09/08/21 Morning Report with @CPSolvers

***Case Presenter**: Rafael Medina (@Rafameed) **Case Discussants**: Franco Murillo(@FrancoMurilloCh) and Daniella Cal (@CalDaniella)*

CC: 34 yoM w/ odynophagia and fever

HPI: 5 days of odynophagia and fever 39C. After 2 days, seen by his PCP and prescribed azithromycin. He noted improvement of his throat pain, but the fever persisted. On the day of admission, also developed abdominal pain and sought the ER. The abdominal pain is described as dull, of insidious onset and progressive worsening to now severe at presentation. It was initially diffuse with gradual localization at the lower right quadrant. No relationship w/ meals/fastening. He notes nausea and hypo-orexia without vomiting.

PMH: Spontaneous pneumothorax(right) drained five years before.

Meds: Denies medications.

Fam Hx: -

Soc Hx: no antecedent of recent travels or unusual activities.

Health-Related Behaviors: Denies alcohol or illicit substances.

Allergies: denies.

Vitals: **T**: 36.9C **HR**: 113 **BP**: 110/70 **RR**: 16 **SpO_2**: 100%

Exam:

Gen: acutely ill-appearing, in moderate distress, alert, fully oriented.

HEENT: adequate dentition, without significant findings.

CV: tachycardiac, regular rhythm, no murmurs or rubs

Pulm: clear bilaterally

Abd: plain, normal tonus, tender to palpation of right iliac fossa, with guarding. Blumberg +, Rovsing +

Neuro:

Extremities/Skin: adequate perfusion, without edema or skin changes.

Notable Labs & Imaging:

Hematology:

WBC: 20780 (neut 87% lymph 6.7%) Hgb: 14.5 Plt: 224000

Chemistry:

Na: 136 K: 4.2 Cl: 109 BUN: 7.9 Cr: 0.88

AST: 42 ALT:34 Alk-P: 58 T. Bili: 1.1 Albumin: 4 GGT: 23

CRP: 144.6

Imaging:

Abd US: inflammatory signal in right iliac fossa topography; cecal appendix not possible to identify. Absence of free fluid in the cavity.

Abd CT: diffuse thickening of the right colon wall, particularly the cecum, assoc. with subtle adjacent fat densification. Prominent right iliac fossa lymph node enlargement. Cecal appendix without signs of acute inflammation.

The patient developed diarrhea while under observation.

Blood and stool cultures -> Final diagnosis: **Yersinia enterocolitica pseudoappendicitis syndrome**

Problem Representation: A 34-year-old male with RLQ abdominal pain, odynophagia, and fever for 5 days with evidence of inflammation in RLQ on imaging studies.

Teaching Points (Kirtan):

- **Fever + Odynophagia** - Infectious vs Non Infectious. Infectious causes - HSV, CMV, Candida. *What phase of swallowing brings the pain? Pharyngeal vs Esophageal.* Aphthous ulcers or medications too can cause odynophagia.
- **Exploring the abdominal pain** - Ileitis vs Colitis vs Hepatobiliary disorder. Infections like Yersiniosis and Leptospirosis can explain abdominal pain along with odynophagia. *Crohn's disease and other autoimmune diseases to be considered.*
- **Clues from PMH and PE** - Pain in the RLQ raises the suspicion for appendicitis, psoas abscess, peritonitis, perforation, appendicolith, or *infections triggering the above entities*.
- **Evaluating labs and imaging studies** - Evidence of inflammation in the RLQ fossa and suggestive examination findings heightens the concern for appendicitis. Key is to find it's cause.
- **Putting everything together** - Evidence of colonic thickening warrants consideration for IBD or infections mimicking IBD.