16 y/o M presents to ED with mother at 8 AM. Reports 10/10 abd pain since last night. Pain has gotten progressively worse since yesterday. Pt reports one episode of vomiting this morning upon waking. Denies CP, SOB, LOC.

Meds: No regular meds. Took Tylenol last night and this morning before throwing up.

Allergies: NKDA. Animal dander.

PMHx: No significant PMHx.

PSHx: Tonsilectomy at 8 y/o, no sequelae.

FamHx: Noncontributory.

SocHx: High school student athlete. Denies recent travel. Lives with family. No one else at home currently sick. Reports social drinking, a few beers with friends on weekends, and recreational marijuana every other week. Denies any other illicit drug use. Denies tobacco use.

ROS: Febrile, lightheaded, and fatigued. Reports nausea, vomit, and abd pain. Denies diarrhea. Denies GU Sx’s. Denies weakness, tingling, or loss of sensation in extremities.

PE:

At 8AM, upon admission, pt febrile, diaphoretic, and tachycardic.

GenSurv: A/O x3, in acute distress. Appears well-developed for stated age. Well-dressed and groomed.

Repeat VS: tachy 110, normotensive. Fever 101\*F. 99% ORA.

Skin: Pale and diaphoretic. No jaundice.

HEENT: normal

Chest: Tachy, regular rhythm. S1/S2 present. No rubs, gallops, or murmurs.

Pulm: CTA b/l. No wheezes, rales, or stridor.

ABD: Non-distended, no discoloration. BS present but diminished x 4. Generalized tenderness and guarding on palpation. Rovsing sing. Positive psoas and obturator. No organomegaly. Negative CVAT b/l.

GU: normal

Rectal: normal, negative guaiac.

Labs:

CBC w/diff: H&H normal. Pt normal. WBC 14k with left shift

CMP: LFTs normal, borderline hypokalemia.

Amylase/Lipase normal

T&S: A+

PT/PTT: normal

UA: Normal

Pt reports pain localizing towards LRQ.

POC TAUS: no evidence of pathology.

CT with contrast per rectum: Negative air-fluid levels. Thickened cecum wall. Thickened appendicular lining, non-patent to contrast.

Paged General Surgery consult. Pt informed of diagnosis and informed consent given for appendectomy.

Pt admitted for surgery at 10 AM

NPO. Started on LR and Cefoxitin 2 g IV.

Lap Appy performed under general anesthesia.

Pt transferred to PACU for 24-48 hr observation.

Orders:

Check V/S and ABD PE Q 6 hrs.

Assess sutures and healing.

Continue NPO. LR until BS or flatus resumes. Attempt clear liquid PO challenge. D/C LR once PO liquids well tolerated.

IV hydromorphone (Dilaudid) 0.5 mg at once and 0.2 mg PCA Q 3-4 hrs PRN.

D/c Dilaudid after 24 hrs, begin IV APAP (Ofirmev) 15mg/kg Q 6 hrs PRN.

Encourage ambulation and use of incentive spirometer.

Call MD/PA if pt becomes febrile, tachycardic, unresponsive, or signs of wound infection.