IHI 8003 6010 5957 0650
DOB 20 Oct 1986 (34yr) MRN 152171
Sex F
Phone Mob 0405164214
Address U 11 51 MCDONALD ST,FRESHWATER,NSW,2096

Discharge Summary

For Further Patient Information please contact
Northern Beaches Hospital, 105 Frenchs Forest Road, Frenchs Forest 2086, NSW 02 91055000

Progress in Hospital / Summary of Stay

Dear Doctor,
Thank you for your ongoing care of Miss Bethany Young, a 34 year old female presenting to the Northern Beaches Hospital on 23/02/21 with fevers, LLQ & raised inflammatory markers in the setting of recent D+C for miscarriage 7 days prior. She was admitted under the O&G team & commenced on IV Abx. Her symptoms settled over the following days & she was deemed safe for discharge home on 25/02/21 with follow up in outpatient gynaecology clinic in 6 weeks.

HOPC:
D7 post D+C for ?septic miscarriage
Presents with fevers and LLQ pain

Presented 15/2 with 2/7 hx fever and LLQ pain (7/40 by LMP)
USS 15/2: Intrauterine pregnancy, irregular gestational sac (MSD 9mm) no fetal pole or yolk sac
WCC 10, CRP 282
24hrs IV cefazolin + metronidazole
16/2: D+C performed
Histopathology: confirmed products of conception, no acute inflammation identified
Discharged home on 5/6 Augmentin DF (completed course last night)

Since discharge has been feeling lethargic and generally unwell
Ongoing dull LLQ pain (less severe than initial presentation)
Has felt warm on and off
Yesterday evening felt hot + sweaty, took ibuprofen, no relief, measured temp (38.7)
Awoke with chills, called GP hotline who advised to attend ED

Reports no abnormal discharge
PV bleeding settled
No nausea/ vomiting
No dysuria
No diarrhoea

Known left sided endometriomas (present on USS since 01/2020) however never had this pain before 1st presentation last week

Gynae Hx:
G2P0 (x1 sTOP)
LMP 26/12
Previous CIN3 managed expectantly (2015), normal CST 2020
Suspected Endometriosis: known to Dr Nesbitt-Hawes
Regular partner (fiance), planning pregnancy
Genital herpes

Examination
Obs stable, afebrile in department
Abdomen soft
Mild tenderness to deep palpation in LLQ
No flank tenderness
Spec: purulent discharge from cervix, HVS sent, no active bleeding
Bimanual: no cervical motion tenderness, fullness in LLQ

Investigations on admission:
WCC 12
CRP 201
Hb 107
hCG 522 (falling)
Chlamydia/ Gonorrhoea PCR Negative (15/2)

Pelvic US (23/02) -
: IU clear of POCs
: L adnexal mass, likely endometrioma, significant in size (9cm) (similar to US last week, although R cyst appears now to be haemorrhagic)

Tx:
IV ceftriaxone + metronidazole
stepped down to oral cefalexin + metronidazole prior to discharge.
Symptoms settled throughout admission
Inflammatory markers down trending

Northern Beaches Hospital

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Patient	BETHANY YOUNG		
IHI	8003 6010 5957 0650		
DOB	20 Oct 1986 (34yr)	MRN	152171
Sex	F		
Phone		Mob	0405164214
Address	U 11 51 MCDONALD ST,FRESHWATER,NSW,2096		

Discharge Plan:
1. Continue oral antibiotics 6 days (last dose 2/3/21)
-cefalexin 500 mg four times daily
-metronidazole 400 mg twice daily
2. Pelvic US at OMNI in 4-5 weeks
3. Follow up in Gynaecology Outpatient Clinic in 6 weeks
-appointment has been booked for April

If symptoms worsen, or there are any further concerns such as fevers, rigors, worsening pain, offensive vaginal discharge etc, please do not hesitate to seek medical attention or return to the emergency department.

Discharge Medications

	Drug Name, Form, Dose, Dose UOM, Frequency, Quantity, Status, Duration, Route, Change Reason, Reason For
1	cefalexin 500 mg capsule, 500 mg Oral Four Times Daily (06:00, 12:00, 18:00, 22:00) every day for 6 days, New
2	metronidazole tablet, 400 mg Oral Twice Daily (07:00, 17:00) every day for 6 days, New

Able to Self Medicate

Medications changed since admission

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Relevant Results

US Pelvis

Clinical notes:
? collection
D&C 6/7. ? septic miscarriage with CRP 280, febrile today with CRP of 200. Left iliac fossa and back pain similar to initial presentation.

