1 Patient Information

1 PATIENT DETAILS

Name:	Howard T. Nguyen	**Date of Service:**	04/22/2026
DOB:	04/03/1974	**Provider:**	Dr. Christine M. Lee, MD, FACG — Gastroenterology
Age / Sex:	52 years / Male	**Facility:**	Houston Methodist Gastroenterology Outpatient Center, Houston, TX
MRN:	GI-2026-052718	**Visit type:**	New patient consultation — GI outpatient; referred post-hospitalization

CC Chief Complaint

2 PRIMARY REASON FOR VISIT

"I had blood in my vomit two weeks ago and I still have stomach pain every day — it burns really bad, especially before I eat."

H History of Present Illness

3 HPI NARRATIVE

Onset:	Epigastric burning: 6 months progressive; acute hematemesis onset 04/06/2026 (sudden, at work)	**Severity (0-10):**	Current epigastric burning 5/10; was 9/10 acutely during hematemesis episode; improving from 8/10 at discharge
Location:	Epigastric — midline, subxiphoid; worse on left lateral decubitus; no radiation to chest or back	**Timing / pattern:**	Fasting pattern — worst 1-2 hours after last meal and pre-breakfast; nocturnal awakening 2-3x/week; relieved within 30 min of eating
Duration:	Chronic burning 6 months; acute GI hemorrhage single episode 04/06/2026 (endoscopically treated); current pain daily x2 weeks post-discharge	**Aggravating factors:**	Fasting; NSAIDs (ibuprofen — discontinued); coffee; spicy food; large meals; alcohol; stress; lying flat post-dinner
Character / quality:	Burning, gnawing; worse when fasting; relieved transiently by food and antacids; no sharp or colicky component	**Alleviating factors:**	Food relieves pain within 20-30 min (classic duodenal pattern); antacids (transient); pantoprazole (partial); small frequent meals

Six-month history of progressive epigastric burning, fasting-related. On 04/06/2026: vomited ~300 mL bright red blood at work followed by two black tarry stools; admitted Houston Methodist 04/06-04/09/2026. EGD 04/07/2026: 1.8 cm duodenal ulcer, duodenal bulb, visible vessel (Forrest IIa); endoscopic hemostasis achieved (bipolar coagulation); H. pylori-positive gastric biopsies confirmed. Nadir Hgb 7.8 g/dL; 2u pRBC transfused. H. pylori triple therapy completed 04/23/2026. Currently: epigastric burning 5/10, early satiety, mild nausea, no recurrent hematemesis or melena. 8 lb unintentional weight loss over 3 months prior to admission (now stable). Pertinent negatives: no dysphagia, no odynophagia, no hemochezia, no jaundice, no abdominal mass. Functional impact: 3-day hospitalization, missed 2 weeks work, ongoing dietary restriction.

4 Past Medical History

4a CHRONIC CONDITIONS

Peptic ulcer disease — active duodenal ulcer, Forrest IIa (K26.0) — confirmed 04/07/2026 by EGD. H. pylori infection (B96.81) — biopsy-confirmed; eradication therapy completed 04/23/2026. Iron deficiency anemia secondary to GI blood loss (D50.0) — Hgb nadir 7.8, now 11.2 g/dL recovering on oral iron. Essential hypertension (I10) — 6 years; amlodipine 10 mg, well-controlled. No prior GI hospitalizations. No IBD, celiac disease, or prior endoscopy before 04/07/2026.

4b PRIOR HOSPITALIZATIONS & SURGERIES

HOSPITALIZATIONS: Houston Methodist Hospital Main Campus (04/06/2026-04/09/2026) — hematemesis, GI hemorrhage from duodenal ulcer; 2u pRBC transfused; EGD with hemostasis performed. No other hospitalizations.
SURGERIES: Right inguinal hernia repair, open (2009, Houston Methodist) — uncomplicated. No abdominal, gastric, or esophageal surgeries. No prior endoscopic procedures before 04/07/2026.

5 Medications

5 CURRENT MEDICATIONS

Pantoprazole 40 mg PO BID — adherent, ongoing. Amoxicillin 1000 mg PO BID (last dose today 04/23/2026). Clarithromycin 500 mg PO BID (last dose today). Ferrous sulfate 325 mg PO daily — adherent; mild constipation tolerated. Amlodipine 10 mg PO daily — adherent. Aspirin 81 mg — DISCONTINUED at discharge (GI bleed risk). Ibuprofen — PERMANENTLY DISCONTINUED (NSAID causally implicated; was using 400-600 mg 3-4x/week for back pain). Multivitamin daily.

