11/18/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Tina Dao (@) Case Discussants: Dr. Chris Jackson (@ChrisDJacksonMD)

CC: Abdominal pain

HPI: 28 year old female (Most history was taken from mother)
Presented to ED with 2 weeks of abdominal pain, nausea and bilious vomiting. The last episode of the vomiting was in the morning.
Abdominal pain was sharp started in umbilical and moved to the suprapubic area.
No vaginal discharge, no STI. She says she doesn't want to urinate.

A few days later, patient became less responsive and mentation became waxing and waning
She was having nausea and vomiting for 3 months

PMH:
Sickle cell trait
HTN
Recent abortion

Meds:
No meds

Fam Hx:
n/a

Soc Hx:
Sexually active
Does Not drink alcohol

Health-Related Behaviors:
n/a

Allergies: n/a

Vitals: T: afebrile **HR:**110 **BP:** 150/100 SpO2: 90s on RA
Exam:
Abd: Mild diffuse tenderness

Notable Labs & Imaging:
Hematology:
WBC: 12.3

Chemistry:
K:2.4 Cr: 0.6 glucose: 276 AST: 53 ALT:121
Elevated t bili, GGT, lactic acid
Negative pregnancy test
UDS negative
UA unremarkable

Imaging:
CT abdomen: thickening of bowel suggesting colitis but no obstruction
Bladder scan: 600 ml
Abdominal US: Normal liver, no focal abnormalities- unremarkable
Transvaginal US:normal appearance of uterus, normal ovaries
CT head: no acute findings
EEG: Normal
MRI: wernicke's encephalopathy- hyperintensity in the mamillary bodies

Dx: Wernicke's encephalopathy

Problem Representation:
28 year old female who presented with abdominal pain,nausea and vomiting who was found to have wernicke's encephalopathy

Teaching Points (Parisa):
Abdominal pain in outpatient setting→ perforation(acute onset);obstruction(N/V/D); embolism; vascular events(older; h/o AF; HF occlusion of SMA, IMA,p/w bloody diarrhea); ectopic pregnancy in any young female.
Anatomical→ organ system-based approach; liver gallbladder RUQ; lower quadrant colitis/ appendicitis/ovarian pathologies/Fitz-Hugh-Curtis Syn
Sickle cell trait → hyperhemolytic crisis; embolic events; right HF (d/t pulmonary HTN)
Young female risk factors: Obstruction recent abortion; vascular events d/t sickle cells traits; malignancy less common; age can not guide infectious causes; hereditary embolic dx
Suprapubic pain→ cystitis; urethritis; nephrolithiasis; pyelonephritis
Umbilical pain → ascending infection → pyelonephritis; PID perihepatic infection;Fitz-Hugh-Curtis Syn
Endometriosis presents w/ dyspareunia; dysmenorrhea
vomiting → not isolated to bladder systemic process is involved
Approach to AMS→ dextrose ;naloxone ;oxygen→ MIST→ infection/toxin (acutely); metabolic/structure (sub acutely) → abdomen imaging (r/o abscess)+ Sickle cell trait →thrombosis in post circulation might lead to sleepiness; Blood culture (r/o bacteremia)
ALT>>AST → focal process in liver → US prehepatic inflammation; ascites around liver/hepatomegaly looking for clot in portal tree; normal size CBD ruling out
Image neg abdominal pain → DKA; hypercalcemia; porphyria (urine chocolate)
By obtaining TVUS we could r/o torsion.
When all imaging is negative and the level of alertness is low → LP/EEG
Wernicke's encephalopathy→ could be d/t hyperemesis gravidarum; chronic alcoholism; malignancies; anyone at risk of developing nutritional deficiencies
Dx happen on the floor after withdrawal → altered mental status + MRI changes + extraocular movements + abdominal plegia → improvement by thiamine