11/28/23 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Parisa Abedi (@parisabediii) **Case Discussants**: Mengyu (@zhoumy07), Alec (@ABRezMed) and Austin (@RezidentMD)*

CC: 94 yo F with abdominal pain

HPI: The pain started 2 days ago. It is diffuse with 2/10 intensity, doesn't radiate; also associated with nausea, bloating and absence of bowel movements.

ROS: No weight loss, chest pain, blood in stool, dysuria, no increased frequency to urinate.

PMH:
dementia, atrial fibrillation, hypertension, HFpEF, hyperlipidemia, CKD stage 4

Meds:
Hydralazine, clonidine, irbesartan, carvedilol, furosemide, atorvastatin, no anticoagulation for AF.

Fam Hx: none

Soc Hx: no smoking hx, no alcohol, no recent travel history and no pets at home.

Health-Related Behaviors:
Processed food, not a lot of vegetables or fiber in diet

Vitals: T: 37.5 C **HR:** 100 **BP:** 184/85 **RR:** 18 **Sat:** 99% RA
Exam:
Gen: no acute distress, mildly restless
HEENT: no swelling eyes, no conjunctival paleness
CV: irregular irregular rate
Pulm: no ronchi, no rales
Abd: distended, hypoactive, mild diffuse tenderness to palpation, no hernia
Neuro: alert and oriented to person, time and place
Extremities/skin: no rashes, symmetric tone, no motor/sen deficit

Notable Labs & Imaging:
Hematology:
WBC: 3.73 Hgb: 14.5 Plt: 155k

Chemistry:
Na: 135 K: 4.4 Cl: 100 Bicarb 28.6 BUN: 37 Cr: 1.67 GFR 28 glucose: 119 Ca: 9.2 Mag: 2.4 Phos. 4.1 Lactate 2
AST: 26 ALT: <9 Albumin: 3.8, Total protein: 7.2

Imaging:
EKG: atrial fibrillation, LVH, no ST elevations or signs of acute ischemia
AbdXR: dilated intestinal loops
CT abdomen: Colonic diverticulosis, impacted stool in rectum, small bowel obstruction, ascites in pelvis, small right pleural effusion

She was transitioned to NPO. Unfortunately, she deteriorated on 2nd day of admission. Her Cr and lactate worsened, accompanied by worsened abdominal pain and associated syncopal episode. Her mental status deteriorated, and had 2 episodes of emesis. She was transitioned to DNR and unfortunately patient passed away.

Dx: Small Bowel Obstruction

Problem Representation:
94 yo F with PMH of AF, HFpEF, CKD and HTN who presented with abdominal pain and signs of bowel obstruction.

Teaching Points (David):
- **Can't miss diagnoses in abdominal pain with vascular risk**: apply VIPO (vascular, inflammation, perforation, obstruction) + vascular:
→ mesenteric ischemia, MI
++ Don't forget image (-) abdominal pain, including metabolic causes (hypercalcemia, DKA, uremia, adrenal insufficiency, hypothyroidism…), meds/toxins, angioedema, zoster, functional…
*Always ask why in chronic conditions. Think of infiltrative disease (eg, amyloidosis could explain HFpEF, CKD, HTN…).
*Careful outweigh of hemorrhage vs thrombotic risk in older pts.
*Abdominal auscultation has very low levels of interobserver agreement, except for when trying to rule out obstruction (normal bowel sounds -> LR: 0.4)
*Abnormally normal Hgb in the setting of age + CKD -> think of polycythemia.
*Normal lactate doesn't rule out mesenteric ischemia.
*Abdominal X ray is a TWDFNR in you have access to CT.
- **Small bowel obstruction causes**:
++ **Extrinsic**: adhesions, hernias, peritoneal carcinomatosis, strictures, hematomas…
++ **Intrinsic**: IBD, neoplasias, ischemia, intussusception
++ **Intraluminal**: gallstones, bezoar, foreign bodies
Adhesions are the most common cause even if no previous abdominal surgery!
*The temporary resolution of abdominal pain in a patient with suspected chronic mesenteric ischemia can be an ominous sign that signals the transition to acute-on-chronic mesenteric ischemia