8/23/23 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Anmolpreet Kaur Grewal **Case Discussants**: Ann Marie Kumfer (@AnnKumfer) and Sharmin Shekarchian (@Sharminzi)*

CC: increasing epigastric discomfort and fullness with nausea

HPI: 48 yo female presented acutely with one day of vomiting, loss of appetite and increasing epigastric fullness
Symptoms started 8 months before with mild epigastric fullness, which did not relieved with meds.
No pain in other regions of abdomen, no loose stools, no blood in stools.

PMH:Migraine for 5 years, asymptomatic gallstones for 12 years, HTN for 21 years

Meds: abortive RX for migraine, telmisartan/HCTZ,

Fam Hx: both parents with HTN and DM

Soc Hx: house-wife, sedentary (avised rest by a physician due to complaint of coccigodinia)

Health-Related Behaviors: no alcohol, doesn't smoke, vegetarian

Allergies:

Vitals: HR: nl, BP: nl, RR: 19 **SpO2** 97% RA, **BMI** 32.9
Exam:
Gen: uncomfortable, mild distress
HEENT: no icterus
CV and pulm: nl
Abd: palpable hepatomegaly, no RUQ tenderness, abdomen non tender
Extremities/skin: no edema, peripheral pulses palpable

Notable Labs & Imaging:
Hematology:
WBC: 8.600 (N 38.3%, L 62%, Eos nl), Hgb: 12.6, Plt: nl

Chemistry:
AST: 83, ALT: 158, GGT 30, Alk-P: , T. Bili:
HbA1c 6%, fasting blood sugar 119, total cholesterol 207, LDL 145, Tg 135, HDL 44, uric acid 6.5

Imaging:
US: hepatomegaly (17cm) - liver homogeneously echogenic with fatty infiltration, chronic cholecystitis, gall bladder distended, mildly thickened with calculous, not perycolecistic fluid.
Intrahepatic biliary ducts normal, no calculous in the visualized CBD

FInal dx: non-alcoholic fatty liver disease due to metabolic syndrome (NAFLD)
She was prescribed exercise and statins, with improvement.

Problem Representation:
48 yo F who presented with epigastric discomfort and nausea. She was discovered to have palpable hepatomegaly and abnormal transaminases. She got an abdominal US that showed NAFLD possibly due to metabolic syndrome.

Teaching Points (Ximena):
-With CC we need to localize the pathology without forgetting of adjacent organs.
-Epigastric pain: esophagus, stomach, pancreas, biliary tract, aorta.
-Ruling out life threatening pathologies.
-Exposure → medications, surgeries
-An important detail is to determine the chronicity and frequency of the presenting symptoms (intermittent in this case)
-Migraine can be related to abdominal migrain and we can consider it even if it's an exclusion diagnosis.
-Palpable liver: liver disease, congestion, infiltration (mass), acute pathologies (viruses), abscesses.
Lymphocytic predominance can orient to malignancies, autoimmune diseases and infectious diseases (virus)
-This patient has risk factor to cardiac disease, so it's always good to check ecg and troponins in case this is an atypical MI presentation (women + mild respiratory distress).
-Less likely: hemochromatosis (can present with newly onset DM), NASH