



# 06/09/21 Morning Report with @CPSolvers



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<p><b>CC:</b> Abdominal pain.</p> <p><b>HPI:</b> 8 year old male comes to the ED complaining of abdominal pain. He refers diffuse pain for 2 days, associated with polydipsia and polyuria. 2 episodes of vomiting last night. No weight loss, diarrhea or constipation.</p>	<p><b>Vitals:</b> T: Afebrile HR: 108 BP: 100/80 RR: 35 SpO<sub>2</sub>: 89%</p> <p><b>Exam:</b></p> <p><b>Gen:</b> Dry mucous membranes.</p> <p><b>HEENT:</b> Normal</p> <p><b>CV:</b> Normal</p> <p><b>Pulm:</b> Normal breath sounds without crackles.</p> <p><b>Abd:</b> Diffuse pain on deep palpation, no rebound sign. Decreased bowel sounds.</p> <p><b>Neuro:</b> Normal</p> <p><b>Extremities/Skin:</b> Normal.</p>	<p><b>Problem Representation:</b> 8M p/w a 2 day history of abdominal pain, polydipsia, polyuria and vomiting. He was tachycardic, tachypneic and his SpO<sub>2</sub> was 89%. UA showed glucose and ketone bodies.</p> <p><b>Teaching Points (Kiara):</b></p> <ul style="list-style-type: none"> <li>● <b>Abdominal pain:</b> Most will require imaging, narrow the Dx with HPI(time course), Hx (Vaccination, trauma, food, contacts), and PE (+ other symptoms). In peds, try to radiate less. Hernias (Inguinal), pancreatitis (trauma, MUMPS rare). - <u>Image negative:</u> Metabolic (DKA), Meds/Toxins, Functional, Others.</li> <li>● You expect for type-1 DM to have weight loss and long-term polydipsia/polyuria (&gt; 3 L/d). Triggers for DKA: 5I (Infection, Lack of Insulin, Ischemia, Insemination, Ingestion).</li> <li>● <b>Polyurea: Excrete water</b> (Primary polydipsia-excessive water intake /DI- central vs nephrogenic) vs <b>excrete solutes</b> (DKA, Na, Intracranial pathology under mannitol).</li> <li>● Abdominal pain → highly suspicious of metabolic cause (DKA: high mortality rate) → correct it → if persist, take image.</li> <li>● How to move forward? Ask glucose, urine studies, basic metabolic panel, venous blood gases, WBC. Later Abs for Type 1 DM.</li> <li>● <b>Management:</b> If K is NI, supply K fluids to replete intracellular stores along w/ Insulin. Check Phos before Insulin. IV fluids (Ringer lactate), Insulin drip until normal gap → Long-acting Insulin. Empiric antibiotics and de escalate if no growth in cultures (Prob high WBC due to stress).</li> </ul>
<p><b>PMH:</b> None</p> <p><b>Meds:</b> None</p>	<p><b>Fam Hx:</b> Grandmother has Diabetes. Both parents are healthy.</p> <p><b>Soc Hx:</b> None</p> <p><b>Health-Related Behaviors:</b> None</p> <p><b>Allergies:</b> None</p> <p><b>Notable Labs &amp; Imaging:</b></p> <p><b>Hematology:</b></p> <p>WBC: 12 000 (bands 3%, 70% neutrophils and lymphocytes 20%) Hgb: 12.2 MCV 81 Plt: 200 000.</p> <p><b>Chemistry:</b></p> <p>Na: 131 K: 5.5 Cl: 95 CO<sub>2</sub>: 9 BUN: 70 Cr: 1.3 glucose: 595 pH 7.09 pCO<sub>2</sub> 19 pO<sub>2</sub>: 56 UA: Glucose +++ and ketones +++.</p> <p><b>Final Dx: Diabetes Ketoacidosis.</b></p>	