



# 4/17/26 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Kevin(@) Case Discussants: Rabih(@Rabihmgeha) & Ravi (@rav7ks)  
<https://clinicalproblemsolving.com/present-a-case/>

**Scribing (Krishna)**  
**CC:** 90 y/o woman presents with **vomiting**  
**HI:**  
Vomiting for **2 days**, containing food particles, triggered by eating. Not associated with nausea Drinking not affected. Central abdominal pain, decreased appetite. Last stool on the day of admission **very hard**. Associated with **dizziness**, pressure-like feeling in the abdomen

**ROS:**  
Denies Fever, weight loss, chest pain

**PMH:**  
STEMI- 2025  
S/p Pacemaker  
HFrEF- 25-30%,  
Plasmacytoma- IgG remission  
CKD  
GERD  
A fib  
HTN

**Meds:**  
Pantoprazole  
Empagliflozin  
Rivaroxaban  
Bisoprolol  
Sacubitril + Valsartan  
l-thyroxine  
Atorvastatin

**Fam Hx:** - Non-significant

**Social Hx:** living alone, home care service visiting

**Health-Related Behaviors:**

**Allergies:** NKDA

**Vitals:** T: 37.7 HR: 94 BP:153/110 RR: 12 Sat 94%: BMI: High  
**Exam:** Gen: Oriented x3  
**HEENT:** No Abnormality detected, HINTS negative  
**CV:** No Abnormality detected **Pulm:** NAD, CTAB  
**Abdomen:** :Non-distended, epigastric tenderness  
**Neuro:** normal  
**Extremities/skin:** slight edema

**Notable Labs & Imaging:**  
**Hematology:**  
WBC: 4.3 Hgb: 12.3 Plt: 160 MCV: 105  
**Chemistry:**  
Na: 134: K: 5.0 Cl: HCO3: 29.3 Cr: 1.2→1.8 BUN: Glucose: Ca: Mg:  
AST:wnl ALT: wnl Alk-P: Bili: 0.6 Albumin: 31.76 Total Protein: 10.6  
CRP: 21.8 LDH: 400 GGT: 112  
ABG: 7.47 , PCO2 : 41.4 Lactate: 1.5  
UA: normal



**Imaging:**  
EKG: Q in III and AvF, left axis deviation  
POCUS: No correlate for pain  
**Hospital course:** Patient developed "coffee ground" emesis (dark brown to black). NG tube lavage showing mostly fecal material.  
USG(repeat): large volume Gastric retention  
CT Abdomen: Showing Adhesion band obstructing the small bowel with multiple dilated small bowel loops.

Patient later developed septic shock →pressor requiring shock→ resolved.

**Dx: Complicated Small bowel obstruction**

**Problem Representation:** 90 yr old female with complex medical history presents with persistent vomiting associated with epigastric tenderness and large volume gastric retention with difficult to visualize adhesion band on CT abdomen.

**Teaching Points (Shriya)**  
-Vomiting = something making the food to be thrown up; Anatomic vs neurologic >internal vs external ; is it associated with nausea ; is it obstruction or spasm  
-Nausea is ingestion induced or not  
-Dizziness > cause of vomiting? Check orthostatic vitals> peripheral vs central  
-b hydroxybutyrate early could r/o euglycemic ketoacidosis in patients taking SGLT inhibitors; Troponin to r/o ACS  
-Epigastric tenderness: r/o structural causes > associated with distension?  
-To consider PPIs in epigastric pain  
1.pain dull and gentle  
2.risk factors for PUD (by 90 should have been earlier right)  
3. No N/V  
-Coffee ground emesis: bleeding vessel from esophageal or gastric or proximal part of small intestine> is it d/t obstruction causing overflow?  
-Dark black gastric retention product: old blood vs stool ( fecalization of stomach)