5/13/22 Morning Report with @CPSolvers

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CC: 81 y/o F upper abdominal discomfort

HPI:

- epigastric pain for a few days, not feeling well, associated with nausea, early satiety, vomiting, but no diarrhea, weight loss of 10 pounds in 2 months
- ROS: NO COUGH, NO FEVER, vomiting, no diarrhea, no dysuria, no blood in the stool, no neurological deficits

PMH: HTN, CAD, +treadmill test followed by quadruple bypass, mild hyperlipidemia, mild elevated fasting glucose

Meds: ASA, plavix (Clopidogrel), atorvastatin

No tolerance to ACE inhibitor or beta blocker secondary to HTN

Fam Hx:

Soc Hx:

Health-Related Behaviors: healthy lifestyle secondary to religious beliefs

Allergies:

Vitals: **T**:36.2 **HR**:86 **BP**: **143/77 RR**: **16 SpO$_2$**: 97 RA
Exam:
Gen: tired appearing, no pallor or jaundice
CV: regular rate and rhythm, no murmurs
Pulm: clear to auscultation
Abd: RUQ tenderness, Murphy sign positive
Extremities/Skin: no rash, no lower extremity swelling

Notable Labs & Imaging:
Hematology:
WBC: 8.5 Hgb:12.2 Plt: 210
Chemistry:
Na: 134 K: 4.6 Cl: 100 CO2: 26 BUN: 16 Cr:1.1 glucose: 99 Ca: 9.4
AST: 198 ALT:175 Alk-P: 375 T. Bili: **0.5** Albumin: 3.7 T.protein: 6.6
CRP: 1.5
INR: 1
UA: not collected
Imaging:
Abdominal US: normal liver echogenicity, no biliary tree ductal dilation
Additional Tests:
Hepatitis panel: neg
Alpha1 antitrypsin: neg
Ferritin and iron panel: WNL
Antimitochondrial antibody: neg
Soluble liver antigen: neg
Liver-kidney microsome: neg
Ceruloplasmin: WNL
Serial IgG and IGA: negative

Dx: Statin-induced hepatitis

Problem Representation: 81 y/o F with important CV PMH presents with subacute right upper quadrant pain associated with N/V, early satiety and elevated LFTs. Negative viral and autoimmune hepatitis panels.

Teaching Points (Samy):

- Upper abdominal discomfort: pseudolocalization -> consider pathologies of the abdomen (GI, liver, spleen, pancreas) and thorax (heart, lung, pleura, etc.)
- Hypothesis driven evaluation -> Clues: Prandial? -> digestive organs (hepatobiliary, GI lumen, pancreas, mesenteric blood vessels); Exertional or associated with shortness of breath? -> Cardiopulmonary system (MI, PAE, pneumonia, pleuritis,...)
- Early satiety: extra-luminal (PUD, malignancies, compression from organomegaly) vs. motility (autonomic neuropathy, e.g. seen in DM)
- Complications from CABG: acute vs. chronic; bleeding, graft-thrombosis, autoimmune pericardial disease, constrictive pericarditis, AFIB, thoracic duct injury, infections (mediastinum, surgical site)
- RUQ-tenderness/pos. Murphy sign has limited sensitivity/specificity for hepatobiliary disease (50-90%) Use these signs with caution!
- RUQ-pain in the setting of HF: congestive hepatopathy and decreased portal perfusion leading to acalculous cholecystitis
- LFTs-patterns: R factor for differentiation (>5 hepatocellular, 2-5 mixed, <2 cholestatic)
- Negative hepatitis-workup and negative abdominal imaging? Consider drug induced causes of liver injury (dx of exclusion, LiverTox) - Hy´s law: predicts mortality risk of DILI
- Statins complications: myopathy (form asymptomatic elevation in LFTs to necrotizing myopathy), drug-induced liver injury
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