8/31/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Eyron* ***Case Discussants****: Rahul(Twitter: @RahulPottabath1) & Youssef(Twitter: @saklawiMD)*

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

Scribing (Noah):
CC: 62 y/o M w/ epigastric pain

HPI: Pain started a couple of hours prior to ED presentation, sudden onset 10/10 with generalized radiation after eating. Some SOB, but no other symptoms, no nausea, vomiting, chest pain.

ROS:
Positive for dyspnea
Negative for other symptoms, including nausea, vomiting

PMH:
Hypothyroidism
Melanoma of right thumb s/p amputation

Meds:
Losartan
Levothyroxine

Fam Hx:
Non-contributory

Social Hx:
No alcohol, no smoke

Vitals: T: Afebrile **HR**: 63 **BP**: 121/66 **RR**: 25 **Sat**: 98% RA
Exam: Gen: unremarkable
Abd: mod distended, no bowel sounds, generalized tenderness throughout

Notable Labs & Imaging:

Hematology:
WBC: 14 Hgb: 13.5 Plt: 220 MCV: 85

Chemistry:
Na: wnl K: wnl Cl: wnl HCO3: wnl Ca: 9.6 BUN: 27 Cr: 1.3
AST: 120 ALT: 84 ALP: 110 T. Bili: 0.8 D bili 0.5
Lipase > 3000
Lipid profile TG 50 LDL 66

Imaging:
EKG: nl
CXR: trace bl pleural effusions
CT: liver mod attenuation, no evidence of intra hepatic dilatation, extrahepatic bile duct mild dilation, gallbladder with stones, pancreas normal attenuation with no focal lesions, new peripancreatic fat stranding
MRCP with no filling defects in the biliary tree

Final Dx: Acute gallstone pancreatitis, underwent cholecystectomy

Problem Representation:

Teaching Points (Manasa)
Red flags to look out for in % epigastric region: Vascular phenomenon/Obstruction/Hollow viscus perforation/GI blood loss.
Lipase, lipid profile, LFTs, ekg, stool H.pylori, tobacco history and a CAT scan may aid in the initial diagnosis.
With other labs being normal, no alcohol or drug history of pancreatitis, Gallstones? Autoimmune? Malignancy? Superinfection of the inflamed pancreas?
Removal of GB in a patient with idiopathic pancreatitis was shown to have reduced incidence of further pancreatitis episodes.
Waterfall trial for Initial pain and Fluid resuscitation.

8/30/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Jahanvi(@)* ***Case Discussants****: Glen & Rahul*

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Scribing (Ramaswamy):

CC: 40 Y M with persistent vomiting since 1 day
HPI: **Persistent vomiting since 1 day preceded by sudden nausea.**

Recent hospital visit 2-3 days prior, where he presented with mild flu like illness, elevated blood glucose and was diagnosed with cellulitis on his back due to a pimple being popped previously

ROS: + chest pain, SOB, dizziness.

No fever, chills, sick contacts

PMH:
T2DM
HTN
Meds:
Insulin glargine
Insulin lispro
Losartan
Amoxicillin-clavulanic acid (cellulitis)

Fam Hx: NA

Social Hx: NA

Health-Related Behaviors: No smoking, alcohol or illicit drug use

Allergies: NA

Vitals: T: 36.8 **HR**: 137 **BP**: 146/97 **RR**: 23 **Sat**: 100% RA **BMI**:
Exam: Gen: Uncomfortable on room air
HEENT: nl, poor oral dentition, dry oral mucosa
CV: S1, S2 , elevated heart rate
Pulm: Clear, **tachypnea with respiratory rate 20-25**
Abd: Normal **; Neuro**: No focal neurologic deficit
Extremities/skin: **2.5x2 induration on L back, (-) discharge or bleeding, non tender**

Notable Labs & Imaging:



Hematology:
WBC: **16.97** Hgb: 14.7 Plt: 323 MCV: 94
Chemistry:
Na: **128** K: 5.6 Cl: 98 Co2: 10; Mg: 10.8 BUN: 20 Cr: 0.96
Glu: **404**; AST: 19 ALT: 19; ALP - 126 T. protein: 9.7 Alb: 5
Beta hydroxybutyrate - **8.08** ; Troponin <3; HbA1c - **9.7**
UA - **Light, + ketones 4+, glucose 4+, nitrite leukocyte esterase (-), protein 1+**



VBG - pco2 -25 HCO3 - <20; UDS - (-) **Bcx - S. Aureus**
Imaging:
EKG: Sinus tachycardia, regular rhythm, 140 bpm, Right axis deviation, T-wave abnormalities, High QRS voltage
KUB: Moderately enlarged bowel loops
MRI Thorax - edema noted over supra and infraspinatus, no localized collection
MRI T spine - Irregular peripherally enhancing fluid collection
Soft tissue USG - collection
Treated with insulin and appropriate Abx with ID consult - patient improved ; Dc - cefalexin
Dx - Pyomyositis secondary to uncontrolled T2DM

Problem Representation: 40 Y M with T2DM and HTN, with recent hospitalization for cellulitis (back), with acute onset persistent vomiting with associated nausea, with tachycardia, tachypnea, notable for leukocytosis, hyperglycemia, ketonemia and ketonuria with metabolic acidosis, staphylococcal bacteremia, with pyomyositis noted on imaging.

Teaching Points (Nithya)

- **Sudden nausea concerning for ICP, want to r/o neuro (FND, headaches, vision), but remember that GI is most common culprit for nausea (ID history). Approach with external ingestion vs internal causes**
  - **How is patient's PO? Do we need to give fluids/how serious is the syndrome**
  - **DKA, acute gastroenteritis, Sepsis, ACS, PE**
- **With the history of DM, want to get RBS in case patient is in HHS/DKA**
- **Pleuritic = 4 P's: pericarditis, pleuritis, pneumothorax, PE**
- **** when you check orthostatics, remember that pt often has already gotten bolus in ED. They may have come in with a positive orthostatic vitals exam**
- **Patient with small PE may have normal sat**
- **Women and DM are at risk for silent MI. Diabetic neuropathy may prevent pt feeling chest pain/arm radiation altogether**
- **Labs in support of DKA (hyperglycemic ketosis with metabolic acidosis), but possibility of HHs to rule out**
  - **Management: first fluid repletion. NS can precipitate NAGMA, so we choose LR. Then, potassium if <5.2, since your insulin infusion is going to cause an intracellular shift of potassium.**
  - **Careful for refeeding syndrome, check mag and phos!**
- **Pseudohyperkalemia in DKA despite patient being deficient (glucosuria**
  - **Acidosis → H^+ moves into cells to be buffered.**
  - **To maintain electroneutrality, K^+ moves out of cells → serum K^+ rises.**
  - **Insulin does the opposite: it stimulates the Na^+/K^+-ATPase, moving K^+ into cells (and H^+ shifts back out)**