06/21/24 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Erin Yang (@) **Case Discussants**: Reza (@)*

CC: Upper abdominal pain

HPI:
84 yo M woke up 2 days ago with sharp upper abdominal pain 2/10 intensity, intermittent, worse after eating, but persistent. Progressed to 10/10 intensity to the point that he couldn't eat for the last 2 days. Nausea wo vomiting. Tried tylenol without relief. Has felt dehydrated. Has not seen a doctor for the last few years. Has not been able to walk the dogs and spend time with his family due to fatigue.

ROS: Generalized weakness, subjective fevers. No headaches, syncope, no chest pain, diarrhea or constipation, no melena or hematochezia.

PMH:
HTN
BPH
DM 2

Meds:

Fam Hx: 4 grandchildren. 2 dogs. No sick contacts.

Soc Hx: Never smoked. 1-2 beers/week. Born in Mexico, migrated in his 20s.
Health-Related Behaviors:

Allergies:

Vitals: T:99.6 **HR:**112 **BP:** 80/50s -> 110/70 (after 3L) **RR:** 20 SaO2 97% on RA
Exam:
Gen: Lying in bed, comfortable.
HEENT: Scleral icterus.
CV: Fast rate, regular rhythm. Right jugular venous distension.
Abd: Mild epigastric tenderness. No hepato or splenomegaly.
Extremities/skin: 1+ pitting edema bl LE. Warm and well perfused. 2+ pulses.

Notable Labs & Imaging:
Hematology:
WBC:18 -> 26 (90% neutrophils) after a few hours Hgb:13.2 Plt:160
Chemistry:
Na:132 K: 3.2 Cl:102 HCO3: 21 BUN:30 Cr: 1.7 glucose: Ca: Mag:
AST: 170 ALT: 380 Alk-P: 150 TB 6.1 DB 4.9 Lactic acid: 6 -> 3 (after fluids) High sensitivity Troponin: 28000 -> 35000 BNP: 3000
Imaging:
EKG: R bundle branch block.
CXR: Diffuse interstitial infiltrates suggestive of pulmonary edema.
Echocardiogram: Decreased ejection fraction, grade 1 diastolic dysfunction. Akinetic mid to lateral segments.
RUQ US: Biliary dilation, multiple gallstones, fat stranding suggestive of pancreatitis.
On admission day 1 had ERCP and sphincterotomy with 2 stents placed. Started on vanc and zosyn. Blood cultures grew E.coli. By day 5 developed bradycardia with persistent hypotension and was started on dopamine drip. Labs improved. Dual chamber Pacemaker was placed on day 8, after he was weaned off dopamine. Left cardiac cath that showed no coronary disease.
Dx: Sepsis-induced bradycardia. Sepsis 2/2 acute cholangitis. Gallstone pancreatitis. Stress cardiomyopathy vs HF.

Problem Representation: A 84Y M presented with worsening epigastric abdominal pain of 10/10 intensity, and was found to have leukocytosis, elevated direct bilirubin, and troponin.

Teaching Points (Shreyas):
1. Activate schema for abdominal pain: **First rule out life threatening causes if pain is very severe. Obstruction:** Visceral organs such as intestinal obstruction / Blood vessels (MI/mesenteric ischemia) ; **Perforation** ; **Ectopic Pregnancy**. Quadrant approach is useful, but sometimes patterns overlap!
2. **Epigastric region**: Gastritis, GERD, Peptic ulcer disease ± Perforation.
3. Constipation, colitis, aortic aneurysm/dissection is often hard to localize and can be in any quadrant.
4. Shock → end organ ischemia. Hypovolemic, cardiogenic, distributive etiologies are possibilities for this patient. Physical exam will help: Warm extremities + hyperdynamic pulse- think **distributive**. JVP elevation prioritizes **obstructive and cardiogenic** etiologies. 10/10 abdominal pain + hypotension is concerning for dissection.
5.In this patient, **leukocytosis + hypotension + thrombocytopenia** makes us think of **inflammatory shock + DIC; Ascending cholangitis** (abdominal pain + elevated bili + elevated WBC), **stress induced cardiomyopathy** (elevated trop and HF features) are possibilities.
7. The heart problem (**Myocarditis/ ACS**) could explain the congestive features, alternately an **infectious process in the hepatobiliary system** can explain the abdominal symptoms and the cardiovascular abnormalities could be a consequence.
8. **Bradycardia - review of telemetry is useful**. Hypotension on pressors + bradycardia is unusual and the suspicious for conduction system abnormality grows.
9. **Beta blockers, hypothyroidism, infiltrative disorders of the heart, Lyme's** are leading etiologies for unexplained bradycardia.
10. Patient eventually developed worsening bradycardia and needed a pacemaker- was ultimately diagnosed with **sepsis induced bradycardia**.