7/26/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Bayan* ***Case Discussants****: Rahul and Anmol*

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

Scribing: Ramaswamy

CC 75 year old male P/W burning during urination

HPI: He reports **dysuria, urinary frequency, urinary urgency and foul smelling urine** for 10 days. Sought care at the local PHC, was prescribed a 1 week course of antibiotics for presumed UTI (no testing done). 2 days ago, he developed a **subjective fever, severe abdominal pain and inability to pass flatus or stool.** Similar symptoms on and off in the past.

ROS: Fatigue + loss of appetite. **Intermittent Nausea, vague abdominal pain and constipation over the past year.** No vomiting.

PMH: T2DM
Hypertension
BPH
Stroke 5 years ago, with residual sided deficits

Meds:
metformin/sitagliptin
amlodipine
tamsulosin, dutasteride
atorvastatin and aspirin

Fam Hx: wnl

Social Hx: retired accountant. Lives with his son and his family.

Health-Related Behaviors:
Wheelchair - stroke.
Smoking - 1 pack/day x50 y, stopped post stroke 5y back. No alcohol/illicit drugs.

Allergies: NKDA

Vitals: T: 38.4 C **HR**: 92 **BP**: 101/70 **RR**: **Sat**:99% RA

Exam: Gen: tired

CV: S1, S2; no murmurs **Pulm**:Wnl

Abd: marked abdominal dilation, generalised tenderness, marked suprapubic tenderness, reducible umbilical hernia, no signs of strangulation or incarceration, no guarding or rigidity.

Neuro: AAOx3, residual right neurological deficits

Extremities/skin: No rashes. No LL edema.

Notable Labs & Imaging:

Hematology: WBC:**33.5 (neutrophil predominant)** Hgb:**9.6** Plt: 232
MCV: 81

Chemistry: BUN: 22 Cr: **1.7** AST: 25 ALT: 27 ALP: T. Bili:1.1 (DB - 0.3)
LDH: 308 Pt/PTT/INR - wnl UA - **turbid urine with interspersed black/brown particles, dipstick +ve glucose, 4+ WBC, 4+ RBC**
HIV, HBV, HCV -ve. ; CA 19- - 9 723, CA 15-3 - 18

Imaging: ECG:wnl, CXR: wnl, Echo: LVEF 50%
Abdominal XR: **markedly dilated bowel loops with air fluid levels**
A nasogastric tube was inserted for bowel obstruction. A Foley catheter was inserted in the ER for urinary retention.

CTAP: Dilated bowel loops, TC - 7 cm SB - 4.8 cm at the distal jejunal loop. **colovesical and enterocolic fistula**. Marked fat stranding, free fluid and foci of extraluminal air pocket posteriorly to the **sigmoid mass.** Few external iliac lymph nodes enlargement largest measuring 1 cm. Bladder - diffuse wall thickening with gas within the urinary bladder, abdominal wall hernia containing bowel loops (+)

PAN CT - CT head: Chronic stroke CT Neck wnl.
CT Chest: Trace B/L pleural effusions. B/L emphysematous changes and few subpleural blebs. No suspicious nodules.

Biopsy obtained later: sigmoid adenocarcinoma
Booked for diverting colostomy

DX:Sigmoid Cancer leading to bowel perforation, Colovesical fistula and bowel obstruction

Problem Representation: 75 y M with BPH, prior CVA and diabetes with prior smoking history, presenting with recurrent dysuria, fever, abdominal distension and constipation with leukocytosis and sepsis with large bowel obstruction secondary to perforated sigmoid mass causing a colovesical fistula.

Teaching Points: Sudharshan

UTI etiology in elderly male: any cause of retention (BPH, prostatitis)
AP etiology: VIPO: Vascular, Inflammation, Perforation, Obstruction
Cystitis doesn't present with systemic symptoms. SS s/o bacteremia/sepsis. Check vitals/lactate/blood cx. CT scan + empiric abx
Always consider medications in elderly pt: anticholinergics are common culprit for AMS/constipation

Urine collection: important to know to contextualize UA: indwelling catheter vs clean catch
Asymptomatic bacteriuria Rx: pregnancy, urological procedures
Abd fullness/suprapubic tenderness s/o full bladder -> catheterize f/b NCCT abd to look for underlying etiology [hydronephrosis, stones]

Post-obstructive diuresis: relief of chronic obs can cause diuresis 2/2 ADH non-response on CD given chronic nature [causes massive fluid loss/shock]

Possible relationship b/w constipation and UTI:

- Chronic constipation directly causes recurrent UTI via obstruction
- Diverticulosis -> diverticulitis -> fistula -> cystitis/retention -> UTI presentation

Chronic constipation etiology: medication, age/ileus, diverticulosis, malignancy [esp iso bowel obstruction]