7/16/20 Morning Report with @CPSolvers

Case Presenter: *Imran Nizamuddin (@INizamuddinM)* ***Case Discussants***: *Kaitlyn Thomas (@smalltownOMS) and Jamal Benson (@jaymillz1010)*

CC: abdominal pain
HPI: 62M presenting with 5 days of RUQ pain
Started suddenly 5 days ago - initially 3/10-->7/10. Constant, no alleviating/exacerbating factors. ?associated with eating but appetite has been worse, decreased PO intake. Associated with one episode of nonbloody emesis
More SOB and anxious recently
Recently at neighboring hospital for similar complaints - had an US, was told something was wrong with his gallbladder and needed surgery but could not be done at this hospital.
At this hospital - got a HIDA scan

PMH:
CAD s/p stent 2004
HFrEF (35%), s/p ICD
Atrial fibrillation
HLD
CVA (remote), VT

Meds:
ASA 81
Amiodarone 400 mg daily
Bumex 1mg daily
Metop succ 100 BID
Simvastatin 20 daily
Apixaban 5mg BID

Fam Hx:
Non contributory

Soc Hx:
Lives with wife who is primary caretaker
No smoking, EtOH or recreational drugs

Vitals: **T**: 98.8 **HR: 101 BP: 91/70** RR: 16 **SpO_2: 93% on RA**
Exam:
Gen: anxious, NAD
HEENT: unremarkable, moist oral mucosa, no scleral icterus
CV: JVD visible at 90 degrees, irregularly irregular, no mrum
Pulm: clear to auscultation
Abd: soft, exquisite tenderness of the RUQ, (-)Murphy's sign, BS(+)
Extremities/Skin: 2+ pitting edema to knees, cool hands/feet

Notable Labs & Imaging:
Hematology:
WBC: 7.2 (normal diff) Hgb: 11.8 Plt: 191

Chemistry:
Na: 131 K: 4.1 Cl: 104 CO2: 21 BUN: 43 Cr: 2.3 (1.4) glucose: Ca: Phos: Mag: 2.3
AST: 111 ALT: 271 Alk-P: 171 T. Bili: 2.4 (1.4) Albumin: 2.4, TP 5.8 Lipase: normal INR: 1/7 Lactate: 3.0

Imaging:
EKG: irregularly irregular rhythm
CXR: congestion/pulmonary edema
TTE: LVEF 25% (limited by afib with RVR)
Report/Images for RUQUS: pericholecystic fluid and edema c/f cholecystitis (overread as congestion, less likely inflammation)
HIDA scan: no acute gallbladder inflammation, but reduced EF of gallbladder

Problem Representation:
62M w/poorly controlled HFrEF, VT, CAD, p/w acute/subacute RUQ pain, cool extremities, volume overload, c/f normotensive cardiogenic shock and hepatic congestion, likely 2/2 VT induced HFrEF decompensation

Teaching Points (Andrea):
Abdominal pain in elderly: higher mortality and morbidity than chest pain. The most typical presentation of ap in elderly is the atypical ones
Emergency cases cannot miss: surgical (obstruction,perforation), vascular (aortic dissection, mesenteric ischemia), OBGYN (ectopic pregnancy) and cardiac (inferior MI)
Abdominal pain according to structure:
Intraabdominal: Think about quadrants and organs related to them
Extra: kidney, urinary, etc
Imaging is key in abdominal pain
Pain can cause anorexia by itself
RUQ pain: liiver, biliary system, gallbladder, diagrapham
Heart failure: always ask if compensated, Dry vs wet (measure congestion like JVP), test perfusion,
HF pat may have coronary disease, periphery disease and poor perfusion to end organs
Gallbladder vs Cardiac: Hepatobiliary system affected by congestion, increased liver enzymes
Low pulse pressure: Cardiac shock
Cardiac pathology supposes poor reserve
Low sodium is a bad prognostic for HF