7/06/22 Morning Report with @CPSolvers

Case Presenter: *Rafa (@Rafameed)* ***Case Discussants***: *Sharmin (@Sharminzi) and Jack (@jackpenner)*

CC: 66yoF p/w watery diarrhea

HPI:

- Started 3wks ago w/ 3 epi/d → now 8 epi/d
- Watery, occasional pink streaking, no frank blood
- a/w ab pain. No related food intake ill contacts
- Occurs at night and during the day
- Fatigue anorexia wt loss for 2wks
- No fever/chills/night sweats

PMH:
HTN

Meds:
Lisinopril (20mg)
No herbal supplements or OTC medication use

Fam Hx:

Soc Hx:
School teacher living in Texas

Health-Related Behaviors:
Non-smoker
Social drinker
No drug use
Unprotected sex months prior

Allergies:

Vitals: **T**: **98F HR**: **100 BP**: **112/56 RR**: **20 SpO_2**: 100%
Exam:
Gen: weak and tired, dry mucosa
HEENT: nl
CV: nl
Pulm: nl
Abd: soft, tender throughout. Rectal exam external hemorr
Neuro:
Extremities/Skin: nl

Notable Labs & Imaging:
Hematology:
WBC: 9.4 Hgb: 9.3 MCV 83 Plt: 533k

Chemistry:
Na: 138 K:3.2 Cl: 95 CO2: 30 BUN: 11 Cr: 0.6 glucose: 103
TSH, lipase, ALT, AST, bilirubin all nl
HIV -ve
ESR 119. CRP 80
Stool calprotectin 99020 (nl: up to 60)
Infx study: -ve infx diarrhea pcr -ve stool O&P -ve

Colonoscopy: superficial and deep ulcerations throughout the colon with normal appearing intervening mucosa

Biopsy: chronic active colitis with crypt abscess and fissuring ulcers

Final Dx: Crohn's Disease

Problem Representation:
66yoF p/w 3wks of watery diarrhea with occasional pink streaking found to have microcytic anemia, skip lesions on colonoscopy, and a biopsy consistent with Crohn's Disease

Teaching Points (Madellena):
Diarrhea: important branchpoint = TEMPO! Acute vs chronic
Transition from acute > chronic? <4ks subacute, >4ks chronic.
For 3 wks, consider both chronic and subacute causes
Acute: prioritize infection!!!! Viral/bacterial (e coli, klebsiella, shigella) gastroentertitis,
Chronic: consider infections and non-infectious causes
Branchpoint: Inflamm vs. non-inflammatory?
- inflammatory: pink streaks > ddx includes IBD, infection, celiac,
- non-inflammatory: secretory vs. osmotic (improves with fasting)
PMH: infx exposure from school teacher/unprotected sex
Exam: underlying syndrome of inflammatory diarrhea
Tachycardia: hypovolemia component? Undering inflammatory process
Work-up for inflammatory diarrhea: stool studies, fecal calprotectin. Etiologies: (1) infectious (GI viral panel) (2) autoimmune (i.e celiac and IBD), (3) malignancy, (4) med-exposure (radiation, immunotherapy), (5) secretory that can mimic inflammatory: microscopic colitic, paraneoplastic
Labs: signature of inflammation!!
- anemia (blood loss?), thrombocytosis (malignancy?), elevated stool calprotectin (do not differentiate infx from autoimmune).
Further work-up: colonoscopy w/ biopsy. Consider IBD
Microscopoc colitis: can present with elevated calprotectin
Colonoscopy findings: Crohn disease (need histo > granulomas),
Crohn disease: Transmural inflammation, ulcerations, skip lesions, bimodal distribution. Consider Mimics such as Behcet.