2/13/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Rahul (@RahulPottabath1) **Case Discussants**: Rabih (@rabihmgeha) & Magnus (@)

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

Scribing (Lera)

CC: 59M with acute **fever, abdominal pain**, N/V

HPI: Abdominal pain, not diffuse – L side of the abdomen lateral to umbilicus. Presents **8 wks after ipilimumab, nivolumab received.**

ROS: No diarrhea.

PMH:
Hx of **melanoma** in 2012 on radiological surveillance -> mts in lungs [oct 2024, Bx proven]

Started on ipilimumab, nivolumab -> hepatitis -> high dose steroid -> **adrenal insufficiency**

New lungs mass with LN -> Bx mts melanoma [old lesions resolving] -> ipilimumab, nivolumab

Afib, HFpEF, HTN, HLD, OSA on CPAP

Meds:
Prednisone 7.5
Spironolactone
Valsartan
Lasix
Aspirin
Atorvastatin
Sotalol
Apixaban
Amlodipine

Fam Hx: none

Social Hx: No travel / new foods.

Health Related Behaviors: never smoked, occasional EtOH use, no drugs

Allergies: none

Vitals: T: 39.2 **HR**: 104 **BP**: 94/58 **Sat**: 94% on RA **BMI**: 153 kg
Exam: Gen: in distress, in pain
CV: nl **Pulm**: CTAB **Neuro**: nl **Extremities/skin**: nl
Abd: tender to palpation in LLQ, bowel sounds nl, no rebound tenderness

Notable Labs & Imaging:
Hematology: WBC: 6 [66% N, 22% L] Hgb: 13.7 Plt: 175 MCV: 93
Chemistry: Na: 135 K: 3.4 Cl: 97 HCO3: 25 **Cr**: 1.51 [bl 0.8] BUN: 24
AST / ALT: nl **Lactate**: 2.5 Lipase: 26 Trops: neg **EKG**: nl, sinus rhythm
CT A/P with con: multiple colonic diverticula, sigmoid colon wall thickening

-> LR fluids [no improvement -> started on norepi, stress dose hydrocortisone], Cefepime + Flagyl, BCx sent -> abdominal pain resolved ***Recurrent abdominal pain*** *in the same location + fever up to 101 + BP 90/60s -> 2 episodes of* ***watery stools*** *-> vancomycin + meropenem + steroid dose increased*

ID workup: C diff: neg BCx: neg Nasal MRSA: neg **CBC & CMP**: nl
CT w con: colonic diverticulosis with significant decrease in "diverticulitis"
MRI abd: no abscesses, perforation – completely nl **CTA abd**: no ischemia

-> discharged [received ipilimumab, nivolumab in outpatient], few months after returned with same Sx ***+ bloody diarrhea***

CT: "diverticulitis" w/o abscesses of perf **Fecal calprotectin**: very high

-> returned again, repeat CT read "colitis / diverticulitis"

Colo: patchy colitis -> **Path:** focal active colitis consistent with…

Dx: ICI colitis.

Problem Representation: A 59 y/o gentleman with Hx of metastatic melanoma on ICI presented with acute inflammatory abdominal pain. Imaging consistent with uncomplicated "diverticulitis". After discharge represented with inflammatory diarrhea. Colonoscopy with Bx + Hx consistent with ICI colitis.

Teaching Points (Glen)

-FEVER AND ABDO PAIN: Infection in one of abdo organs. Imp to check vitals. Localise pain. R/O ACS (e.g troponins). Less likely benign unlike other body organs. Benign feature is infectious gastroenteritis but mostly present with diarrhea. Others diverticulitis, appendicitis.

-Melanoma: Could be causing symptoms by metastasis. Adrenal insufficiency caused by steroids can also cause abdo pain.
-Metabolic syndrome: R/O mesenteric ischemia.

-Low BPs and FEVER: give IV fluids and give abx covering anaerobes and gram neg(gut), less likely gram pos(enterococcus, streptococcus). If immunocompromised cover candida too.
-Increase dose of steroids because unstable.

-Is the diverticulitis real or not? Imaging does not match the severity. Adrenal insufficiency could be worsening it. Or Cardiogenic vs distributive shock. Abdo pain could be referred from thorax.

-Recurrent: Could the infection be coming somewhere else. As time goes on, diagnosis can become clear.

-ICI Colitis: Dx delayed by steroids and difficulty with trying stress test. Follow-up with patient and radiology was key.