



02/11/25 Morning Report with @CPSolvers

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"One life, so many dreams" Case Presenter: Seeme(@) Case Discussants: Ravi (@rav7ks), John

<p>CC: 38 yrs old F with abdominal pain from 6 hrs</p> <p>HPI: She presented with epigastric pain associated with nausea and vomiting, She was not able to describe the nature of the pain, the intensity 8/10, radiates to back, She has two episodes in previous three weeks.</p> <p>ROS (-): fever cough chest pain dysuria constipation joint pains.</p>	<p>Vitals: T: afebrile BP: 110/70 RR: 20 HR: 92 Sat: 97 Exam: Gen: discomfort, BMI 17 HEENT: no icterus Neck: nl CV: RRR, no murmurs, Pulm: normal, no wheezing Abd: diffuse tenderness, more prominent in epigastrium and right hypochondrium, bowel sounds normal Neuro: AOX3</p>	<p>Problem Representation: 38yo F with hypothyroidism presents with intense abd pain radiating to back for 3wks; labs: elevated ALP & amylase; US shows cystic duct stone, indicating gallstone pancreatitis.</p>	
<p>PMH: Hypothyroidism</p> <p>Meds: Thyroxine (dosage unknown)</p>	<p>Fam Hx: HTN (mother)</p> <p>Soc Hx:</p> <p>Health-Related Behaviors: no Hx of alcohol or drug use</p> <p>Allergies: no allergies</p>	<p>Notable Labs & Imaging: Hematology: WBC: nl Hgb: nl Plt:nl Pregnancy test negative</p> <p>Chemistry Na: K: Cr: BUN: Ca: nl Ph: Mg: Glu: Cl: HCO3: CRP: ESR: LDH: AST: nl ALT: nl ALP: 417 Bili: TSH 0.05 T4 high T3 nl (2.89) Amylase 1675</p> <p>Imaging: EKG: normal sinus rhythm AbdUS: small calculi 2-3 mm, pericholecystic edema with wall thickness of 4.6mm (high). No calculus in common bile duct, pancreas normal, echogenic focus inferior to the neck of gallbladder (likely representing cystic duct calculus) Fluids, and pain medication were given to the patient</p> <p>Dx : Gallstones Pancreatitis</p>	<p>Teaching Points(HEE MUN): A 38-year-old with acute abdominal pain—rule out red flags VIPO such as vascular issues (mesenteric ischemia), inflammation, perforation, or obstruction—requires Abd imaging. Anticipating questions: PMH (why now, what improves), food-related, bowel movements, vomiting, diarrhea; primary GI, systemic (fever), cardiac (ACS), even atypical (toothache) from upper or lower diaphragm; look for abd distention and VS (tachycardia, BP).</p> <p>HPI :Patient is unable to explain pain, pointing to inflammation of surrounding structures, possibly involving viscera or peritoneal irritation.Association with food: pancreatitis (radiating to back), ischemia (blood flow while eating), hepatobiliary issues.->Lipase, amylase, and abd CT</p> <p>VS: BMI 17 (chronic process, nutrition def (refeeding syndrome careful->posphate), hypermetabolic, intrinsic condition and catabolism-> malignancy), tachycardia (due to pain), abd pain (6 hrs acute, 2 episodes in 3 wks, -> pointing to subacute),hx hypothyroidism (hypercalcemia or adrenal insuff), vomiting (met alk, low Mg/Cl).</p> <p>LAB: Electrolytes, AST ALT WNL; ALP (liver or bone → GGT); thyroid (overdose levothyroxine, no severe thyrotoxicosis); severity hyperthyroid storm not present Liver imaging to rule out biliary stones, stricture, infiltration, weight loss (malignancy/ or due to levothyroxine overdose.) Amylase: pancreatitis, intestinal ischemia (lactate).</p> <p>Imaging: USABD shows thickened gallbladder, stones, cystic duct inflammation (cholecystitis) → hydatid scan; abd CT (oral contrast) to evaluate pancreas; acute vs chronic cholecystitis (wt loss), is this really causing pt's abd pain to consider? Careful with US imaging, as it can be misleading if stone has passed → MRCP; NPO, bowel rest → oral feeding as soon as pt improves.</p> <p>DX:Gallstone pancreatitis, abd pain, lipase 3x higher, pt US showed stone, so abd CT not done (2/3).</p>