9/7/26 Mainstream Monday with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Daniel Lim* ***Case Discussants****: Youssef Saklawi (@saklawiMD) & CPS Team*

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

Scribing (Praveen):

CC: 32 F presenting with RUQ and epigastric pain associated with nausea and vomiting

HPI:

Pain started at 2AM (12 hours ago) while the patient was sleeping. Multiple episodes of vomiting, - nonbilious and non bloody. Her last meal - fried chicken sandwich- vomited once after eating. Given Zofran and PPI @ Urgent Care, but abdominal pain worsened. Her last bowel movement was earlier today and was normal.

ROS:

She denies diarrhea, dysuria, hematuria, vaginal bleeding or discharge, or prior abdominal surgeries.

PMH:

16 weeks postpartum
Gestational diabetes
Asthma

Meds:

Albuterol as needed
Iron tablets

Fam Hx:

Nil Relevant

Social Hx:

Pre-Pregnancy 5 beer cans per week

Health-Related Behaviors:

N/A

Allergies: NKDA

Vitals: T: afebrile **HR**:nl **BP**: nl **RR**:nl **Sat**: **BMI**:

Exam: Gen:

HEENT: Normal

CV: S1S2 Heard, no murmurs

Pulm: B/L AE+, No added sounds

Abd: RUQ pain tenderness. Negative Murphy's, no McBurney's point tenderness, no CVA tenderness.

Neuro: NFND

Extremities/skin: Normal

Notable Labs & Imaging:

Chemistry:

AST: 513 ALT: 615 ALP: 177 T. Bili: 2.2 D.Biii: 1.5 T. protein: 8.4
Alb: 4.8
UPT : Negative

Imaging:

USG: Gallstones without gallbladder wall thickening, Normal CBD

MRCP: Cholelithiasis without evidence of choledocholithiasis

Clinical Course:

The patient was given toradol injection and Zofran in the ED. Pain resolved at the time of USG. ALT and ALP increased in trending and decreased later on. She had a laparotomy cholecystectomy.

Diagnosis : Choledocholithiasis with suspected passed stone

Problem Representation: 32 F presented with RUQ and epigastric pain, found to be image-negative despite transaminitis and elevation in cholestasis markers. Recovered symptomatically.

Teaching Points (Seeme)

-Approach to abdominal pain:

-Think anatomically- skin, organs (liver, colon), upper structures (heart) and lower structures (GU tract).

Approach to HPI:

-Post operative history makes us think about cholestasis or post surgery complication
-We can think about VIPO (vascular, inflammation, perforation, obstruction)
-Focal vs diffuse pain can help us make progress, it is important to see vitals to narrow our differentials
-In abdomen sudden onset can make us think about block by stone or block in GI lumen

Tests to do:

-We can start with US, CT scan can miss some etiologies of bile duct and ERCP is sometimes needed, CT scan can detect pancreatitis
-US 80% sensitive for biliary stones

Approach to direct hyperbilirubinemia:

-when a patient has pain, elevated bilirubin and abnormal LFTs- obstruction of biliary tree is likely
-Symptomatic cholelithiasis is indication for cholecystectomy