7/18/20 Morning Report with @CPSolvers

***Case Presenter**: Gurleen Kaur (@Gurleen_Kaur96) **Case Discussants**: Alex Horne (@AlexHorneMD) and Rabi Geha (@rabihmgeha)*

CC: Abdominal pain

HPI: 20 F Down syndrome presented with abdominal pain

History from parents: Abdominal pain started 5 days ago. It got progressively worse. It started in the lower abdominal moved to the right breast and then became diffused . No association with food. Improves with warm baths. Pain was not relieved tylenol. She had nausea and not bloody vomiting 1 day ago. She has hard stools and feeling of bowel movements that did not occur. Denied fever, chill, diarrhea

ROS: Recent leaking? Anxiety and irritability. NO

ED: bowel movement with blood strings

PCP did Abdominal US: normal, no abnormalities

PMH:
Down syndrome
Anxiety

Meds:
Extended release Bupropion (4 months ago)
Loratadin
Melatonin
Oral Contraceptives
Discontinued CBD

Fam Hx:
Father: HTA, IBS
Mother: migraine
Grandparent: Crohn syndrome

Soc Hx: Lives with parents. No drugs, no sexually active

Health-Related Behaviors:
No recent travel

Allergies: None

Vitals: **T**: 37.3 **HR**: 120 **BP**: 129/80 **RR**:20 **SpO$_2$**: 96 **BMI**:35

Exam:

Gen: Lying in distress. Uncomfortable

HEENT, Pulm, Neuro, Extremities/Skin: normal

CV: Tachycardic, RR, no murmurs

Abd: Soft, not distension, diffuse tenderness in all quadrants no rigidity or guarding. Large hemorrhoid thrombosis

Notable Labs & Imaging:

Hematology:
WBC: 19.2 Hgb: 14.5 (at admission)-->11.6 (1st day) Plt: 412
MCV 102 Hct: 42.7 (at admission)-->35 (1st day)

Chemistry:
Na: 137 K: 3.6 Cl: 103 CO2: 22 BUN: 10 Cr: 0.74 glucose: 131
Ca, Phos, Mag: Normal AST, ALT: normal T Bili:1.7 Pregnancy: negative
Lipase: normal Lactic acid: normal Hg1ac: low normal PT:12.3 INR: 1.05
UA: 1+ proteins, ketones, specific gravity: 1.065
Fecal occult test: Positive Ferritin:226 Iron: 16 TIB: 0.3 %SAT: low
Folate and vit B12: normal Anticardiolipin, beta-2 glycoprotein, Protein C/S: wnl, Thrombin time normal, Factor V Leiden: normal DRVVT normal, homocysteine: low normal 4.1 Anti-thrombin: low at 62 (normal >80%) repeated normal 126 Cultures: negative

Imaging:
EKG: Sinus tachycardia
CT Abdomen and pelvis: diffuse submucosal edema, concern for **enteritis of mid-small bowel**, infiltration of mesenteric fat, defect of **thrombus in the main portal vein** extending into the right portal vein with periportal edema in R/L hepatic lobes and occlusive **thrombus of superior mesenteric vein**
Hepato Duplex: Partial thrombosis in superior and hepatic vein
Patient treated for hemorrhoid and thrombosis was due to minor risk factors

Problem Representation:
20 woman with Down syndrome presented with abdominal pain and bloody stools found to have portal vein and superior mesenteric venous thrombosis with associated small bowel edema of unclear etiology.

Teaching Points (Smitha):

Approach to abdominal pain: 1) location, 2) associated symptoms (e.g., fever). Remember pelvic (e.g., torsion, PID), cardiac (inferior MI), intrathoracic causes irritating diaphragm

CPR: Eating is a stress test on the GI system. Not worsening of with food → may not be dealing with organs that have prominent role in digestion

GI manifestations of Down syndrome: Hirschsprung's, Meckel's diverticulum

Bloody stools: melanotic stools localizes to proximal to ligament of treitz, BRB more likely to localize to lower GI tract (AVMs, diverticulosis, malignancy, hemorrhoids, fissures).

Before abdominal imaging → EKG, bladder scan, upreg

Macrocytosis: nutritional, liver disease, EtOH use, reticulocytosis

CPR: Identify the most morbid diagnosis and prioritize diagnostics/treatment there

CPR: What is the chicken and what is the egg? Did the clot come first → edema, or small bowel infection → clot.

Who gets hypercoag w/u? unprovoked, clear family hx, visceral clots. Better to do at least 2 weeks off AC. Not good in the acute setting because things that cause clots are consumed in the making of the clot

Hypercoagulability causes: antithrombin deficiency, FVL, APLS, Protein C/S deficiency, myeloproliferative d/o (usually concomitant splenomegaly). Polycythemia vera → mast cell response → ulcer formation in the stomach which leads to IDA

CPR: The test of time can be diagnostic!

Antithrombin deficiency: true antithrombin deficiency = heparin resistance