



04/22/25 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Seeme (@) Case Discussants: Dr. Ravi (@rav7ks) and Yaz (@minheredia)

<p>Scribing (Minahil) CC: 64 year old female presented to ED with abdominal pain and distension</p> <p>HPI: Patient mentioned that she had EGD for varices last month and develop and swelling after it but had significant discomfort for last week and presented today. She had diffuse abd discomfort with no fecal area of pain associated with decreased appetite. There are no relieving or aggravating factor. She also complains of dysuria and increased urinary frequency for 15 days.</p> <p>ROS: no bleeding or melena, no fever, chills, nausea or vomiting</p>	<p>Vitals: T: af BP: 140/70 RR: 17 HR: 82 Sat:98% BMI: 30 Exam: Gen: awake, alert, not apparent distress HEENT: nl CV: nl Pulm: nl Abd: distended, slightly tender diffusely, multiple spider angiomas, no asterix Neuro: follow commands, no tremors MSK: mid b/l leg edema, warm, well perfused, no skin bruising</p>	<p>Problem Representation: 64F with alcohol use, varices and metabolic comorbidities presented with abdominal distension post EGD, with diffuse discomfort and new onset dysuria. Exam and imaging revealed cirrhotic morphology with ascites and lab showed mild synthetic dysfunction.</p>	
<p>PMH: HTN, T2DM, HLD, esophageal varices, gastric ulcers, recurrent UTI, anxiety</p> <p>Meds: Metformin, insulin, pantoprazole, carvedilol, empagliflozin</p>	<p>Fam Hx: uterine carcinoma (mother)</p> <p>PSH: laparoscopic cholecystectomy (2020)</p> <p>Health-Related Behaviors: non smoker, 20-30 beers/mo</p> <p>Allergies: Penicillin</p>	<p>Notable Labs & Imaging: Hematology: WBC: nl RBC: nl Plt: nl</p> <p>Chemistry Na: nl K: nl Cr: Ca: 8.3 (low) Glu: 133 (high) Cl: nl HCO3: nl AG: eGFR: AST: 65 (high) ALT: nl ALP: 146 (high) T. Bili: nl D. Bili: 0.4 (high) Amylase: nl UA: infection with E. coli (nitrofurantoin started to treat cystitis) PT: 16 (high) PTT: nl Hepatitis Panel: neg, albumin: 3.2 (low) RUQ US: ascitic fluid, increased echogenicity in liver Ascitic fluid analysis: Cloudy fluid, high SAAG, ascitic fluid albumin: low</p> <p>Imaging: CT abdomen & pelvis: cirrhotic morphology of liver with enlarged main portal vein Biopsy report: focal steatosis</p> <p>Dx : Decompensated liver cirrhosis</p>	<p>Teaching Points (Lera): Initial approach:</p> <ul style="list-style-type: none"> - Assess hemodynamic stability, make sure to r/o acute ischemia (eg mesenteric ischemia) and obstruction. - Anatomical approach + abdominal distention -> Air? Fluid? (esp. blood) Solid? (mass, stool in elderly patients!) -> percussion + US! - Investigate the Hx (comorbidities? DM, constipation...) Esophageal varices -> portal HTN (cirrhotic or not? -> exam!) + higher chance of ascites -> Worry about SBP! <p>Understanding the COG:</p> <ul style="list-style-type: none"> - Where's the problem -> Kidney? Heart? Liver! - But what's the cause? EtOH? (Keep an eye on withdrawal symptoms) MASLD? (1/3 progresses to cirrhosis!) Malignancy? (age-appropriate screening (GU!), Hx for inherited syndromes) - R/o acute liver failure (AST / ALT + INR + AMS + 26 wks cutoff) and pseudocirrhosis (fibrosis index >> biopsy). <p>Liver injury patterns:</p> <ul style="list-style-type: none"> - EtOH: hepatic steatosis -> steatohepatitis -> fibrosis -> cirrhosis. - Labs: increase in ALP >> AST / ALT -> Infiltration? Cholestasis? <p>Ascitic fluid interpretation:</p> <ul style="list-style-type: none"> - SAAG -> if high = portal hypertension. - Cloudy appearance -> possible infection. But normal WBC count -> Caught early? Immunocompromised? <p>Decompensated cirrhosis:</p> <ul style="list-style-type: none"> - Features: worsening ascites, HE, variceal bleeding, worsening synthetic liver function (INR!) - Not an end-point diagnosis -> need to understand the cause. - Target -> remove trigger + compensation + liver transplant?