8/14/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Austin (@RezidentMD)* ***Case Discussants****: Glen (@) and Rabih (@rabihmgeha)*

Scribing (Seeme)

CC: 25 y/o M acute onset abdominal pain

HPI: Woke up from sleep with pain. Vitals nl in the ER, abdominal & testicular US -> spleen 14 cm, epididymal cysts

ROS (-): vomiting, diarrhea

2 mo later: pain not resolved, waxing & waning, RUQ -> epigastric, groin, chest, sometimes stabbing. OTC initially helpful, now ineffective. + episodic vomiting

ROS: lost 15 lbs over last mo, fatigue, chills (no true fever), skin in RUQ changes color

Intermittent episodes of nausea and vomiting over the years (self resolving). Abdominal pain episode a year ago, similar in character but not so intense.

PMH:
Depression
HSP

Meds:
Ibuprofen
tylenol

Fam Hx: multiple with HS, dad carotid dissection + early MI

Social Hx:
Socially isolated, not sexually active, works in office

Health-Related Behaviors: marijuana daily +vapes, no alcohol or other substances

Allergies: NKDA

Vitals: T: nl **BP:**129/ 76 **HR**: 100 **RR:**20 **Sat:** 99% on RA **BMI:** 21
Exam: Gen: non-toxic, uncomfortable
HEENT: wnl
CV: tachycardia, no murmurs
Pulm: wnl
Abd: soft non-distended, tender in RUQ
GU: nl femoral pulses, no tenderness or lymphadenopathy
Neuro: wnl
MSK: no edema, no rashes

Notable Labs & Imaging:
Hematology:
WBC: nl Hgb: nl Plt:nl MCV:nl
Repeat CBC:nl
Chemistry
Basic metabolic panel :wnl

Imaging:
Abdominal and testicular US: nl
CT: bilateral epididymal cyst and splenomegaly of 14cm
CTA: Patent vasculature, mild splenomegaly and stool burden, no abnormalities in gallbladder
Duplex US of mesenteric vessels: all patent ,elevated flow velocity in SMA
PBS: few spherocytes, Repeat chemistry: all nl, lipase nl, UA nl
HIV negative Lead, urine porphyrins, am cortisol: all nl
PPI with no improvement, but worsening (especially postprandial)
EGD with random Bx: negative
HIDA scan: nl, but gallbladder EF 82% (nl 40 - 60 %)
Psychiatry was consulted. Surgery was consulted and was thought to be sludge related dyskinesia.

Dx : Biliary Dyskinesia

Problem Representation: A 25 y/o M presented with waxing and waning abdominal pain and RUQ tenderness associated with intermittent episodes of self-resolving nausea and vomiting and fatigue.

Teaching Points (Lera):

Acute onset abdominal pain:
- ***Should I be scared?*** R/o *life threatening* causes first -> **ischemia**, peritonitis 2/2 **perforation** [clues – awakened from sleep = *abrupt aggressive problem*, rebound tenderness]
- ***Where exactly?*** Location narrows down the DDx
- ***RUQ pain*** -> liver, biliary system, gallbladder. **Filter through additional Sx** -> weight loss + chills -> *consumptive process*.

Sequence of events: pain as *response* vs. pain as a *primary issue*

Imaging with a grain of salt:
- Cause vs. noise. ***Can the findings explain the presentation?***
- If not, ***who to trust*** -> *imaging or patient?* ⊕ Let the *other labs and Sx* guide you [nl CBC -> splenomegaly likely noise]*
  - ** Hereditary spherocytosis -> **mild** hemolysis rate -> smear!*

Hx relevance: *psychiatric conditions, substance use* -> workup negative pain ⊕ **influence patient's perception of the disease**

Image negative RUQ pain:
- ***Celiac artery ischemia*** [MALS = recurrent episodes of radiographically negative abdominal pain, esp w/ low BMI],
- ***Liver capsule disease*** [Fitz-Hugh-Curtis syndrome, both F & M],
- ***Gallbladder disease*** [biliary sludge -> HIDA scan] ⊕ ***nerve!*** [very localized + test of Rx with US guided s/q lidocaine injection]

Invisible severe disease:
- ***Why can't you see it?*** *Microscopic* problem vs. change *perspective* [eg dynamic ischemia -> MALS related to breathing] vs. *functional* disorder [eg biliary dyskinesia – **Dx of exclusion!**]
- ***How to Dx MALS:*** endoscopic gastric perfusion, celiac plexus block, dynamic imaging (CTA)