6 Allergies

6 KNOWN ALLERGIES & REACTIONS

Sulfonamides (TMP-SMX) — diffuse urticarial rash; documented on all allergy lists. No known food or latex allergies. No prior contrast reaction (CT with contrast 2022, no incident).

7 Family History

7 HEREDITARY & FAMILIAL CONDITIONS

Father: Gastric cancer (diagnosed age 64, died age 67) — highly relevant; warrants enhanced EGD surveillance given patient H. pylori-positive PUD. Mother (alive, 74): hypertension, hyperlipidemia. Maternal uncle: colon cancer (age 58, survived with surgery). No IBD, hereditary polyposis, or celiac disease. Both gastric and colorectal malignancy in family elevates this patient's cancer surveillance priority.

8 Social History

8 SOCIAL CONTEXT

Occupation:	Marketing Director — corporate, primarily desk-based; high-stress environment	**Living situation:**	Married; lives with wife (age 49) and two adult children; Houston, TX
Tobacco use:	Never smoker	**Exercise habits:**	Minimal — occasional walking; primarily sedentary work
Alcohol use:	4-6 drinks/week (beer); was 6-8/week prior to admission; reduced following counseling	**Diet:**	High-fat, irregular meals; skips breakfast frequently; heavy spicy food; 3-4 cups coffee/day (reduced to 1 since hospitalization)
Substance use:	Denies illicit substances; chronic OTC ibuprofen use — permanently discontinued post-hospitalization	**Functional baseline:**	Fully independent; working full-time; no prior functional limitations before this illness

9 Review of Systems

9 SYSTEM-BASED SCREENING

Constitutional:	Mild fatigue (improving); 8 lb unintentional weight loss (3 months pre-admission, now stable); no fever or night sweats
Cardiovascular:	No chest pain, palpitations, or peripheral edema; HTN well-controlled
Respiratory:	No dyspnea, cough, or wheezing
Gastrointestinal:	Epigastric burning 5/10 (primary); early satiety; mild nausea; no vomiting; no hematemesis; no melena since 04/08/2026; mild constipation (iron supplement); no diarrhea or rectal bleeding; no dysphagia
HEENT:	Mild conjunctival pallor (resolving); sclerae anicteric; no oral lesions; no lymphadenopathy; no thyromegaly
Dermatologic:	No jaundice, spider angiomata, caput medusae, or petechiae; mild pallor resolving with iron supplementation; no rash
Neurological:	Alert; mild lightheadedness resolved as Hgb improved; no focal neurological deficits
Musculoskeletal:	Chronic mild low back pain (L4-L5 disc bulge 2022); NSAIDs permanently discontinued; acetaminophen substituted
Psychiatric:	Mild health anxiety post-hospitalization; work-related stress; no prior psychiatric history
Genitourinary:	No dysuria, hematuria, or urinary frequency changes; no renal symptoms
Endocrine:	No polyuria, polydipsia, or thyroid symptoms; no heat/cold intolerance; no adrenal symptoms
Hematologic / Lymphatic:	IDA recovering — Hgb 11.2 g/dL from nadir 7.8 g/dL; on oral iron supplementation; no lymphadenopathy; no bleeding from other sites; no clotting disorders

10 Physical Examination

10a VITAL SIGNS

BP:	132/80 mmHg	**Temperature:**	98.5°F (36.9°C)
HR:	76 bpm, regular	**O2 Saturation:**	99% on room air
RR:	15 breaths/min	**BMI:**	27.8 kg/m² (192 lbs, 5'10")

10b EXAMINATION FINDINGS

General appearance:	Well-nourished, mildly fatigued male; mild conjunctival pallor; no jaundice; cooperative and articulate; no acute distress
HEENT:	Mild conjunctival pallor (resolving with iron therapy); sclerae anicteric; no oral lesions; no lymphadenopathy; no thyromegaly
Cardiovascular:	Regular rate and rhythm; S1/S2 normal; no murmurs, rubs, or gallops; no peripheral edema
Respiratory:	Clear to auscultation bilaterally; no wheezing or crackles
Abdomen:	Soft; mild epigastric tenderness to deep palpation (3/10); no rebound or guarding; no hepatosplenomegaly; normal bowel sounds; no palpable masses; no CVA tenderness
Musculoskeletal:	No joint swelling; normal gait; no asterixis
Neurological:	Alert, oriented x4; CN II-XII grossly intact; strength 5/5 all extremities; no focal deficits
Skin:	Warm, dry; mild pallor resolving; no jaundice; no spider angiomata; no petechiae

