



7/10/24 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Maddy (@Madellenac) Case Discussants: Sharmin (@Sharminzi) and Mengyu (@zhoumy07)

CC: Abdominal pain and diarrhea

HPI: 33 yo male presented to the ED with abdominal pain, nausea and diarrhea for 8 days. 6 days ago went to the ER with abdominal pain and diarrhea and was discharged with symptom medication. Symptoms persisted, abdominal pain is worse in the left lower quadrant, nausea and worsening abdominal distension. Diarrhea is 3 times a day with blood on the toilet paper.

ROS: Nausea, vomiting 1-2 per day, abdominal distension. No fever, rashes, SOB.

PMH:
Migraines, seizure disorder (last seizure 17 years ago). Constipation. Fundoplication surgery for reflux.

Meds:
Carbamazepine. No NSAID use.

Fam Hx:
None

Soc Hx:
Works at waste management. Born in El Salvador. In Colorado the last 10 years.

Health-Related Behaviors:
Binge alcohol drinking 10-12 beers on weekends.

Allergies: None

Vitals: T: 37.5 HR: 98 BP: 127/86 RR: 25 SaO₂ 97

Exam:

Gen: Uncomfortable.

Abd: Markedly distended, tender diffusely, more prominently in the LLQ. No guarding.

Extremities/skin: No rashes.

Notable Labs & Imaging:

Hematology:

WBC: 10 Hgb: 14 Plt: 288

Chemistry:

Na: 132 K: 3.2 Cl: 103 HCO₃: 22 BUN: 11 Cr: 0.79 AST: 65 ALT: 69 Alk-P: 111

CRP 120.5 Lipase 30 Fecal calprotectin: 321

Imaging:

CT Abdomen and pelvis: diffuse circumstantial inflammation of the sigmoid colon. Focal narrowing of the prox sigmoid colon with moderate upstream colonic dilation and colitis. Substantial fat stranding within the LLQ without abscess. Colovesical fistula from the thickened sigmoid colon extending to the thickened bladder wall. Possible fistula between the proximal and distal sigmoid colon.

GI recommended starting prednisone, an **abdominal X Ray** showed colonic gaseous dilation (9mm in the mid transverse colon).

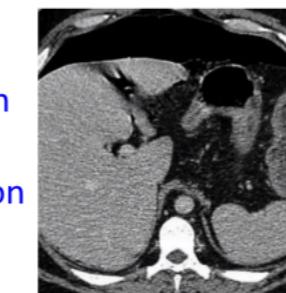
Flex sig with biopsy: Moderate diverticulosis in the sigmoid colon. Narrowing of the colon in association with the diverticular opening, with colonic dilation proximal. Peridiverticular erythema. A single 10mm ulcer was found at the splenic flexure and was biopsied. The patient was started on antibiotics and followed with daily US.

Biopsy: Descending colon showed ulceration. Colonic mucosa showed quiescent colitis. Transverse colon showed ulceration, but no active or chronic colitis. No granulomas nor ischemic changes identified.

A control abdominal X Ray showed concerning findings and an Abd CT showed pneumoperitoneum and bowel perforation From the L colon.

Emergent XLap with hemicolectomy and ileostomy: The L colon Was necrotic and there were extensive adhesions.

Dx: Severe colitis causing fistulas, strictures, large bowel obstruction and perforation.



Problem Representation: 33 yoM p/w abdominal pain and diarrhea for 8 days. PMH of alcohol abuse. Physical exam showed abdominal distension. CT scan showed diffuse inflammation with fistulas. Colon biopsy showed ulceration w/o granulomas or ischemic changes. Complicated w/ bowel obstruction and perforation.

Teaching Points (Parisa):

Abdominal pain (no miss diagnosis): VIPO vascular, inflammation, perforation, obstruction **Anatomical approach** → LLQ (colitis; diverticulitis; / make sure not referral pain(thorax; pelvis (Testicular torsion)) /generalized pain(in all quadrants) Infectious colitis

Diverticulitis: mostly in older patients; in younger patients happen in context of genetic predisposition and history of constipation.

Nausea + diarrhea → GI tracts localization + distention → obstruction → gas; liquid; solid (time course makes it less likely)

Diarrhea (no miss diagnosis): C. diff (community acquired, sick appearing patients, toxic megacolon, ileus)

Who is the patient's → young no PMH vs multiple comorbidities

History of exposure: travel; toxin; infections; (Immune status)

Blood on toilet paper → hemorrhoids, bloody diarrhea → check Hb

Surgical procedure complications → anastomosis leak, perforation, stenosis

Pt w/ abdominal pain and alcohol use disorder: PUD; acute liver failure; pancreatitis; ascites

Fistula: crohn's disease (IBD)

Mimickers → HIV(associated infection); chronic infection (TB; Histo; Entamoeba histolytica); NSAIDs colitis; Lymphoma

Ulcerative colitis : terminal ileum ; sigmoid colon (mimickers of terminal ileitis: Shigella, TB, Behcet)

Mutual features Crohn/Behcet: oral ulceration; erythema nodosum (F)

Exclusive to Behcet: genital ulcers

Steroids can mask abdominal exam.

Perforation: NPO; IV access; Abx (Zosyn); close monitoring; surgery consult

Diverticulitis complications: Perforation (Frank; microperforation), Abscess (peri-diverticular; abdominal pelvic; liver), Obstruction (Partial (acute), complete (chronic)), Fistula(bladder, vagina, intestine, uterus, skin