8/9/24 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Zakariyya (@pouroverguy) **Case Discussants**: Reza (@DxRxEdu) and Rabih (@rabihmgeha)*

CC: 22 M w/ chronic loose stool 1-2x/d for the last 8 months

HPI:
One period of severe nausea and abdominal pain (coming and going) w/o vomiting - nl vitals and physical. GI clinic then underwent upper endoscopy showing chronic gastritis, no evidence of H. pylori. *PPI trial minimal improvement.*
ROS (-): weight loss, fever, night sweats, dysphagia, odynophagia, acid reflux, rash, joint pain

Further course: Years later presented to the same GI clinic with continuous loose stools, nausea and abdominal discomfort. Reported a certain pattern: when he was left the city the symptoms would get better (stress-related?).
Reports a **history (since the age of 12)** of severe pruritus, especially in the context of hot showering/exercise. After scratching, he would get a burning rash that appeared like welts, but would appear with no trace.

PMH:
Healthy

Meds:
None

Fam Hx:
Asthma (mom)
Graves (dad)

Soc Hx:
Uni student

Health-Related Behaviors:
No substances

Vitals: Normal vitals
Exam:
Gen: Well appearing
HEENT: no conjunctival pallor, icterus or LAD
CV: nl
Pulm: nl
Abd: No distension, organomegaly, mild epigastric discomfort
Neuro: Nl
Extremities/skin: No rashes

Notable Labs & Imaging:
Hematology:
WBC: 7 (nl diff) Hgb: 17.6 Plt: 318
Normal UE, Ca slightly elevated
Chemistry:
AST: 15 ALT: 12 Alk-P: 65 GGT: 15 Albumin: nl
CRP 1, Ferritin 63, TSAT 42% B12/folate/iron nl
Celiac negative (TGA, anti-Gliadin) including nl IgA
Skin disorder: chronic urticaria, dermatographic, improvement on antihistamine, developed before they moved to the city
Repeat celiac nl, CBC nl, TSH nl, ANA neg, Calprotectin nl.

Repeat endoscopy: duodenal mild increase in intraepithelial lymphocytes, esophagus showed inflammatory cells comprising of lymphocytes (wnl) and many eos (30/HPF), no granulomas, ulcers, parasites, or evidence of malignancy - histological Dx of eosinophilic esophagitis was made
Rule out of IBD, high IgE levels, course of predni did not improve (no rule out for EoE). Lower GI symptoms>>upper GI.

Problem Representation: 22 yo M w/ 8 month Hx of loose stools, pruritic rash exacerbated by hot water and exercise, PMHx chr.gastritis. High Hb, Ca, neg celiac serologies.

Teaching Points ():

- Distinguishing between discomfort and dysfunction in history given by the patient.
  - Specially important in GI complaints.
  - Time course of symptoms here is important in distinguishing between different ddx.
  - When nothing guides you to a specific direction it's time to ask why the patient came to the ED
- Approach to diffuse abdominal pain
  - Gut is the organ that encompasses the entire abdomen
    - VIPO
      - Vascular
      - Perforation
      - Obstruction
      - Inflammation
  - Other diffuse organs
    - Nerves
    - Peritoneum
    - Substances -> think about how DKA causes abdominal pain
  - When to go for imaging?
    - CT is high yield if you suspect the bowel and low yield for everywhere else
    - Another important clue is where the patient can tolerate eating food after hydration, if they cannot its your clue to pursue imaging
- In electrolyte abnormalities keep dehydration in the back of your mind, hemoconcentration may falsely alarm you to problems that don't really exist, results of abnormalities after hydration is going to be telling.
- Dermatographism -> Dermatographia is a condition in which lightly scratching your skin causes raised, inflamed lines or welts. These marks tend to go away in less than 30 minutes
  - Usually a benign condition, types include:
    - apruritic dermatographism
    - Symptomatic
      - Usually idiopathic
      - Inflamed and swollen
      - Faster onset
      - If suspected look for secondary etiologies
  - Most common form of inducible urticaria
  - If persistent one should pursue other conditions
    - Myeloproliferative neoplasms specifically polycythemia vera
    - Systemic mastocytosis -> causes a specific lesion known as urticaria pigmentosa
- Another way to frame this finding in the current case would be to frame the entire thing as a mucocutaneous disease with mast cells triggering the symptoms -> mast cell triggers such as alcohol, warm water, spicy food, exercise map out to this presentation
- Eosinophilic disease vs mast cell phenotype
  - Atopic history of the disease
  - Environmentally induced vs other pathology
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