6/22/23 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter*** *and* ***Discussants****: Youssef Saklawi (@SaklawiMD) and David (@Davserantes)*

CC: 50 year old male presented with bilateral edema

No pain, fever, wt loss, night sweats, nutrition po appropriate
Abdominal discomfort without pain.

HPI:
Endorses mild exertional dyspnea & orthopnea.

ROS: Denies fever, chest pain, cough, palpitations.

PMH:
Type 2 DM
HTN
Obesity III
Lower back pain

Meds:
Metformin
Losartan
Ibuprofen

Fam Hx: None

Soc Hx:

Health-Related Behaviors:
5 cigarettes a day
4 beers on weekend

Allergies: None

Vitals: T: 36.9°C **HR:** 94 **BP:** 98/56 **RR: SpO2 93% on RA**
Exam:
CV: Regular rhythm, no murmurs
Pulm: No crackles or wheezes, diminished breath sounds at bases
Abd: Distension, soft, non-tender, w/o rebound or guarding, no palpable organomegaly
Extremities/skin: 3+ pitting edema up to knees in both legs, signs of venous insufficiency, no signs of DVT, no rashes, spider angiomata on chest

Notable Labs & Imaging:
Hematology:
WBC: 9k Hgb: 13.4 Plt: 105k
Chemistry:
Na: 132 K: 4.6 BUN:48 Cr:2.7 glucose: 128
AST: 55 ALT: 40 Alk-P: 98 GGT 215 Albumin: 3.2 TP 5.7
LDH 201

Imaging:
CXR: No consolidation, no pleural effusion, no cardiomegaly
Abd US w/ doppler: ascites, no signs of portal vein thrombosis
UA: Bland
Urine electrolytes: Sodium 8, K 14, Crea 89
Paracentesis: 3.1 Total Protein, Albumin 1.6, Leukocytes 360, 385??, Culture: neg.
SAAG: >1.1 *(3.2 - 1.6 = 1.6)*

Final dx: Decompensated Cirrhosis with unknown etiology

Problem Representation: 50 year old male presents with bilateral lower limb edema and mild abdominal pain. Further investigation showed decompensated cirrhosis of unknown etiology.

Teaching Points (Promise):
-BLE edema causes → think heart lungs kidney: if lungs involved first, more likely cardiac vs hepatic ascites first vs renal involvement usually presents with facial swelling
-Cirrhosis: ascites +LR 7.2, spider angioma LR 4.3, hepatomegaly LR 2.4, Lok index, Bonacini cirrhosis discriminant score
-Cirrhosis can present with subtle exam findings
-5 most common ways cirrhosis decompensate: ascites, hepatic encephalopathy, hepatorenal syndromes, variceal bleed, infx - SBP
-other decompensations: hydrothorax, hypoNa, heptopulm syndrome , adrenal insuff
-w/u: paracentesis, renal labs and UA/Urine lytes
-AASLD recs: pts with cirrhosis should get paracentesis regardless of reason for admission! Studies have shown that pts with cirrhosis can have SBP w/o any typical symptoms. Delayed paracentesis inc mortality rate. SBP is a serologic dx with paracentesis NOT based on H&P
-SAAG >1.1 (high = portal hypertension; low = no portal HTN). **protein <2.5 cirrhosis** (low protein = prodn problem ~cirrhosis or urine loss ~ex. Nephrotic syndrome), >2.5 RHF, hepatic vein thrombosis
HRS AKI: type 1 - rapidly progressive kidney failure in pts with cirrhosis with ascites vs type 2 progresses slowly over weeks to months
HRS dx: cirrhosis with ascites, Cr elevation >0.3 in 48h or >1.5 from baseline, no improvement with albumin infusions after 2 consecutive days, absence of shock, absence of current/recent use of nephrotoxic drugs, absence of renal injury/dx, no serum Cr improvement after at least 2d of diuretic w/d
Indications for albumin in cirrhosis: large vol paracentesis (>5L) → give 8g albumin/L ascites fluid removed
IV administration of terlipressin and albumin tx of choice for pts with type 1 and 2 HRS leads to overall reduction in short-term mortality rates
Caring for pts w/ cirrhosis → VIBE: volume (diuretics), Infx (check SBP and r/o infx), Bleeding, encephalopathy (laxatives), screening (malig, vax, transplant eligibility, GOC)