Week 4: Genitourinary Clinical Case

Patient Setting:
28-year-old female presents to the clinic with a 2 day history of frequency, burning and pain upon urination; increased lower abdominal pain and vaginal discharge over the past week.

HPI
Complains of urinary symptoms similar to those of previous urinary tract infections (UTIs) which started approximately 2 days ago; also experiencing severe lower abdominal pain and noted brown fouls smelling discharge after having unprotected intercourse with her former boyfriend.

PMH
Recurrent UTIs (3 this year); gonorrhea X2, chlamydia X 1; Gravida IV Para III

Past Surgical History
Tubal ligation 2 years ago.

Family/Social History
Family: Single; history of multiple male sexual partners; currently lives with new boyfriend and 3 children.
Social: Denies smoking, alcohol and drug use.

Medication History
None
Trimethoprim (TOM)/ Sulfamethoxazole (SMX) rash

NKDA
ROS
Last pap 6 months ago, Denies breast discharge. Positive for Urine looking dark.

Physical exam
BP 100/80,
HR 80,
RR 16,
T 99.7 F,
Wt 120,
Ht 5′ 0″

Gen: Female in moderate distress.
HEENT: WNL.
Cardio: Regular rate and rhythm normal S1 and S2.
Chest: WNL.
Abd: soft, tender, increased suprapubic tenderness.
GU: Cervical motion tenderness, adnexal tenderness, foul smelling vaginal drainage.
Rectal: WNL.

EXT: WNL.
NEURO: WNL.

Laboratory and Diagnostic Testing
Lkc differential: Neutraphils 68%, Bands 7%, Lymphs 13%, Monos 8%, EOS 2%
UA: Starw colored. Sp gr 1.015, Ph 8.0, Protein neg, Glucose neg, Ketones neg, Bacteria – many, Lkcs 10-15, RBC 0-1
Urine gram stain – Gram negative rods
Vaginal discharge culture: Gram negative diplococci, Neisseria gonorrhoeae, sensitivities pending
Positive monoclonal AB for Chlamydia, KOH preparation, Wet preparation and VDRL negative