



12/19/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Maddy (@MadellenaC) Case Discussants: Rabih (@rabihmgeha) & Mengyu (@zhoumy07)



<p>CC: 62 male presenting w/ large volume red blood in stool and hypotension</p> <p>HPI: presented to the ED 1 day prior w/4 days of cough, SOB, muscle aches , flue pos</p> <p><i>On the floor:</i> unresponsive sitting in bed , pulse palpable, long trail of bright blood on the floor, diaphoretic, pale, unresponsive,</p> <p><i>Management:</i> LR 2l, ceftriaxone, pantoprazol, blood units ordered, transfer to the MIC U</p> <p>ICU : Octreotide, intubation, transfusions 5 units of blood, 5 1 FFP, 1 PLT, OG tube 800cc dark blood was drained</p>	<p>Vitals: T: BP: 80/50 -> 120/70 RR: HR: 120-130 Sat: 2l NC Exam: Gen: intermittently responding HEENT: CV: Pulm: Abd: abdominal distension, no jaundice Neuro: MSK: warm well perfused</p>	<p>Problem Representation:</p>
<p>PMH: alcohol use disorder, h/o withdarawal, HT</p> <p>no h/o cirrhosis</p> <p>Meds: Osetamivir , sartane</p> <p>Fam Hx:</p> <p>Soc Hx:</p> <p>Health-Related Behaviors: 2 pints daily, 1 day prior</p> <p>Allergies:</p>	<p>Notable Labs & Imaging: Hematology: WBC: 9 Plt: 68-> 50 Hgb: 11-> 8.7 (AM) -> 6.6-> 5.3 after 1 unit of blood -> 10.3</p> <p>Chemistry Na: nl K: nl Cr: BUN: Ca: Ph: Mg: Glu: Cl: HCO3: Lactate: 1.4-> 5 -> 1 CRP: ESR: LDH: AST:246 ALT: 77 ALP: Bili:0.7 INR 1.36</p> <p>Imaging: EKG: CXR Endoscopy: Severe esophagitis , no varices, stomach: diffuse gastritis, hematin, 2 large duodenal ulcer, intervention: 1 ulcer w/ clot -> epinephrine and clip placement</p> <p>Dx duodenal ulcer bleed complicated by hemorrhagic shock</p>	<p>Teaching Points (Nowrine & Yaz <3): BE BROAD: Lower GI bleed with hypovolemia-don't forget upper GI bleed. 15% hematochezia -UGI vs. 85% hematochezia- (Why we should bother: UGI subset imp bc the pt is hemorrhaging fast(rate of bleed/worsening). Huge drops in hb that is more sneaky - lesion far away from the exit site. Rx: Large bore IV, empiric PPI, octreotide(esp with CLD), type and screen blood for a potential massive transfusion protocol, consent STABILIZE - KEY will be ENDOSCOPIC visualization. Consider getting a CT angio for those with more hemodynamic instability to id bleed. - Upper GI differential esp in cirrhosis - varix If Vomiting blood: Mallory Weiss(esp with Alcohol H) or Boerhaave. Blood transfusion indication: 1. Symptomatic anemia/ Hb,7. (HEMOGLOBIN)2. Acute blood loss ongoing(LOSS OF WHOLE BLOOD WITH N Hb). Why not use an OG tube: NPV of OG tube is low-still do an EGD and risk of trauma as well Bleeding is downward direction: viewing from above EGD(ability to intervene)>>>viewing from below Colonoscopy, Whale sign - on endoscopy - varix that clots - Alc history-CLD signs: erythema, PHTN signs, palmar erythema gynecomastia, thrombocytopenia, MCV elev, AST:ALT ratioAbdominal distension in alcoholic pt who is usually cachexic/nutritional def- think of CLD - be careful about transfusing too much and increasing their total pressure and increasing bleeding risk(careful about over and under perfusing - aim to reach a Hb of 8"sweet spot") Ulcer on scopy: NSAID related, H.pylori,malignant ulcer - important to repeat scopy</p>