# 06/4/24 Morning Report with @CPSolvers

*"One life, so many dreams" Case Presenter: Sohil (@sohilpatel23) Case Discussants: Elena (@) and Rabih (@rabihmgeha)*

**CC**: 63 YO M who presents with intermittent diarrhea for the past 1 month

**HPI**:
Symptoms began 1 month ago after returning from a 2-week trip to Mexico . one week after returning from the trip he went to his PCP for evaluation of his diarrhea, but he was told it was mild gastroenteritis and will most probably resolve. However, the diarrhea did not resolve. The patient had diarrhea up to 4 times a day. This prompted him to visit the ED.
ROS: no fever, night sweat or chills, slight shortness of breath, slight decrease in appetite and mild (204->189 lb over 2 months)weight loss.
Some watery diarrhea ,no blood or mucus in stool.

**PMH**:
1 hospitalization for bacterial cholangitis which resolved with abx. This was done at OSH , we don't have further info

**Meds**: ibuprofen as needed, has been taking more lately d/t shoulder pain

**Fam Hx**: colon cancer on his father at the age of 63

**Soc Hx**:
Drinks occasionally
Smokes ½ pack since 20 years .
No drug use

**Health-Related Behaviors**:

**Allergies**: no known drug allergies

**Vitals: T:** 36.9 **HR:** 90 **BP: 130/90 RR:16 O2 sat: 97%** on RA
**Exam:**
**Gen:** NAD
**CV:** RRR, normal S1/S2, no gallops or murmurs
**Pulm:** CTAB
**Abd:** soft non tender, no rebound, or guarding . RECTAL: no tenderness , bleeding,or palpable masses
**Neuro:** No focal deficits
**Extremities/skin:** no rashes or lesions

**Notable Labs & Imaging**:
**Hematology**:
WBC: 13k Hgb: 10.7 Plt: 530k
ESR: 27 CRP 18
**Chemistry**:
Na:133 K:3.8 Cl:101 HCO3:26 BUN: 12 Cr: 0.9 glucose:95 Ca: Mag:
AST: 46 ALT: 70 Alk-P: 323 Albumin: TBILI: 1.1 TSH, T3, T4: wnl
**Advanced labs:**
Serum Iron: low ferritin: high transferrin: low vit b12 was normal
**Infectious:**CMV, HSV, HIV, hep b/c:, yersinia, campylobacter, STEC neg
C.diff negative
Stool + for occult blood
**Rheumatology:**
IgM elevated , IgG elevated, IgG4 normal
**ANCA - , ANA:1/640 ,Anti-smooth , anticardiolipin , thyroperoxidase ,RF all negative**
**Imaging**:
RUQ U/S:diffuse thickening of bile duct walls . no gallstones , gallbladder thickening or pericholecystic fluid.
ERCP: multiple strictures in the intrahepatic and extrahepatic bile ducts.
Colonoscopy : was normal .
Biopsy: rectum was normal , some colitis in terminal ileum with crypt abscess, crypt atrophy , no granulomas , normal vasculature
Anti-Saccharomyces cerevisiae antibody was positive .
Started on Ursodeoxycholic acid and budesonide. And stopped NSAID
Dx: IBD and PSC

**Problem Representation**: A 63 YO M with no PMH p/w chronic intermittent diarrhea and PSC with a positive Anti-Saccharomyces cerevisiae antibody.

**Teaching Points (Parisa)**:
1) **Diarrhea**: acute/hyperacute settings(infection/ medication); Subacute → r/o of mimickers (hyperdefecation; overflow); **Chronic diarrhea** → inflammatory; osmotic; secretory→ Origin → small bowel(osmotic, malabsorption,laxative), large bowel(secretory, not absorbing water), both (inflammatory, distributive)

2)**Weight loss**: sinus tachycardia of chronic disease. Inflammatory>osmotic>secretory. Weight loss + secretory → dehydration

3)**Chronic inflammatory diarrhea**→ **1**.IBD (excluding mimickers **2.**chronic infection (HIV; TB; Histo; Entamoeba histolytica); **3.**Meds(NSAIDs enteropathy→ chronic usage; inflammatory diarrhea, mimics IBD, withdrawal sx resolution

4)**ANA** + dx → lupus/Scleroderma/Mixed connective tissue Dx → AI: PBC; PSC(Thickening on bile duct) associated with IBD; excluding cancer and infection

5)**Biliary stricture** (procedure related; critical ill ischemic injury to biliary tree, spontaneous → cholangiocarcinoma; infection (HIV); chronic biliary flukes / AI: PSC; IgG4

6)**Anti Saccharomyces Cerevisiae antibody** (IgG/IgA)→ associated with Crohn; Multiple antibodies(+) in IBD; Crohn's involving terminal ileum

7) **Crohn's** clinical findings might not match with colonoscopy findings. PSC and IBD → severity is inversely connected, the more severe PSC the less severe IBD could be.