12/14/23 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Parisa Abedi (@parisabediii) **Case Discussants**: Rabih (@rabihmgeha) and Youssef (@saklawiMD)*

CC: 60yo M with bloody stool and fever

HPI: Patient traveled to the Philippines 10 days ago. Symptoms started 4-5d ago. He had profuse diarrhea (10 episodes) with red appearance, accompanied with abdominal pain, no related to food intake. He consumed clean water and under cook food. The stool examination revealed 1-2 entamoeba cysts. He experienced no improvement with medication (oral metronidazole, rifaximin and racecadotril). Patient came back to the US 1d before admission.

ROS: weakness, abdominal pain and fever. Rest of the exam negative.

PMH: hypertension, GERD, anxiety, skin lesion diagnosed last year as BCC with no treatment

Meds: lisinopril, hydrochlorothiazide , alprazolam, pantoprazol

Fam Hx: mother w/coronary artery disease, father w/htn, maternal aunt w/colon cancer.

Health-Related Behaviors: crack and cocaine use, but no alcohol

Allergies: unremarkable

Vitals: T: afebrile **HR:** 105 **BP:** 122/66 **RR:** 16 **Sat:** 98% RA
Exam:
HEENT: dry mucosas
CV: tachycardia
Pulm: unremarkable
Abd: lower abdominal tenderness with guarding
Neuro: unremarkable
Extremities/skin: pale, no rash or jaundice

Notable Labs & Imaging:
Hematology:
WBC: 8.9 29% bands Hgb: 12.1 Ht: 34 MVC: 78 Plt: 370k
Haptoglobin: 133
Chemistry:
Na: 126 K: 3.1 Cl: 84 BUN: 8 Cr: 0.76 glucose: 162
AST: nl ALT: nl Alk-P: nl Albumin: 2.4 LDH: 169 Bili: normal
Total prot: 5.2 lipase: normal
HIV & HPV neg , blood & stool culture: neg
C diff: neg, giardia antigen: neg
Shigella, yersinia, campylobacter: negative

Imaging:
Abdominal CT: diffuse colitis, indeterminate hypodensity in liver and spleen (1.7 liver) (1.4 spleen)
MRI: Hemangioma with cystic degeneration

Patient came back with hematoquezia and low BP (107/67)
Colonoscopy: Severe pancolitis with areas of deep cratered ulcers
Biopsy: Mucosal expansion and crypt distortion. Crypt abscess with neutrophilic infiltration
Entamoeba histolytica antigen: neg

Dx: Ulcerative colitis

Problem Representation: 60 year old with PMH of HTN,GERD, BCC & recent travel history presents with the complaints of bloody stool and fever. Labs showed MCV:78, ABD CT: diffuse colitis. Stools: entamoeba cyst. He didn't improve with initial treatment. Symptoms recurred and worsened.

Teaching Points (Anmolpreet):
[I] All **GI bleed** represent a connection between a blood vessel and lumen. 3 important questions->
1. Are they actually bleeding? Bloody stools- blood per rectum, represents GI bleed, – triage, imp to know vitals and amount of blood they are losing (no. of bowel movements) to check for hemodynamic instability. **(severity)**
2. **Localisation-** Imp to know Colour of stools- frank blood or melena to localise upper or lower GI bleed
3. **Depth of bleeding**- how much has the process eroded into the intestinal wall. Most GI bleeds are surface bleeds. vast majority of GI bleeds are **painless**, **afebrile** and **don't show up on regular CT scan**
Fever+bloody stools= [Deep (transmural) bleeds; which can have the above three features.]
[II] *Salmonella, Malaria, Dengue*= common in **returning travelers**
[III] Symptoms represent acute inflammatory diarrhea=> infective etiology until proven otherwise;
[IV] Entamoeba species in stools:- could be pathogenic species refractory to Rx or non pathogenic forms.
[V] Cx of infectious diarrhea: to look for in this pt:- **1.** Toxic megacolon **2.** HUS **3.** To look for shock- *hypovolemic* (most common)- not hemorrhagic, Hb does not fall that early on, it's mostly dehydration due to fluid loss in diarrhea , *septic.*
[VI] 90% of acute diarrhea in US is viral in origin; other circumstances : Exposure to antibiotics:- C Diff
Chance of non viral causes in travelers' diarrhea is 95%
[VII] Low MCV:- makes us think about a chronic process; acute on subacute
[VIII] CT Scan: hypodensity- LIVER LESIONS- could be due to : amoebic liver abscess, culture negative IE; infectious causes are a priority in this case because of acute nature
Colitis :- ISCHEMIC, INFLAMMATORY, INFILTRATIVE, INFECTIOUS
Diffuse colitis- ischemic colitis less likely; simultaneous SMA-IMA involvement; virtually incompatible with life.; infiltrative less likely as well.
Suggestive of infection/ inflammation. Colitis without ileitis makes Crohn's less likely.
[IX] Next Test :- stools (PCR, for ova/ parasites) , blood (for antibodies against parasites like Entamoeba and Strongyloides); then Colonoscopy (organisms like isospora, CMV colitis only seen on colonoscopy)
Viral CMV → rarely TB → parasitic → if negative, then Biopsy to rule out inflammation IBD or its mimics)
[X] Sexual history imp in pt- to rule out HSV, LGV, Syphilis but unlikely in this pt with diffuse colitis; more likely in proctitis.
[XI] The current symptoms can be related or unrelated to travel. The diagnosis made was of UC, entirely possible that an unrecognised infection flared up the UC .
[XII] Key clues to diagnosis:- MCV(chronicity), diffuse colitis; usually presents as bloody diarrhea; and In the West, UC presents with a bimodal age distribution with a peak in the incidence at around 20–30 years and a second peak in the incidence at 60–79 years