7/17/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter:Sohil (@) Case Discussants: Yousef (@) and Sharmin (@)

CC: 28 YO M presents with diarrhea and abdominal pain.

HPI:
Diarrhea worsened a day prior to admission , about 10 bowel movements /day . he described it as watery/loose, yellowish brown , no blood. He has been taking his Lomotil and Imodium without adequate improvement. 7/10 diffuse, dull non radiating abdominal pain that has been intermittent since day prior to admission . he has Nausea but no vomiting. The abdominal pain is refractory to pain medications. Has been able to tolerate his oral meds and some fluid, little food.

ROS: +malaise, fatigue , weight loss(20lb)
Migratory arthralgia in knees and elbows since last year .

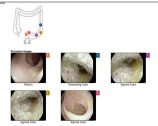
PMH:
B-ALL , 11/2023 allogeneic HCT c/b CMV viremia treated with acyclovir.
GVHD: 12/2023 from sigmoid biopsies; Facial rash,vomiting,diarrhea discharged on steroids and tacrolimus

Meds:
PPX meds:
Acyclovir ,
Atovaquone , levofloxacin
Immunosuppressive meds : budesonide , prednisone, tacrolimus

Fam Hx:
Non contributory
Soc Hx:
-
Health-Related Behaviors:
No smoking, alcohol,or drug use

Allergies: -

Vitals: T: 36.9 **HR:74 BP:** 131/89 **RR:18 SpO2:98 on RA**
Exam:
Gen: ill appearing but not in acute distress
HEENT: normocephalic , atraumatic . MMM,EOM
CV: RRR, no murmurs
Pulm: no rales, ronchi, or wheezing . normal effort
Abd: soft non distended, +diffuse tenderness but no guarding
Neuro: AO *4 ,no focal or gross deficit
Extremities/skin: warm, dry . no joint swelling ,tenderness or deformity

Notable Labs & Imaging:

Hematology:
WBC:4.2 Hgb: 12.5Plt: 149
Chemistry:
Na:130 K:4.1 Cl:99 HCO3: 23 BUN:10 Cr: 0.78 glucose: 134
AST: 21 ALT:7 Alk-P:71 Tbili:0.8
CRP:204
Advanced Labs
Bacterial,viral,parasitic stool : negative
C diff, Campylobacter, E coli O157, ETEC, STEC, Vibrio cholera, Salmonella, Shigella
Adeno, Rota, Noroviruses, Cryptosporidium, Entamoeba, giardia
CMV DNA titers: positive
Imaging:
CTAP: wall thickening and edema and hyperenhancement of entire colon . no free air or drainable fluid collection.
EGD: grossly normal .
Colonoscopy: Severely edematous, ulcerated mucosa circumferentially throughout areas of examined colon (proximal descending colon and sigmoid). <10% of mucosa was normal in this area. Healthier, though still erythematous rectum. Possibly pseudomembranous colitis although hard to definitively say if pseudomembranous or just severe colitis. Procedure was aborted given risks of perforation.
Dx: biopsy of sigmoid colon: **+ Staph aureus** , (-)for IBD and CMV colitis

Problem Representation: A young immunocompromised male with a PMH of B-ALL and GVHD presents with a subacute picture of watery diarrhea, weight loss and arthralgias.

Teaching Points (Julia):
Diarrhea approach: 80% infectious (VIRAL) 20% Meds (toxidromes, ischemia) - MINT
1. Center of clinical presentation vs. accompanying symptom
2. acute vs. chronic, small vs. large , osmotic vs. secretory, time point: nocturnal, food related, PHM: surgeries, DM
Red flags: blood, weight loss, immunocompromised, IBD

In young people diarrhea is often infection related: travel history, HIV status, sexual history

Graft versus host disease:
acute(less common): skin(~70%), intrahepatic cholestasis, secretory diarrhea, pneumonitis, cave: acute GVHD can present years out after immunosuppressants are decreased
Defect in Neutrophil function→ pt. more prone to infections with extracellular organism e.g. candida (*acute* presentation)
subacute- chronic: Mycophenolate itself can cause diarrhea, also leads to T cell dysfunction → intracellular infections e.g. fungal, viruses, mycobacteria (*subacute* to *chronic* picture)

In immunocompromised pat.: more disease with less symptoms →risk for underestimation of exam findings

colitis most commonly caused by CMV, HSV ; Staph aureus (rare) predispositions in pt. immuncomprIBD, recent antibiotics