6/16/22 Morning Report with @CPSolvers

Case Presenter: *Marcus Loureiro* ***Case Discussants:*** *Rabih (@rabihmgeha) and Kirtan (@KirtanPatolia)*

CC: abdominal pain X 10 days

HPI: 28yo M p/w abdominal pain- in the umbilical region, radiating to the back, started 10 days ago with some episodes of vomiting

+ Anorexia, asthenia
+ odynophagia
+ Icterus (started 9 days ago)

No fever, no hematemesis,

PMH:
Daily ETOH since 15 years old.
Stopped 4 days ago
Schizophrenia
2 doses covid vaccine

Meds:
Risperidone
Naltrexone
Escitalopram

Fam Hx:
Mother-eclampsia

Soc Hx:

Health-Related Behaviors:
- Smoke
- Drugs

Allergies:
NKDA

Vitals: T: 37.1 HR:91 BP: 116/67 RR: 18 SpO_2 97%
Exam:
Gen: awake, alert and oriented Jaundiced
HEENT: Scleral icterus
CV: nl
Pulm: nl
Abd: distended, pain on palpation the umbilical area
Neuro: No flapping tremor
Extremities/Skin: No edema

Notable Labs & Imaging:
Hematology:
WBC: 11,020 Hgb: 11.9 MCV 101 Plt: 177,000

Chemistry:
Na: 135 K: 3.5 Cl: HCO3: BUN: 25 Cr : 0.7 Glucose: 183
Ca; 8.5 AST: 216 ALT: 58 T. Bili: 44.1 D Bili: 31.52 I. Bili: 12.89
Alb: 2.5 GGT: 315 ALP: 184 LDH: 444 Amylase: 254
LIPASE: -

Serology:
HIV neg Hep A, B, C Neg Syphilis: Neg BAL: neg
Imaging:
US: Liver normal, echogenicity moderate high of parenchyma,, Steatosis of liver grade II, pancreas with no cystic or solid findings
CT: ADB: Liver normal, diffuse steatosis, small amount calcifications of pancreas.

Dx: Diffuse fatty liver (Alcoholic hepatitis)
Esophageal candidiasis (non-HIV)
Chronic pancreatitis

Problem Representation: 28yoM with PMH of smoking and alcohol use p/w umbilical pain for 10 days. Labs significant for leukocytosis, anemia, and altered liver panel. Found to have diffuse steatosis on CT.

Teaching Points (Madellena):
Abd pain: consider intra-abdominal & extra-abd organs (thoracic, pelvic)
Anatomic approach to drive differential
Ex: Radiation to back > consider retroperitoneal organs
Ex: Odynophagia: esophagus or retropharyngeal structures
Important to consider timecourse and severity
Must not miss diagnoses: obstruction, perforation, ischemia
https://clinicalproblemsolving.com/wp-content/uploads/2017/05/abd_pain_schema.pdf
When is using medical hx to guide diagnostic approach helpful?
Risk = anchoring/bias.
Useful when: hx expands ddx (i.e. HIV) or alcohol + abd pain
Alcohol + abd pain:
Lab + diagnoses: alcoholic steatohepatitis, pancreatitis, ketoacidosis
Lab - diagnoses: alcoholic gastritis, mallory-weiss tear, GI beri-beri
Distended abdomen (phases of matter approach): liquid (blood - hemoperitoneum, ascites), solid (HSM), gas
Labs: Direct hyperbiliuribemia: intra or post-hepatic?
Concomitant AST, ALT elevations > suggest pathology in liver
Portal HTN: suggest intrahepatic disease (except PSC)
Intra-hepatic a/w portal HTN: cirrhosis or infiltration by fat
Significantly high bilirubin: steatohepatitis, AFL of pregnancy, leptospirosis
AST:ALT ratio >2: raise suspicion for alcoholic injury to liver
Elevated LDH: hemolysis? Hepatocellular injury?
Ratio of ALP/T.bili <4, AST/ALT > 2.2 high specificity for Wilson
Serology:
Steatosis in 28yo: alcohol use? Non-alcoholic steatohepatitis?