controlled by medication.
Varicose veins, operated approx 25 years ago.
No history of chest pain, ankle oedema, SOB, or claudication.

Respiratory
No history of SOB, cough, sputum, fevers, chills, rigors, TB & pneumonia

Gastro Intestinal
Nausea & loss of appetite associated with painful umbilical lump. No weight loss noticed.
No associated vomiting.
No history of dysphagia, heart burn, jaundice, colitis, peptic ulcers, or bowel cancer.

Neurological
"Stroke" - TIA 4 years ago. Medical notes suggest: left dominant parietal TIA.
No history of migraine.

Genitourinary
No history of UTI or renal stones.

Endocrine
Thyroidectomy approx 20 years ago.
Denies any history of diabetes, although BSL is elevated.

Gynaecological
No available history on pap smears & breast examinations.

(Note: Ms JT was tired & in considerable pain, and was reluctant to engage in any more conversation)

Musculoskeletal
No admissions for painful, swollen, stiff joints.
No history of rheumatoid arthritis or osteoathritis.

Dermatological
No history of dermatitis or eczema.

Physical Examination

Alert obese lady lying flat, uncomfortable at rest with no movement.
Scars on her lower neck and right medial leg.

Pulse rate – 72
Blood Pressure – 145/90
Temperature – 37.0
Respiratory Rate – 18

Abdominal Examination
No peripheral signs of chronic liver disease.

Inspection:
No scleral icterus or conjunctival pallor
No abdominal scars, prominent veins, visible aortic pulsation, visible organomegaly.
Reduced abdominal movement with respiration.
Red spherical shaped mass present in umbilical area – 5cm by 6cm, with surrounding erythematous skin.

Palpation:
Guarding (+) and tenderness (++++) in epigastric & umbilical regions.
An erythematous spherical shaped hard mass at umbilical area of size 5cm by 6cm, extremely tender, well-defined margins, smooth surface, with erythematous surrounding skin, warm to the touch, non-fluctuant, immobile, incompressible & irreducible, with no expansile pulse/non-pulsatile and no regional lymph nodes palpable.
Murphy's and Boas' sign negative.
No other masses or organomegaly palpable.

Percussion:
Mass – dull to percussion
Percussion tenderness in central abdomen.
Liver dullness – present

Auscultation:
BS absent on mass and no bruits heard on mass.

BS present and normal at other abdominal areas.
No bruits, hums or rubs at other areas.

Rectal examination not performed.

Cardiac Examination
Regular pulse rate and rhythm.
JVPNE
Apex beat not displaced.
Heart sounds dual, and with no murmurs.
No peripheral oedema or basal crackles.

Respiratory Examination
No peripheral or central cyanosis.
No cough, wheeze, dyspnoea.
No cervical lymphadenopathy.
Chest normal upon inspection, palpation, percussion & auscultation.

Urinalysis
GLU: 100mg/dL
BIL: -ve
Ket: -ve
Prothrombin: 30mg/dL
LEU: -ve

Full Blood Count
WCC: 6.4 N
Neutrophils: 4.7 N
Monocytes: 0.4 N
Hb: 140 N
PT: 12.2 N
Glucose: 12.6mmol/L

Abdominal X Ray
The abdominal X ray showed no air-fluid levels or small bowel distension.

Discussion of diagnoses

Paraumbilical Hernia: Ms JT presented with a painful palpable mass atop her umbilicus, where the pain was not colicky. The mass does not bulge into the centre of the umbilicus and evert it. The mass was noticed before the pain, and the position of the mass is characteristic of a paraumbilical hernia. Risk factors for paraumbilical hernias are: female gender, obesity and ascites. Ms JT was an obese female, and her history gives good indication of strenuous work therefore increasing intra-abdominal pressure. The pain & tenderness, redness, and irreducibility associated with the mass are good indicators of strangulation. Strangulation indicates that the blood supply to the affected area is

compromised; therefore necrosis and perforation are possible. Paraumbilical hernias are more likely to strangulate due to the narrow space through which the structure protrudes. In terms of the structure that is herniating through the defect, the most likely possibility is omentum. The examination findings are not suggestive of small bowel.

Small bowel obstruction: Small bowel obstruction due to bowel protruding through the defect surrounding the umbilicus is a possible diagnosis, but is not suggested by Ms JT's history, examination and plain abdominal X ray findings. Small bowel obstruction characteristically presents with vomiting, colicky pain in umbilical area, abdominal distension due to gas filled loops of bowel proximal to obstruction, and constipation. Ms JT's history did not reveal any of these cardinal symptoms of small bowel obstruction. Furthermore, the plain abdominal X ray (erect) did not reveal any air-fluid levels. Although none of the symptoms of small bowel obstruction as a result of a paraumbilical hernia were present, this is part of the differential diagnosis because of its severe consequences if left untreated.

Summary and Diagnosis

71 year-old female presents with a 3-day history of a painful mass with associated nausea, but no vomiting, and appetite loss. From the discussion of diagnoses, the following provisional & differential diagnoses are given:

Provisional diagnosis: Paraumbilical hernia
Differential diagnosis: Small bowel obstruction