General Surgery Paper Case #3

General Data:

H.B. is a 60 y/o male, farmer, from Samar with a chief complaint of jaundice.

History of present illness:

Pt was previously well until

8 weeks PTC: Patient noted a change in his urine color (tea-colored)

7 weeks PTC: (+) body malaise, icteric sclerae, still with tea colored urine. Also noted palpable mass in the RUQ.

6 weeks PTC: noted loss of appetite and weight loss, (+) generalized jaundice , with acholic stools.

Sought consult in the local hospital where workups were done and was eventually refer to PGH-OPD and was admitted by GI-IM service for ERCP

Review of systems:

General: (-) fever, (-) anorexia, (+) weight loss

HEENT: (-) ear/nose/throat discharge, (-) lymphadenopathies

CVS: (-) chest pain (-) palpitations

Chest/Pulmo: (-) difficulty of breathing, (-) cough/colds, (-) shortness of breath

GI: (-) diarrhea/constipation, (-) hematochezia/melena

MSK: (-) ear/nose/throat discharge, (-) lymphadenopathies

Past Medical History:

The patient denies other comorbidities. (-) History of past surgeries/hospitalizations.

Family Medical History:

There are no history of cancers in the family (-) diabetes, hypertension, asthma, stroke, heart disease

Personal Social History: The patient is a 10 pack year smoker, currently consuming 1 pack per day and with history of alcoholism, 1 bottle per day for 20 years. The patient currently has one allegedly non-promiscuous sexual partner who is also his married wife.

Physical exam

The patient is seen ambulatory, awake alert not in distress.

Anthropometrics: 169cm 60kg

Vitals: 120/70 88 18 36.3 98% O2 sats on room air

HEENT: Icteric sclerae, pink palpebral conjunctivae, no lymphadenopathies, no discharge from ear, nose throat or eyes

CVS/Pulmo: There are no chest wall deformities. Equal chest expansion, clear breath sounds.

Adynamic precordium, distinct heart sounds, regular rate and rhythm, no noted murmurs, no heaves or thrills.

Abdomen: Normoactive bowel sounds 12/min. Palpable mass on RUQ region. No tenderness appreciated, Traube's space was obliterated, digital rectal exam: intact rectal vault, no palpable mass, noted light gray colored stools in examining finger

Extremities: jaundice with scars all over the extremities, full equal pulses. Pink nailbeds. No edema.

Labs:

CBC: Hgb 120 g/l, WBC 7 x 10^9/L, Platelet count 180 x 10^9/L, Crea 67 umol/L, Na 130 mEq/L, K 4.5 mEq/L ALT 100 U/L, AST 85 U/L , TB 20 mg/dL, DB 17 mg/dL, IB 3 mg/dL, Alk P 350 IU/L, Alb 3 g/dL. Protime 60% act, INR 2

Upper abdominal ultrasound: distended gallbladder with no stone, dilated IHDs, CBD 2.5cm, no mass noted in the liver, pancreas and bile ducts, the liver parenchymal has a 'lace-like' pattern in ultrasound

Course in the Ward:

Patient underwent ERCP with stenting but failed. The next day patient developed RUQ abdominal pain with high grade fever and was referred to GS3 (surgery) for co-management

Guide Questions:

INITIAL HX/PE (disregard the Course in the ward for now) patient was admitted by the surgery service (instead of GI-IM)

1. What are the salient points in the history and physical exam?
2. How do you differentiate between Obstructive jaundice and parenchymal(medical) jaundice?
3. What is your primary working impression for this case? Any differential diagnosis (please don't put in DDx for the sake of having a differential, it's ok to have none)? Or co-morbid disease that you can identify
4. Given the primary working impression
    a. What is the significance of the location of the lesion in the involved organ (e.g. pancreatic head tumor vs body or tail tumor; distal bile duct tumor vs hilar tumor)?
    b. What are the possible complications of this disease?
5. What diagnostic modalities would you recommend this patient to undergo before any intervention? What would be the typical findings for imaging? (CTscan/MRI/EUS)
6. What initial treatment and medical management would you recommend for this patient as you prepare patient for surgery?
7. How do you determine resectability of the disease?

8. What are the surgical options you may offer this patient? (for resectable and non resectable disease)
9. In general, when is ERCP with stenting indicated in the management of periampullary cancer? What are the possible complications of ERCP

GOING BACK TO THE COURSE IN THE WARD:

10. What happened to the patient after the ERCP? Explain the pathophysiology
11. Define cholangitis. Charcot's Triad? Reynolds Pentad? What are the criteria used to diagnose and classify patient with cholangitis based on the latest Tokyo Guidelines (TG18)?
12. What is the intervention needed for this patient now? When will be the best time to perform the definitive surgery?
13. What is the usual presentation of patient with periampullary tumor?
    (describe in 3 words)