04/02/25 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Austin Rezigh (@RezidentMD) **Case Discussants**: Steph (@StephVSherman) and Zaven (@sargsyanz)*

Scribing (Rahul)

CC: 73Y/F admitted for Failure to thrive, waiting to be transitioned for g tube placement.

HPI: Progressive decline in PO, readmitted multiple times for SBO, last surgery was 6 wks before.
Tube feeds are stopped due to abdominal discomfort and vomiting.
Received blood transfusions as needed.
Ae appro cancer screening was done
Previous admission: progressive postprandial pain, bloating, N/V, wt loss of 40 lbs.
Unsuccessful medical treatment, and surgically treated. Was admitted for 2 wks, and represented 2 wks later to this current admission.

PMH:
T2DM(a1c: 6.9)
hypothyroidism(Last TSH: 12, normal fT4)
HTN

Past surgical Hx:
2 ex-laps for SBOs over last 8 mo (last 6 wks ago)
Cholecystectomy

Meds:

Fam Hx:None

Soc Hx:former smoker(50 pack year)

Health-Related Behaviors: **None**

Allergies:None

Vitals: T: afebrile **BP:** 99-127/85-49 **RR:** 14-18**HR**: 84-90**Sat:**93-100RA
Exam: Gen: thin, wasted appearance, wt: 41kg, BMI: 17
HEENT: NG tube in place **Neck**: **CV, Pulm:** Normal
Abd: soft, mildly distended, surgical incisions from prior surgery
Neuro:sleepy, but arousable, AO X 2, **MSK:** 3+ edema up to her thighs

Notable Labs & Imaging:
Hematology:
WBC: 1.06(ANC:1100, ALC: 200) Hgb: 5.6 Plt:130K MCV:80 Retic count: low
Chemistry
Na: 132 K:3.4 C r:0.25 BUN: 40 Glu:90 Cl: 99 HCO3: 32
CRP: ESR: LDH:147 AST: 30 ALT: 30 ALP: 40 Bili:0.4 alb: 2.7, TP: 5.2
Iron studies, vit D, vit A, vit B12, Zn: Normal. Low B1 (supplemented).
HIV, viral hepatitis: Negative. CA-125: elevated, consulted, US abd & pelvis: Normal

Imaging: CT head negative. **CT abd pelvis w/ contrast:** WNL, Calcifications in vessels
Patulous distal esophagus, dilated loops of small bowel, distal small bowel loops in the RLQ were decomposed. Diffuse ascites and anasarca worse from prior exams
CT chest w/o con: b/l pleural effusions + soft tissue edema, no cardiomegaly, pulmonary edema or pericardial effusion, CA and mitral valve calcifications.
Paracentesis: cell count: 73, gram stain, culture: Neg, albu: 1.1, TP: <2, LDH: 58
Echo: pending. UA, UPCR: NI; CD4: <40
Liver US with doppler: heterogeneous and coarse hepatic parenchymal echotexture, moderate ascites, rt pleural effusion. No clots/ abnormal flow, spleen:nl
Next day: Desaturated to 70s, pulseless, Was DNR and died.

Autopsy: luns 2/2 to smokin, pneumonia; no evidence of malignancy, uterus and adnexa: absent; liver: congestive hepatopathy. Esophagus : distal severe esophagitis, Bowel: pan small bowel, colon, rectum: diffusely dark and ischemic
Severe mitral valve calcification (likely lead to MS), ischemic damage in that area.
Outside records: significant food avoidance, N/V, CTA: mesenteric atherosclerosis, mild stenosis, no trombosis. CBC was normal except for anemia. Endoscopy: erosive esophagitis and colonoscopy: wnl

Dx : Severe ischemic bowel disease possibly thromboembolic disease.

Problem Representation: 73Y/F wit PMH of multiple admissions for SBO, failure to thrive with pancytopenia Dx as: Severe ischemic bowel disease possibly thromboembolic disease.

Teaching Points (SEEME):

Approach to Failure to thrive:
We can focus on patient's weight and diet. Unintentional weight loss with pancytopenia is concerning.

Approach to small bowel obstruction:
It can be secondary to **extrinsic** compression such as adhesions or scarring secondary to surgery or **intrinsic** issue such as foreign body. Inflammatory bowel disease and cancer can also contribute to obstruction.

Approach to Pancytopenia:
Pancytopenia may be related to any tumour, bone marrow infiltration or nutritional deficiencies such as B12 and folate deficiencies. We can also think about substance or space occupying lesion. Can be confirmed with flow cytometry or bone marrow biopsy.

Approach to Anasarca and Ascites:
Anasarca can be related to malnutrition or protein losing enteropathy. There might be underlying gut disorder. High SAAG ascites may be secondary to portal hypertension. Constrictive pericarditis may contribute to high SAAG ascites.

Approach to imaging:
Dilatation of bowel loops may be due to motility issues or primary gut disorder.

Low CD4 count- may be secondary to pancytopenia or inflammatory disorder. HIV test can be done.

Heart failure can lead to bowel ischemia, always be mindful of ischemia in cases of small bowel obstruction. Protein losing enteropathy can contribute to pancytopenia.