A Assessment

11a PRIMARY DIAGNOSIS & DIFFERENTIALS

PRIMARY: Active duodenal ulcer with prior GI hemorrhage, H. pylori-positive, NSAID-related (K26.0 + B96.81). Recovering iron deficiency anemia (D50.0). DIFFERENTIALS: Gastric malignancy — lower probability but mandatory surveillance EGD given father died of gastric cancer, H. pylori positive, 8 lb weight loss; GERD — likely concomitant; esophageal assessment at follow-up EGD. REASONING: Index EGD-confirmed Forrest IIa ulcer endoscopically treated; H. pylori eradication completed; NSAIDs causally implicated (chronic 3-4x/week use, now permanently discontinued). Family history of gastric cancer + H. pylori + age 52 mandates aggressive surveillance. STABILITY: Stable, recovering; Hgb improving; no rebleeding signs.

11b RELEVANT RISK FACTORS & COMORBIDITIES

Comorbidities: HTN well-controlled; IDA recovering. Risk factors: H. pylori infection (eradicated — confirm UBT at 4 weeks); chronic NSAID overuse (ibuprofen 3-4x/week x2+ years, permanently discontinued); alcohol 4-6 drinks/week (reduced, counseled); strong family history gastric malignancy (father, age 64). Contributing factors: high-fat irregular diet, work stress, NSAID overuse, H. pylori infection — all identified and addressed at this visit.

P Plan

12a DIAGNOSTIC TESTS ORDERED

H. pylori urea breath test (UBT) — scheduled May 26, 2026 (4 weeks post-antibiotic); confirms eradication; critical milestone before surveillance EGD.
Repeat EGD — scheduled June 2026 (8 weeks post-index EGD); confirm ulcer healing, exclude malignancy, biopsy residual lesions; assess esophageal mucosa for GERD/Barrett's.
CBC and ferritin — ordered today; track Hgb trajectory and iron stores.
Colonoscopy — recommended (first screening; age 52, maternal uncle colon cancer at 58); to be scheduled.

12b MEDICATIONS & PROCEDURES

Pantoprazole 40 mg PO BID — CONTINUE x8 weeks; reassess at follow-up EGD; transition to 40 mg daily maintenance if healed, given NSAID history and H. pylori risk.
Ferrous sulfate 325 mg daily — CONTINUE; recheck Hgb/ferritin at 6 weeks. Target Hgb >13 g/dL.
Sucralfate 1g PO QID — NEW; mucosal cytoprotection and symptom relief; take on empty stomach 1 hour before meals and at bedtime.
Ibuprofen — PERMANENTLY DISCONTINUED; acetaminophen 500-1000 mg q6-8h PRN substituted.

12c PATIENT EDUCATION & REFERRALS

Education: H. pylori eradication and UBT confirmation (May 26); NSAID mechanism of mucosal injury — permanent avoidance; dietary modifications (smaller meals, avoid spicy food/coffee/alcohol during healing); return precautions. Family history of gastric cancer — surveillance EGD importance discussed; patient verbalized understanding and willingness to follow plan. PCP (Dr. Collins) notified via EHR message with visit summary and medication changes.

D Disposition & Follow-Up

13a DISPOSITION

Disposition (discharge/admit/observation): Outpatient; discharged from office today; no hospitalization indicated

Condition at time of disposition: Stable, clinically improving; Hgb recovering; no active bleeding; epigastric pain expected during mucosal healing

13b FOLLOW-UP

Return in: 8 weeks (June 2026) for EGD; 4 weeks (May 26) for UBT; 6 weeks for CBC/ferritin

Purpose of follow-up: EGD — ulcer healing confirmation + malignancy exclusion; UBT — H. pylori eradication; CBC/ferritin — anemia trajectory; colonoscopy scheduling

Earlier if: Recurrent hematemesis, melena, severe abdominal pain, syncope — ER immediately; significant symptom worsening — call GI office