11//24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Zaheer Irani (@) Case Discussants: Zakariyya Gardee (@) and Rabih Geha(@)

CC: 48 yo female p/w abdominal pain in the epigastric region/RUQ for the last 6 days

HPI: Constant achy abdominal pain radiates down to the belly button & back, unrelated to meals, bloating, unresponsive to Tylenol, intermittent nausea, no vomiting, 1 month nights sweats and weight loss, increase in reflux

no fever, chills, diarrhea, bloody stools, no SOB, urinary frequency , no rash

PMH:
Depression

Meds: no meds

Fam Hx: Mother has DM, father: surgery in possible colitis

Soc Hx:

Health-Related Behaviors: smokes, no alcohol, iv heroin (until 10 y ago), new partner 3 month ago, Has not been sexual active for 3 years, no sick contact

Allergies: Denied

Vitals: T: 37 **HR:** 90 **BP:** 108/75 (baseline) **RR:** 16 Sat 99% RA
Exam: BMI 20,4
Gen: Oriented, no acute distress
HEENT: Normocephalic mucus membrane moist, no scleral icterus
CV: RRR, no murmur
Pulm: clear to auscultation, no wheeze
Abd: mildly distended, moderate pain UQ, pos. Murphy sign, splenomegaly, no guarding / rebound, dark coloured urine, no hematuria
Extremities/skin: no rash

Notable Labs & Imaging:
Hematology:
WBC: 8.1 58% Neutrophils, 13% lymphocytes Hgb:13.5 hk 39 Plt: 310, MCV 98
Chemistry: Na: 142 K:3.8 Cl: 110 HCO3: 27 BUN: 15 Cr: 0.6 glucose: 107 Ca: 8.6 , Bili 0.9 -> 3.8 AST: 546 ALT: Alk-P: 313, GGT 348, Alb: 3.8 INR 1.1, LDH 363
Pregnancy test: neg.
Bland UA
Imaging:
EKG: SR; no ST elevation,
US: gallbladder contraction wall thickening and edema
hydro-scan negative for acute cholecystitis Periportal edema, no stones, suggestive for a primary liver process, no biliary obstruction
Hep A neg, HBs c neg, **Hep C AB pos, RNA (Viral load 16,7 Mil)** PCR
Negative : HIV, CMV & EBV IgG IgM , viral load, syphilis, ANA IgG nl, AMA neg, T and B cells in flow cytometry nl

Dx: Acute Hepatitis C

Problem Representation:

Teaching Points:
Reasoning bimodal dimensions of a time-course (hyper, acute, sub, chronic)
Most abdominal pain will not need hospitalisation, and won't cause severe disability, but the subacute nature to it was certainly concerning
Acute disease often allow to go back to baseline
Hyperacute may resolve as well BUT often tend to have acute high mortality, but Subacute time course often implies that there is no opportunity to go back to baseline
Character of abdominal pain
Multiple approaches (thinking of emergencies - abdominal/thoracic: VIPO-PE/ACS, anatomical approach, pain radiating to another site)
Acute abdomen warrants immediate surgical intervention
Exam and vitals often helps defining the severity, history, labs and imaging with localisation.
Splenomegaly
Additional labs: Smear, diff (lymphocytosis: Mono-like diseases), LDH
Environmental exposure (entry site: lung - evaluation via history and potentially CT chest)
LDH - what cells are being destructed?
LDH: lab (hemolysis, CK, liver), imaging (lungs/PJP, kidney/spleen infarction) - LDH-great negative predictive value in PJP
LFTs here proportional to LDH
Acute liver injury
Extrahepatic: obstruction, ischemia >> parenchyma: DILI, viral hepatitides, autoimmune (AIH), metabolic (Wilsons), malignancies (lymphoma), pregnancy-related (acute fatty liver disease)
Subacute nature: very much in keeping with infectious hepatitides
Hepatitis C
Most common cause of acute infectious hepatitis in the US (80% chronic, 20% acute - especially in young women)
Acuity means there is a higher chance of seroconversion and clearing the virus (same true for HBV infection)