08/20/21 Morning Report with @CPSolvers

Case Presenter: (@) Case Discussants: Rabih (@RabihMGeha) and Reza (@DxRxEdu)

CC: Persistent abdominal pain

HPI: 63-year-old female with persistent epigastric and RUQ pain along with vomiting. Patient had laparoscopic cholecystectomy 3 months back, complicated by possible bile leak (negative HIDA scan). Endorses nausea & vomiting.

ROS- Denies appetite changes, diarrhea, or respiratory complaints

PMH: Cholecystectomy, hernia repair, colonoscopy, dyslipidemia, cervical stenosis

Meds: Atorvastatin

Fam Hx:

Soc Hx:

Health-Related Behaviors: Occasional alcohol

Allergies: Augmentin

Vitals: **T**:36.8 **HR**:72 **BP**:132/69 **RR**: **SpO_2**:97
Exam:
Gen: Alert, no stress,
HEENT:
CV:
Pulm:
Abd: Mild tenderness in RUQ, fistula with drainage from port, slight erythema
Neuro:
Extremities/Skin:

Notable Labs & Imaging:
Hematology:
WBC:6000 Hgb:12.2 Plt: 320k

Chemistry:
Na: 137 K: Cl: HCO3-24 CO2: BUN: Cr:0.9 glucose: Ca: Phos: Mag:
AST: 24 ALT:28 Alk-P:76 T. Bili: Albumin: 4.1 Total protein- 7
ESR-16, CRP-3.2
Normal lipase levels

Imaging:
CT scan: Stomach- Soft tissue mass in posterior wall and distal thickening at the distal antrum.

Final dx- Gallstone ileus (Bouveret syndrome)

Problem Representation: A 63 year old female with past medical history of cholecystectomy presents with persistent epigastric abdominal pain and evidence of a mass in stomach.

Teaching Points (Rafa):

- **63YOF W/ PERSISTENT ABDOMINAL PAIN**
  To scan or not to scan? : 6 diagnosis not having the need for CT
  Exam:Zoster, Hernia
  Labs: Pancreatitis, DKA
  EKG (inferior MI), blader US (acute urinary retention)
  Rule out emergencies: Obstruction, perforation, ischemic, hemorrhage, inflammation - , cholangitis, massive hemorrhage (ruptured AAA)
  Rule out extra-abdominal causes: MI, PE, PNA
  CT negative - mesenteric ischemia, cholecystitis, ovarian torsion, adrenal insufficiency, AIP, anaphylaxis, angioedema
- **EPIGASTRIC** - 4 Gs: gastroparesis, gastric ulcer, gastritis, GERD + constipation, colitis,
  Don't forget that the pain can be referred!
- **CHOLECYSTITIS COMPLICATIONS**
  Bile duct injury , biliary peritonitis, fistulazations (including stomach and duodenum - gastric outlet obstruction)
- **POST-CHOLECYSTECTOMY SYNDROME**
  Persistent abdominal pain or dyspepsia: occurs either postoperatively (early) or months to years (late).
  PCS can be due to biliary (eg, retained common bile duct or cystic duct stone, biliary dyskinesia) or extra-biliary (eg, pancreatitis, PUD, CAD) causes.
- **CT: SOFT TISSUE MASS IN THE GASTRIC POSTERIOR WALL**
  Does it correlate to the patient's clinical syndrome? Consider neoplasias, stones, infections - upper endoscopy - Bouveret syndrome - gastric outlet obstruction due to gallstones.