4/28/22 Morning Report with @CPSolvers

Case Presenter: *Travis Smith (@RosenelliEM)* ***Case Discussants***: *Rabih Geha (@Rabihmgeha) and Sharmin Shekarchian (@Sharminzi)*

CC: Epigastric pain & bloating

HPI: 49yo M p/w epigastric pain and bloating for 2 days. Worsened after eating sandwich. Tried PPI with no relief. No pain in chest, vomiting, change in BM and melena. Pain is bloating w/ nausea. Sx gets worse w/ eating. Appetite decreased. No sx like this before.

PMH:
Obstructive sleep apnea
GERD
Obesity
Alcoholic fatty liver disease
HTN

Surg:
colonoscopy normal 12 years ago

Meds:
Atenolol

Fam Hx: squamous cell lung ca (mom)
Dad died at 24 from gunshot

Soc Hx: separated, 5 children, school bus driver

Health-Related Behaviors: no tobacco or illicit drug use
Drinks 6-8 alcoholic drinks per week

Allergies:

Vitals: **T**: 36.2 **HR**: 108 **BP**: 132/82 **RR**: 16 **SpO_2**: 99%, BMI 33.7 (253 lbs)
Exam:
Gen: awake, comfortable
HEENT: no JVD, MMM, no conjunctival icterus
CV: wnl
Pulm: wnl
Abd: pain to deep palpation to epigastrium and periumbilical. Protuberant. Symmetrical distension
Neuro: wnl
Extremities/Skin: wnl, no rashes or stigmata

Notable Labs & Imaging:
Hematology:
WBC: 9.5 Hgb: 13.2 MCV 92 Plt: 199

Chemistry:
Na: 136 K: 4 Cl: 105 CO2: 24 BUN: 9 Cr: 1.13 glucose: 102
Lipase 45 AST: 21 ALT: 34 Alk-P: 60 T. Bili: 0.8, Lactic acid: 1.1
UA: no WBC, RBC, casts

Imaging:
CT: mesenteric volvulus, focal occlusion of SMV, extensive occlusive thrombus of SMV. Main portal vein thrombus. No evidence of bowel obstruction. Reactive ascites

Hospital course: Pt went for ex-lap for volvulus treatment. Terminal ileum removed. Congenital colemic (extraperitoneal) sac removed.

Final diagnosis: Mesenteric volvulus due to congenital colemic sac

Problem Representation: 49 y.o. M with acute epigastric pain and bloating with unsignificant physical exam and labs found to have mesenteric volvulus with SMV and portal vein thrombosis.

Teaching Points (Samy):

- Epigastric pain: between 2 interfaces (thorax/abdomen) -> entertain diseases of adjacent space (inf. OMI, cong. hepatopathy, PE, pneumonia, but also hepatobiliary, colonic, gastric disease, pancreatitis, etc) -> broad ddx, broad array of workup (how far do you go?) -> Quick tests: ECG, LFTs, lipase, troponin, CBC, BMP
- Postprandial abdominal pain: esophageal, hepatobiliary, luminal gastric/duodenal, pancreatic and intestinal blood vessel disease
- Causes of chest/abdominal pain can be hard to detect on physical examination due to their deepness (don´t rise to surface) -> don´t dismiss them, use indirect findings (e.g. sinus tachycardia) as a clue.
- Abd. pain + unremarkable workup: heart burn/dyspepsia, constipation, cannabinoid hyperemesis syndrome, opioid toxicity/withdrawal, but also all other causes of intraabdominal pathology (many don´t leave a track on the labs)!
- Cholecystitis can have completely normal labs and a benign abdominal exam!
- Congenital intraabdominal encapsulation: rare, most cases undiagnosed, congenital extra peritoneal sac, which contains bowel -> predisposes to volvulus formation and mesenteric ischemia and thrombosis
- Take abdominal pain serious in the context of tachycardia (obstruction, perforation, -itis, ectopic pregnancy, vascular event)