12/05/25 Morning Report with @CPSolvers

"Double Barrel Horror" ***Case Presenter****: (Khashayar Khosravi)* ***Case Discussants****: @Rabih & academy*

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

Scribing (Fahed) ***CASE 1***

CC: Abdominal Pain

HPI: 85 year old male presented with generalized abdominal pain since this morning, pain is progressive, continuous and no referred to anywhere. It is positional and gets worse with lying down.
Pain has no relation to food intake.
no altered bowel habits.

PMH: IHD, DM, HTN

Meds: Unsure which drugs, Not on insulin

Fam Hx: wnl

Social Hx: addicted to an unclear substance. Possible precursor of heroine.

Vitals: T: - **HR**: 96 **BP**: 110/70 **RR**: - **Sat**: -

Exam: Gen: Looks ill but not toxic.
HEENT: wnl, dry mucosa
CV: wnl
Pulm: wnl
Abd: soft, non tender, no guarding
Neuro: wnl
Extremities/skin: wnl

Notable Labs & Imaging:

VBG: Ph: 7 HCO3-: 18

Imaging:

EKG: normal

Faints during CT scan. Started CPR. Regains pulse.

Explorative laparotomy: Air and fluid present, reveals perforated stomach. Moved to ICU. Unfortunately didn't make it through the night.

Dx: Gastric perforation with possible perforation peritonitis.

CASE 2

CC: Hypogastric abdominal pain

HPI: 15 year old male presented with hypogastric abdominal pain since a week, pain is progressive, continuous and no referred to anywhere. it is non-positional. Pain has no relation to food intake.
Slight Nausea without vomiting for past week.
no altered bowel habits.

PMH: wnl

Meds: none

Fam Hx:wnl

Social Hx: smoking history +

Vitals: T: 38.3 **HR**: 84 **BP**: 120/80 **RR**: - **Sat**: -

Exam: Gen: wnl
HEENT:wnl
CV:wnl
Pulm: wnl
Abd: 7cm scar on left flank in mid axillary line, due to a penetrating stab wound. Abdomen is tender mainly in hypogastric region.
Rectal exam: wnl
Neuro: wnl
Extremities/skin: wnl

Notable Labs & Imaging:

Imaging:

CT scan: Grade 2 laceration of spleen with fecaloid content in abdomen.

Explorative laparotomy: Pus and fibrin in the abdomen, adhesions between omentum and stomach, hematoma behind spleen.

After surgery moved to ICU, discharged after 4 days.

Dx: Splenic laceration + contained gastric perforation.

Problem Representation: A 85 year old male with progressive diffuse abdominal pain and a 15 year old male with progressive hypogastric abdominal pain following a stab wound injury on the left side.

Teaching Points (Manaswini)

Case 1:

Abdominal pain: ***VIPO:*** [Mesenteric ischemia(**Vascular**), Inflammation/Ingestion, **Perforation**, **obstruction**

- VPO: Diffuse abdominal pain -usually emergencies involving the BOWEL
- I: Inflammation -Focal abdominal pain - many structures could be involved (diverticulitis, appendicitis etc)
- 1st Rule out emergent causes, then see if there is Positional pain: Is it a distractor? (Patient might just be uncomfortable)
- Think other emergent causes Above and below Diaphragm: Eg; ACS, Ruptured Ectopic.

Interpreting VBG: Metabolic acidosis: Although the instinct is to think of Anion vs Non Anion gap
- Think is it an endogenous or exogenous cause?
- What replaced the bicarb? - 1. Could be chloride(which is a physiological process, unless patient is on diuretics) 2. If not replaced by Chloride - indicates a pathological cause
- Molecules that cause the anion gap- ***KLUI*** - 1st most important to keep in mind:**Lactate**! 2nd-Ketones, then uremia, ingestion
- Another important question to ask: -Here, there is abrupt change in pH and lactic acidosis: (time course of change is disproportional with his Vital signs)- What could be the cause?

Disproportionate Lactic acidosis: THINK INGESTION(Diffuse abdominal pain seen)- may be due to Metformin(in Pt with DM),or SGLT2i causing ketoacidosis, Co-ingestion with methanol/opiate withdrawal/Cannabinoid ingestion), DKA

CPR: Important to give the Pt Bicarb infusion in addition to focusing on resuscitating the patient

Case 2:

Hypogastric pain: 1. May be due to an unusual presentation of appendicitis, diverticulitis involving one quadrant radiating to the other OR 2. Centrally positioned organs- cystitis, of involvement of GU organs
Hence High suspicion to find something on Imaging due to focality of pain (vs diffuse pain)
Approach to giving antibiotics: Do we have a high suspicion ?
If not suspicious, is the high pretest probability high- if patient 1. Septic 2. Neutropenic 3. Cirrhosis with Upper GI bleed
- Here, Gram -ve rods and anaerobes to be targeted. Less likely to give broad spectrum Antibiotics

Case 1 Vs 2-

Age, time course, quadrants of abdomen involved, Symptoms associated(Fever)

- **Who do you want to get the CT scan for?**
- **How to get abdominal pain right- 1. Get an EKG 2. Get a Post void residual bladder scan 3. Who do you want to Image(get a CT scan for?)**