6/3/20 Morning Report with @CPSolvers

***Case Presenter**: Scott Walker (@Scoott) **Case Discussants**: John Woller (@) and Rachel Anderson (@)*

CC: Stomach pain and vomiting

HPI: 35M p/w severe stomach pain in the epigastric region with no radiation. It is a sharp pain that comes in waves that started 2 days before with nausea and non biliar vomit no blood. Insidious pain not associated with eating. Patient denies anorexia.

Clinical update: intubated in ICU

PMH: none

Meds:
None

Fam Hx:
non-contributory

Soc Hx: Accountant, office jobs.

Health-Related Behaviors:
Healthy diet
Denied drugs nor ETOH
No sex past 6 months

Allergies: NKDA

Vitals: **T**: 100.1 **HR**: 124 **BP**: 94/48 **RR**: 28 **SpO_2**: 93%
Exam:
Gen: normal built, no pain, pale
HEENT: dry mucous membranes, no lymphadenopathy, no JVD, capillary refill greater than 2 seconds
CV: tachycardic, no m/r/g
Pulm: poor inspiratory effort, bilateral decrease of respiratory sounds, bilateral crackles
Abd: severe epigastric pain, positive fluid wave, no hepatosplenomegaly, no abdominal distention, positive guarding sign
Neuro: wnl
Extremities/Skin: cold to touch, no jaundice

Notable Labs & Imaging:
Hematology:
WBC: 20 Hgb: 10 MCV: 75 Plt: 170
PT 16 PTT 33? INR?

Chemistry:
Na: 140 K: 3.5 Cl: 98 CO2: 18 BUN: 68 **Cr: 1.9** BUN 68 glucose:78 Ca: 16.2 AST: 206 ALT: 269 Alk-P: 209 T. Bili:2.5 Albumin: 3.6 TP: 10
Amylase: 1239 Lipase 988 ABG: 7.24/40/18

Imaging:
EKG: sinus tachycardia
CXR: diffuse bilateral dense consolidation compatible with RADS
ABDOMINAL US: normal liver, bulky pancreas, rest normal
CT: Acute pancreatitis, mild ascites, bilateral pleural effusions, osteolytic lesions
SPEP: monoclonal spike
BM biopsy: greater than 60% plasma cells

Problem Representation: 35yo previously healthy man p/w acute insidious epigastric pain and vomiting to ED. Found to be in shock, exam notable for epigastric pain, fluid wave and guarding. Found to have metabolic acidosis, AKI, protein gap, hypercalcemia with elevated lipase & amylase. CT scan notable for e/o acute pancreatitis and the presence of osteolytic lesions diagnosed with multiple myeloma based on SPEP and BM biopsy w/ > 60% plasma cells

Teaching Points (Priyanka):
Anatomic approach to abdominal pain: Organs: stomach, gallbladder, pancreas; appendix, colon. Epigastrium (GERD, dyspepsia, gastritis, PUD; must not miss perforation); pancreatitis, AAA. Vascular areas- celiac distribution. Superficial structures in abdominal wall- skin (herpes zoster). Referred pain- inferior cardiac event; inferior PE, PNA→ anything irritating inf. Portion of lung/pleura.
CP 1: Lack of anorexia can clue us into chronic inflammatory dz.
CP 2: Perforation of ulcer- acute, sudden; less likely insidious onset (like in this pt).
Positive Fluid Wave: incr. LR for ascites.
Ddx for Abdominal pain + resp distress: acute pancreatitis + ARDS, perf viscus/ reactive ascites, acute liver failure/ injury with acute ascites (ie: from stone, Budd Chiari, EtOH)
Microcytic Anemia: IDA, **ACD/ anemia of inflammation**, Thalassemia, sideroblastic anemia (2/2 toxin ie: lead poisoning).
***CP3: Prioritizing problem list from least explained to most explained*:**
Hypercalcemia (PTH dependent?; lytic bone dz; PTHrP, 1,25 vit D; Endocrine, milk alkali)); Protein Gap: Monoclonal (multiple myeloma; microcytic anemia, hyper Ca, renal injury, bone pain) or polyclonal; high AG Met acidosis (methanol. Uremia, DKA, lactic acidosis, ethanol, iron); Pancreatitis (alcohol, gallstones, hypercalcemia, toxins)
Consider other causes of Hyper Ca/ Lytic lesions: Lymphoma, granulomatous dz; Crohn