11/30/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Sana* ***Case Discussants****: Kirtan (@KirtanPatolia) & Rahul (@RahulPottabath1)*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Bahae)

CC: 20 year-old female presents with **diarrhea for 2 years.**

HPI: Apparently normal 2 years ago, Sx became the new normal. Diarrhea: 3-4 episodes / day, small volume, increasing urgency of late. No mucous, **few drops of blood** on occasion. Endorses **nausea and abdominal pain** for past 3-4 mo, moderate, cramping, episodic, lasts 30 to 40 min. Reports being tired after defecation.

ROS: no weight loss, anorexia, fever. Appetite is normal.

PMH: Atopic dermatitis

Meds: none

Fam Hx: CAD on paternal side

Social Hx: Law student, no recent travel Hx, no pets

Health-Related Behaviors: —

Allergies: —

Vitals: T: afebrile **HR**: 98 **BP**: 96/64 **RR**: nl **Sat**: nl

Reports that is bl hypotensive.

Exam: HEENT: no LAD

CV: normal **Pulm**: CTAB **Abd**: soft, non tender

Neuro: conscious, coherent and oriented

Notable Labs & Imaging:

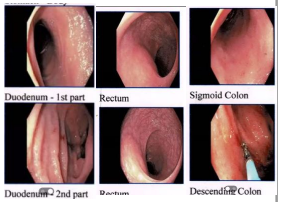
Hematology: WBC: 7500 -> diff: Neutrophils 54, Lymphocytes 30, eosinophils 5, monocytes 10, basophils 1

Hgb: 12.2 Plt: 375 MCV: 84.7 Hct: 37.8% **RDW**: 15.8 [slightly ↑]

Chemistry: LFTs and RFTs: nl **CRP**: 17.87 [slightly ↑]

-> Prescribed Rifaximin

-> Came in 1 yr later with CC of ***dark stool with blood and mucous****, crampy pain, increased urgency and perianal burning during defecation/ LUQ pain not relieved on food intake.* ***ROS (+):*** *Weight loss 10 lbs, LLQ pain, not associated with menstrual cycle. Appetite was increased.*



ID workup: HIV, HCV, HBV neg.

Fecal calprotectin: 421 very elevated

UGIE with gastric and duodenal Bx w/ sigmoidoscopy: Loss of vascularity and granularity and superficial ulceration in the sigmoid colon, haemorrhage in the DC. Moderately severe corpus predominant gastritis on UGIE Bx, Gastric biopsy gastritis h. Pylori related, Left colon biopsy Crypt abscesses, plasma cells & lymphoid aggregates, no granulomas.

Dx: ulcerative colitis

1.2 g Mesalamine , prednisolone 30 mg and taperine 5 mg, Sx improved

Problem Representation: 20 y/o F presented with 2 years of diarrhea, increasing urgency and later abdominal pain and weight loss. CRP and fecal protectin was elevated → colonoscopy revealed features of UC.

Teaching Points (Masah)

-**Diarrhea**: is the patient hemodynamically stable?

-Time course: Acute, subacute, chronic —> help us point out the underlying etiology.

- Is the diarrhea severe enough to cause end organ dysfunction

- **Center of gravity?** systemic problem or local GI problem causing the diarrhea: any accompanying symptoms like blood in stool, crampy abdominal pain, weight loss, constitutional symptoms. any immunocompromise? Any substances/meds the patient is taking?Family history of malabsorptive problems

-**Inflammatory or non inflammatory:** *inflammatory* (infectious- indolent organisms like entamoeba histolytica, or noninfectious - IBD, radiation induced proctitis). *Non inflammatory* (secretory eg. neuroendocrine tumors or osmotic eg. lactose intolerance)

-Presence of **drops of blood** could be from wear and tear rather than an inflammatory process

-If pain when passing stools (**tenesmus**) → inflammatory process

-Some conditions like malabsorption syndromes can cause increased appetite with weight loss → no weight change can be misleading → look for wasting in Temporal muscles

-Elevated CRP → acute on chronic diarrhea or chronic indolent inflammatory disease process? Having serial CRP can help.

-When type 1 thinking is not matching the presentation → thorough review of systems

-Work up: 1) Infections (HIV HBV HSV, stool cultures, giardia & cryptosporidium) fecal calprotectin (helps us identify if there is inflammation or not as it measures WBC turnover in GI lining), stool fat & alpha 1 antitrypsin.

2)Osmotic vs secretory: Osmotic → Stool osmotic gap>50-100mOsm

3)Neuroendocrine symptoms can cause solely diarrhea (gastrin, secretin, somatostatin, VIPoma), other endocrine: TSH, T3 T4, Serum cortisol

Erosive vs non erosive: *Erosive:* IBD, peptic ulcer, ulcers from malignancy *Non erosive:* infiltrative (sarcoidosis, small bowel lymphoma, SLE)

4)Celiac: iron deficiency or vit D deficiency → iron panel, ferritin, vit D level

5)Full lipid profile → if low → pancreatic insufficiency

Nausea from Upper GI & other systemic factors rather than lower GI. Endoscopy could help us visualize the GIT.

-Evolution of symptoms: **LUQ abdominal pain:** Sigmoid or spleen or descending colon with referred pain CT abdomen & pelvis with contrast to help see fat stranding, vessels, and all structures.

-Young patient+weight loss+abdominal pain: early autoimmune disease: 1) IBD 2) GI Behcet's + more common in asian countries 3) SLE (APLS) → bowel wall vasculitis 4) IgA/PAN → CT abdomen Pelvis with angiogram

-Female Gyne problems that can cause GI symptoms: eg. Endometriosis - intermittent hematochezia, Nausea, abdominal pain

- Plasma cells in GIT → Syphilitic colitis, bartonella, IgG4