4/3/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter:** *Eyron (@)* **Case Discussants:** *Robin (@) & Prof Rcz (@)*

Scribing (Saketh)

CC: 59 y/o M coming in for lightheadedness

HPI:

Associated with Blurry Vision, no LOC. Felt sweaty at that time, no Chest Pain, cough, no trouble breathing. A few hours prior to arrival, was at work shoveling, after a period of leaning over went to stand up and felt lightheaded so presented to the ED.

Currently denies any symptoms.

PMH:
HTN
Dyslipidemia
T2DM
CAD s/p CABG
Gout

Meds:
Aspirin
Metformin
Losartan
Rosuvastatin
Farxiga
Glimepride
Allopurinol
Pantoprazole

Fam Hx:

Social Hx:

Health Related Behaviors:
Former vaping
No alcohol

Allergies:
None

Vitals: T: 37.2 **HR:** 106 **BP:** 144/75 **RR:** 20 **Sat:** 97% **BMI:**
Exam: Unremarkable

Notable Labs & Imaging

Hematology:
WBC: 8.5 Hgb: 12.2 Plt: 127 MCV: 96

Chemistry:
Na:140 K: 4.5 Cl:104 Cr: 1.36 BUN: 58 Glucose: 228 Ca: 8.8
Troponin: 13 (nl); D-dimer: nl

EKG: sinus tachycardia

Patient given fluids -> felt better -> discharged
2 hours later -> ep of bloody stools (bleeding PR) -> returned to ED

Vitals in ED
Afebrile, HR 112, BP 88/54, 97% Ra, RR 18, [illegible] Gross blood, intact pulse

Repeat labs in ED
Hb: [illegible], Plt: 120, WBC 9
Electrolytes nl, BUN 56, Cr: 1.33, LFT nl, Total protein 6.2, INR 1.1
Rpt Troponin -ve, Rpt EKG: sinus tachycardia

Further course (admitted for further eval)
Patient had 5 black BMs -> BP 70/30s -> moved to ICU -> GI consulted

EGD and Colonoscopy: Large amount of blood in colon. No active extravasation.

CTAP w contrast: Ectasia of the abdominal aorta and Rt. iliac arteries. Thrombosed left iliac artery aneurysm.

Tagged RBC: abnormal focus in left upper abdomen. Positive GI bleed in small intestine, difficult to differentiate b/w jejunum from ileum.
Rpt colonoscopy w enteroscopy: negative for bleeding source

Day 3 hospital day: Hb dropped to 4 (undergoing MTP)
Brought to OR for ex-lap: visible vessel at the proximal jejunum (distal to the ligament of Treitz) -> clipped endoscopically -> small bowel resection performed for scope access

Dx: Small Bowel Dieulafoy Lesion

Problem Representation: 59-year-old man with CAD (s/p CABG) on aspirin, T2DM, and HTN presenting with initial orthostatic/lightheaded episode followed by delayed massive GI bleed, progressing to hemodynamic instability and severe Hb drop (12.2 → 4 g/dL), with workup localizing bleeding to proximal jejunum.

Teaching Points (Kuchal)

Episodic symptoms: recreate the scenario (controlled env) which causes the symptoms. -
Lightheadedness- essential to record Orthostatic vitals.
risk factors for Pre/Syncope: CVS- focal : CAD, - second attack with drugs, arrhythmias, hypovolemia, autonomic insufficiency → needed for the focal event to become diffuse disease is needed in the background to precipitate the syncope.
Electrical causes: transient - Vasovagal, episodic arrhythmia. Persistent cause: eg. structural lesion in the Heart or vessel.
ST : usually physiological response to an underlying condition; - If with AKI think of hypovolemia has the ppt cause of ST, it would subside with Fluid bolus (LR preferably) → but watch out for the BUN/CR ratio if the actual cause is still elusive.
hematochezia : 5% can be due to Brisk UGI bleed → might need massive transfusion of protocol
GI bleed: scope (endo and colonoscopy). If Scope negative (the cause can be dynamic) CT Angio / capsular Endoscopy → Small Bowel disease (Ulcer, mass or vascular) - ; Intraluminal cause (Cameron, Dieulafoy, Parasites like stringy)vs Extraluminal caus (haemosuccus Pancreaticus, Aortoenteric fistula, Hemobilia).
Last resort: Exploratory lap to resect the part of bowel which is likely causing the bleed and HPE