3/11/22 Morning Report with @CPSolvers

Case Presenter: *Mohammad Alsanea (@DrMalsanea)* ***Case Discussants***: *Rabih Geha (@rabihmgeha) and Reza Manesh (@DxRxEdu)*

CC: Abdominal pain

HPI: 73-year-old male with poorly localized abdominal pain for 3 days. He ate outside and then abdominal pain developed gradually; pain worsened at night and on walking, relieved upon lying down. Decreased appetite Non bloody diarrhea, non mucoid diarrhea. Nausea without vomiting

ROS: No vomiting, bleeding, chest pain, SOB, diaphoresis

PMH: cirrhosis/class C, Wilson disease, PUD/ H. pylori.
Multiple clean ulcers in duodenum (inflammation with eosinophilia). Gastric varices

Meds: Penicillamine, Spironolactone, Furosemide

Fam Hx: None

Soc Hx: Camel milk ingestion

Health-Related Behaviors: No smoking, drugs, or alcohol

Allergies: None

Vitals: **T**: 38.5 **HR**: 113 **BP**: 102/65 **RR**: 19 **SpO_2**: 99% on RA

Exam:
Gen: Alert conscious and oriented. Icterus present.
HEENT, **CV**, **Pulm**: normal
Abd: abd tenderness , shifting dullness present, negative for fluid wave.
Neuro: Normal
Extremities/Skin: +2 pitting edema to the knees.

Notable Labs & Imaging:
Hematology:
WBC: 8.47 Hgb: 11 Plt: 81
Chemistry:
Na: 128 K: 4.9 Cl: 102 Azotemia Cr: elevated Ca: 1.9 Phosphate: 1.1 AST, ALT: Normal 217 Alk-P: 217 T. Bili: 173, direct: 148 Albumin: 2.1
INR, aPTT: elevated Lactic acid: elevated.
UA: normal Blood and stool cx- negative.
Ascitic fluid: WBC-2710, 79% neutrophils, high SAAG, turbid orange fluid.
CTX started for 5-7 days and Vit K for 3 days.
Cx: Gram negative organism → E coli.

Final Dx: <u>Bacterial Peritonitis secondary to E. coli.</u>

Problem Representation: A 73-year-old male with PMH of cirrhosis presenting with diffuse abdominal pain that was worse with movement, fever, and evidence of ascites on examination

Teaching Points (Madellena Conte):
<u>Abdominal Pain:</u> Abdominal organs are so close together so pathology in 1 can present as pain in different regions. (Hard to put weight on location of pain b/c proximity.)
- Usually peritoneum. BUT consider referred pain from outside viscera (kidney, heart, lung, GYN)
- Few diagnoses can make w/o radiologist. Workhorse = CT scan
- Even with sx pointing to GI causes of Abd pain, do not exclude pathology of thorax/cardiac b/c of severe morbidity

<u>Nausea:</u> Autonomic nervous system NOT specific (i.e. nausea), but sensitive.
Nausea = alarm feature (vs. pain w/o nausea is less concerning)
<u>Inflammation</u> + acute > prioritize infection (IMADE)
<u>Decompensated cirrhosis</u> = acute on chronic process
Diagnosis: either evidence of parenchymal dysfunction (prolong INR, elevated bili) or increase portal pressure
- Parenchymal causes (eg. HCC), Portal HTN: worsened by reduced flow into portal vein
Vein issue: thrombus decreasing flow
Artery issue: vasodilation from infection
<u>Ascitic fluid in cirrhosis: look at SAAG score</u>
Portal HTN: SAAG elevated
SBP (>250 neutrophils): low immunoglobulin > vulnerable to translocation from GI tract in combination with perforation
spontaneous : monomicrobial, secondary: polymicrobial
<u>Helpful SBP resource:</u>
https://clinicalproblemsolving.com/wp-content/uploads/2020/05/Spontaneous-Bacterial-Peritonitis-Final-Draft.pdf