Findings:
On ultrasound, the uterus appears bicornuate. Dimensions are 7.8 x 3.5 x 6.1 cm, estimated volume 88 cc.
Endometrium is thin, homogeneous, echogenic, 4 mm, regular.
On ultrasound, no evidence of macroscopic retained products of conception.

Small amount of pouch of Douglas fluid.

Both ovaries are expanded.
Right ovarian volume 42 cc. It has multiple complex cysts within it with posterior acoustic shadowing and internal debris. In the first instance, this could be haemorrh agic follicles or even endometriomas. Largest is 2.8 cm. Surrounding ovarian tissue has normal Doppler and colour flow.

Left ovary is grossly expanded to approximately 150 cc. It contains complex non-
vascular spaces, likely cystic with posterior through enhancement and internal swirling and layering debris. The septations have increased colour and Doppler flow. L argest is 5.8 cm.

Appearance of the right ovary has changed from 15 February. Therefore, haemorrhage into follicles or haemorrhage into cysts is the likeliest.
Once again, we cannot tell simple haemorrhagic follicles from endometrial diverticulum cysts.

I also cannot tell if this superinfection.

Conclusion:
Thin regular endometrium but bilateral ovarian enlargement, left greater, by convex cystic spaces. The right ovary has changed from 15 February.

Electronically Signed by: Prof Alex Pitman
Sonographer: Daniel Miele
#50850954 : There is a mild anaemia. There is a mild neutrophilia. There is a mild thrombocytosis. **CLINICAL NOTES:** Comments:

HAEMATOLOGY **SPECIMEN: WHOLE BLOOD**

	Date:	16/02/21	22/02/21	**24/02/21**	(#Refers to current
	Coll. Time:	06:50	23:45	10:27	result only)
	Lab Number:	50815636	50851929	#50850954	
HAEMOGLOBIN	*	**110**	* **107**	* **110**	(115 - 165) g/L
RBC	*	**3.76**	* **3.71**	3.84	(3.80 - 5.50)x10 ^12 /L
HCT	*	**0.34**	* **0.33**	0.35	(0.35 - 0.47)
MCV		89	88	91	(80 - 99) fL
MCH		29.3	28.8	28.6	(27.0 - 34.0)pg
MCHC		333	324	314	(310 - 360) g/L
RDW		12.0	11.5	11.6	(11.0 - 15.0)%
WCC		8.0	* **12.6**	* **11.1**	(4.0 - 11.0) x10 ^9 /L
Neutrophils		6.2	* **9.7**	* **8.5**	(2.0 - 8.0) x10 ^9 /L
Lymphocytes		1.0	2.3	1.7	(1.0 - 4.0) x10 ^9 /L
Monocytes		0.7	0.6	0.8	(< 1.1) x10 ^9 /L
Eosinophils		< 0.1	0.0	0.1	(< 0.7) x10 ^9 /L
Basophils		0.0	0.0	0.0	(< 0.3) x10 ^9 /L
PLATELETS		272	* **486**	* **461**	(150 - 450) x10 ^9 /L

#50850954 : There is a mild anaemia. There is a mild neutrophilia. There is a mild thrombocytosis.

FBE-C CRP-W

This request has other tests in progress at the time of reporting

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In the setting of infection, CRP levels >100 mg/L are supportive of bacterial rather than viral aetiology.

Note results from this CRP assay should not be used for cardiac risk assessment. Please request the high sensitivity assay (hsCRP) instead.

CLINICAL NOTES: Comments:

BIOCHEMISTRY

C REACTIVE PROTEIN (CRP) **SPECIMEN: SERUM**

Date	Time	Lab No.		CRP	Units	Ref. Range
15/02/21	10:40	50817097	***	**282.3**		
16/02/21	06:50	50815636	***	**238.6**		
22/02/21	23:45	50851929	***	**200.7**		
24/02/21	10:27	50850954	***	**172.7**	mg/L	(‹ 3.0)

In the setting of infection, CRP levels >100 mg/L are supportive of bacterial rather than viral aetiology.

Note results from this CRP assay should not be used for cardiac risk assessment. Please request the high sensitivity assay (hsCRP) instead.

FBE-R CRP-C

All tests on this request have now been completed

Document Details	Version
Finalised By	Date
DANIELLE TENBRINK - Resident Medical Officer	25 Feb 2021