03/8/21 Morning Report with @CPSolvers

***Case Presenter**: Dhruv Srinivasachar (@TheRealDSrini) **Case Discussants**: Parth VIsrodia and Sonia Silinsky Krupnikova*

CC: Hypotension and Abdominal Pain

HPI: 40 yo F p/w hypotension to the ED after being low at dialysis, no response with midodrine prior to dialysis. She feels lightheaded, does not have CP, SOB, fevers, chills. She also has acute on chronic abd pain that started two years ago.given broad spectrum abx (Vanc/Zosyn) in the ER suspecting infection

PMH: DM with last A1c 8.5%, ESRD on HD, prior cardiac arrest, anoxic brain injury, adrenal insufficiency ,recurrent systemic infections, chronic abdominal pain

Meds: Hydrocortisone, basal bolus insulin, midodrine

Fam Hx:Mother with DM, HTN. Father has HTN

Soc Hx:

Health-Related Behaviors: no tobacco abuse, no alcohol abuse, no illicit substances

Allergies: Rash to bactrim, cipro flagyl, pcn

Vitals: T: **36.8 C** HR: 90-**108** BP: **70-100/40-60s** RR: **20-30s** SpO_2: 99%

Exam:

Gen: mild distress, uncomfortable appearing

HEENT: MM, PERRLA, EOMI

CV: Nml, tunneled dialysis catheter in chest wall, fistula LUE (not in use)

Pulm: Clear

Abd: Soft, obese, td in L and R Upper quadrants w/o rebound or guarding

Neuro: nml

Extremities/Skin: no peripheral edema, scattered lesions/scabs to UE and LE, diabetic ulcer on right foot

Notable Labs & Imaging:

Hematology:

WBC: 19.8 Diff with 90% neutrophils 0.5% Eosinophils Hgb:11.6 Plt: 211

Chemistry:

Na: 131 K: 5.2 Cl: 93 CO2: 27 BUN: 15 Cr: 4.7 glucose:186 Ca: nml

AST: nml ALT: nml Alk-P: nml T. Bili: nml Albumin: nml

Trop: neg , Beta Hcg: Neg

Lactic 2.1 (H)

Blood cultures: + MRSA day 1 but cleared before TEE was done

Imaging:

TTE: Suboptimal, no overt valvular lesions

TEE: 1 day after line removed and placed, A large echodense mass in atrium, adherent to right atrial wall and central venous catheter, likely thrombus vs infection

CT abd pelvis: Negative for acute findings

Final Dx: Catheter related right atrial thrombus

Problem Representation:

40 year old F w/ ESRD and adrenal insufficiency presents with hypotension and acute on chronic abdominal pain in the setting of tunneled catheter and diabetic foot ulcer, found to have tachycardia, leukocytosis, normal CT A/P, and atrial thrombus.

Teaching Points (Gurleen):

- **FIRST THINK OF HYPOTENSION:** shock: cardiogenic, hypovolemic, obstructive (pneumothorax, tamponade), distributive (septic)
- **ABDOMINAL PAIN:** don't forget extra-abdominal causes: kidney, pelvis, bladder, MI, HF, pneumonia, PE
- **VENN DIAGRAM (*pivot, filter)*: HYPOTENSION + ABDOMINAL PAIN:** what came first? → abdominal source of infection, ischemic colitis/mesenteric ischemia, DKA, adrenal insufficiency
  Filter with hypotension: distributive (infection, AI, pancreatitis), hypovolemic (hemorrhage - AAA, peptic ulcer, AE fistula vs. none), obs (abd compartment syndrome)
- **Who is our patient?** *Foreground vs. background.* Comorbidities, ESRD → infection risk, endocrine abnormalities - adrenal insufficiency
- **Clues:** tachycardia, leukocytosis, risk for infections - tunnelled catheter, fistula, diabetic foot ulcer/scabs
- **IMAGE NEGATIVE ABDOMINAL PAIN**: metabolic (DKA, Ca, uremia, adrenal), toxins (opioids, anticholinergic, lead), functional (IBS), other (angioedema, zoster)
- *Prioritize infection* - endovascular source, skin flora (Staph, Strep), when (acute)? From where?
- *MRSA bacteremia* - need to find out source, consult ID, treat
- **CLOT IN HEART:** thrombus vs. infective thrombus; causes: A. fib, low EF (high stasis), indwelling line
- **ENDOCARDITIS:** treat for 6 weeks, concern for mycotic aneurysm