

## Pitfalls in Diagnosing Abdominal Pain in Post Cholecystectomy Patients

**Islam Issa\***

*Internal Medicine Specialist, Madinat Zayed Hospital, UAE*

**\*Corresponding Author:** Islam Issa, Internal Medicine Specialist, Madinat Zayed Hospital, UAE.

**Received:** February 07, 2020; **Published:** October 30, 2020

### Abstract

**Introduction:** Abdominal pain is a common presentation to ED and OPD as well and it has wide range of causes whether urgent or non-urgent. Indeed, approach to abdominal pain could be difficult and causing emotional and financial expenses.

**Case Report:** This case study describes the steps doctors take to diagnose the cause of moderate to severe abdominal pain in patient with non-disclosing Laboratory and radiology investigations.

**Conclusion:** Always consider the physical examination and patient's complaints regardless of radiology report or laboratory results. And keep open eye on unexplained mildly fluctuating results. Trust the patient and impose your clinical skills.

**Keywords:** Pitfalls; Abdominal Pain; Post Cholecystectomy

### Introduction

Post cholecystectomy abdominal pain is not an uncommon medical dilemma which is difficult to deal with due to the wide range of possible differential diagnosis and sometimes the need for sophisticated investigations.

### Case Report and Discussion

40 year female, visited Emergency Department (ED) complaining of 2 days history of vomiting, epigastric and right upper quadrant abdominal pain (RUQ abd pain).

In ED physical examination revealed upper abdomen and RUQ tenderness, ultrasound abdomen (US Abd) disclosed previous cholecystectomy.

Otherwise normal. Past Medical History: laparoscopic cholecystectomy 2015 - cholangitis due to biliary stones 2017 treated with ERCP - hormonal contraceptive implant for 9 years.

Vitals were normal aside from mild tachycardia (HR = 100-120/min) Lab: AST = 75 (up to 32), ALT = 120 (up to 31), bilirubin total (BT) 15 = mmol/L (up to 21), bilirubin direct (BD) 7 mmol/L (up to 5.4), alkaline phosphatase-alk pho-: normal, amylase and lipase: normal, CRP = 4 (normal up to 5), CbC normal, kidney function and electrolytes normal.

After surgical consultation was done and patient was cleared surgically, she was treated symptomatically and sent home.

Next day patient came back to ED having the same complaint. Physical examination was almost similar to previous day, with HR = 100-135/min and fever was detected T = 38.

US Abd was done again with the same result.

Lab: AST = 75, ALT = 126, BT = 32.6, BD=18.9, ALK pho=normal, White Blood Cells (WBCs) and Hemoglobin (Hb) normal, Platelet (PLT) decreased = 108, PH=7.39 and ketonuria 3+, hematuria as well. Due to the unexplained complex of symptoms and persistent tachycardia (with no shortness of breath, no tachypnea, no calf pains), d-dimer was requested by ED physician and found to be significantly elevated (d-dimer 6,8), So CT chest PA was carried out and came back negative for PE.

Patient was admitted under medical for observation and further investigations.

Surgical consultation was done and patient again was cleared.

Next day patient started to have rigors with the fever, with episodic upper abdominal pain and loss of appetite.

Lab: AST = 36, ALT = 82, BT = 13, BD = 8.3, Alk pho = normal, GGT =77 (normal up to 36). PLT = 80 (normal 150 - 450), d-dimer decreased to = 1.2 (up to 0.5) the preliminary diagnosis was acute gastritis.

The day after, patient clinically was the same.

Lab: AST = 31, ALT= 61, BT 21.2, BD 19.4, PLT 83, HB 11.6, other parameters were within normal. Again surgically was cleared.

3rd day of admission: patient developed leukocytosis (11.3), PLT = normal, Hb 11.6, BT = 17.9, BD = 8.5, CRP = 205, procalcitonin = 1.7 (up to 0.5), blood C/S initial results were negative.

Ceftriaxone was started, IV fluids increased to overcome dehydration. Aside from surgical assurance, MRCP was ordered and scheduled after 2 days.

MCRP showed 2 intrahepatic duct stones. Antibiotic was switched to tazocin.

Patient sent for ERCP.

### Conclusion

The case was upper abd pain, with PMH of cholecystectomy and post cholecystectomy biliary colic, with minor fluctuations in bilirubin and LFTs, positive inflammatory markers, with negative US and normal alk pho.

The case could have been missed for acute gastritis and patient could get unresolved sepsis especially after reassured from surgery [1-4].

### Bibliography

1. Robert M Penner and Mary B Fishman. "Evaluation of the adult with abdominal pain". Published in UpToDate.
2. Nezam H Afdhal. "Acute cholangitis". Published in UpToDate.
3. Charles Patrick Davis. "Abdominal pain causes". medicine net.com.
4. Jill Seladi-Schullman., *et al.* "Right upper quadrant pain" (2019).

**Volume 4 Issue 11 November 2020**

**©All rights reserved by Islam Issa.**