07/21/21 Morning Report with @CPSolvers

Case Presenter: *Rebecca Berger(@RebeccaEBerger)* ***Case Discussants***: *Nilayan Sarkar (@nilayansarkar) and Franco Murillo (@francomurilloch)*

CC: Left flank pain

HPI: 57 yo M L flank pain for several hours. 7 pm night prior: Took acetaminophen with no improvement. Pain progressed, after 5h of symptom he came to the hospital.

Denies: Fever, chills, NV, diarrhea, urinary dysuria, hematuria.

This is his first event

PMH: None

Meds: Acetaminophen PRN

Fam Hx: None. Parents HTN, hyperlipidemia

Soc Hx: Physician

Health-Related Behaviors: No recent travel or exposures.

Allergies: None

Vitals: **T**: 36.6 **HR**: 70 **BP**: 145/86 → 122/82 **RR**: 18 **SpO_2**: 100%
Exam:
Gen: Well appearance, no acute distress
HEENT: Anicteric sclera, mucous membrane
CV: Normal
Pulm: Clear
Abd: Soft mild tenderness L mid abdomen, No suprapubic tenderness.
Neuro: Normal
Extremities/Skin: Normal pulses, no edema, rashes, skin changes

Notable Labs & Imaging:
Hematology:
WBC: 4.8 Hgb: 14 Plt: 405
Chemistry:
Na: 140 K:4.4 Cl:105 CO2: 28 BUN:20 Cr: 1.0 glucose: Ca: Phos: Mag:
AST: Nl ALT: Nl Alk-P: T. Bili: Albumin:
UA: No blood or protein, glucose, ketones, leukoesterase.
Imaging:
EKG: Nl
CT abd-pelvis w/o contrast: Kidneys, ureters and urinary bladder: unremarkable. No urinary calculi. No hydroureteronephrosis or peri nephroureteral stranding
CT abd-pelvis w/ contrast: Nl Aorta, mesenteric vasculature, L-renal dissection on bifurcation. L-kidney infarcts 30-40% of renal parenchyma.
Final Dx: Spontaneous L renal artery dissection w/ associated renal infarction.
Surgeons recommended conservative management. 2nd imaging, no evidence of FMD. Rheum workup was negative.

Problem Representation: 57 yo M w/o PMH presents with acute L flank pain and hypertension with unremarkable labs and UA

Teaching Points (Gabriel):

- **Hyperacute flank pain:**
  - Localize the lesion: Kidney (pyelonephritis, renal stones, perinephric abscess), colon, spleen, skin (HZV), MSK, systemic (embolic diseases, porphyrias)
- **Collecting clues:**
  - **High BP:** stress, perinephric abscess compressing renal parenchyma
  - **Skin changes:** HZV, endemic mycoses.
  - **Hyperacute and progressing pain:** Morbid conditions such as vascular problems (renal venous thrombosis, aortic aneurysm).
    - *In hyperacute flank pain, fever could not be expected. Still maintain high index of suspicion for infectious etiologies.*
  - **Basic WBC & basic metabolic panel within normal limits** → MSK and skin issues on top of the list. Beginning of vascular, infectious and metabolic diseases.
  - **Non contrast CT normal** → extra-abdominal etiologies. Still vascular etiologies should not be ruled out.
    - **Carnett sign:** pain gets worse when the abdominal wall gets tense. Suggests the pain has an extra-abdominal source.