03/05/21 Morning Report with @CPSolvers

Case Presenter: *Gabriel Ralledo(@gabrieltalledop)* ***Case Discussants***: *Rabih (@rabihmgeha) and Reza(@DxRxEdu)*

CC: 36 yo M with 6 months of abd and diarrhea

HPI: Symptoms started 6 months prior with abd pain that started in RLQ &radiated to right lumbar region, worse with movement. No worsening with food intake. 4 months prior, noted fever and diarrhea, 4/day with mucous. Denies blood. Tx with cipro for infectious diarrhea, no improvement. Took it for 2 months. 3 months ago he developed a painful RLQ mass. He lost 15 kg as well during this time. No salt craving

PMH: Chronic anal fissure, xtr TB a few years back and was treated.

Meds: Cipro x 2 months

Fam Hx: unremarkable

Soc Hx: denies

Health-Related Behaviors:

Lives in the NE Peru, Amazon region. Now in Lima.

Allergies: None

Vitals: **T**: **37 C** **HR**:86 **BP**: 150/70 **RR**: 18 **SpO_2**:
Exam:
Gen: Pale, skinny
HEENT: Nml
CV: Nml **Pulm**: Nml
Abd: 4x2 cm mass in RLQ td to palpation and immobile.
Neuro: Nml
Extremities/Skin: No rash or edema
Lymph: No adenopathy cervical, + axillary LN with suppuration

Notable Labs & Imaging:
Hematology:
WBC: 16.6 Hgb: 7.5 Plt: 760 Retic: 2% MCV: 84
Chemistry:
Na: 133 K: 3.2 Cl: 105 CO2: BUN: Cr: 1 glucose:87
AST: 90 ALT: 35 T. Bili: 0.6 Albumin: 4
INR: 1.3
HIV Elisa: Negative
ESR: 52
Fecal WBC: 70/hpf
Giardia Stool +
Colonoscopy: Showing ulcerated lesions in the transverse colon and cecum
Imaging:
Double Contrast X Ray: Lack of oral contrast not passing into cecum
Biopsy: + for **Paracoccidioidomycosis**
Treatment: Preferred treatment is Amphotericin B 1mg/kg/day until clinical recovery. Then followed by Itraconazol 200 mg/day for 6-24 months.

Problem Representation: 36 yo man w/ hx of chronic anal fissures and 6 months hx of abdominal pain, diarrhea and fever resistant to ciprofloxacin and a painful RLQ abdominal mass p/w chronic RLQ abdominal pain and diarrhea. On abdominal exam, RLQ 4x2 mass is palpable. Labs show leukocytosis, thrombocytosis and normocytic anemia. Imaging suggests cecal wall thickening colitis enteritis.

Teaching Points (Gabi Pucci):

- **APPROACH TO CHRONIC DIARRHEA:** inflammatory **(fever, hematochezia, blood, pus)** X noninflammatory cause.
  - **Inflammatory:** IBD: Chron, RCU, infections (tuberculosis, CMV, HSV, Schistosomiasis, Entamoeba histolytica), radiation therapy, ischemia, infiltrative (lymphoma)
  - **Noninflammatory:** look for osm. Gap: < 50: secretory. > 50: osmotic, fatty or functional
- **APPROACH TO ABDOMINAL PAIN - ACUTE** -> abdominal CT!! **Only 5 do not show up:** inferior myocardial infarction, pancreatitis, urinary retention, zoster, hernia.
  - Exams to exclude those: EKG (MI), lipase (pancreatitis), POC US (urinary retention), clinical exam (for hernia and zoster)
- **APPROACH TO ABDOMINAL PAIN - CHRONIC: 5 causes:** irritable bowel syndrome, endometriosis, ACNES (anterior cutaneous nerve entrapment syndrome), chronic pancreatitis, and chronic mesenteric ischemia
- **Pain in the RLQ:** cecum (cecal diverticulitis), appendix (appendicitis if acute), ileum (lymphoid tissue: local disease or metastatic disease)
- Local infection + mass in ileum: Whipple's disease, TB, histoplasmosis and Entamoeba histolytica. Lymphoma - non infectious cause
- **Annal fissure + diarrhea: constipation (posterior midline), if anterior/lateral: systemic causes-> Crohn's, TB, Actinomycosis, Entamoeba histolytica**
- Inflammatory process leading to thrombocytosis: subacute/chronic organism
- **"Pairs"of infectious agents for DDx: Actinomyces and Nocardia / TB + Histo**
- Giardia +: if isolated diarrhea-> treat and see if gets better (not this case with more symptoms/signs)
- Paracoccidioidomycosis brasiliensis: intestinal manifestations is rare.