Patient #053

Chief Complaint: The patient was referred from an outside hospital for evaluation of GI bleeding.

History of Present Illness : This 30 year old man with a history of aortic stenosis, repaired at age seven, started having right lower quadrant abdominal pain three months ago. Two weeks prior to admission he noticed a dark bowel movement. Two days before presentation to the outside hospital he noticed bright red blood per rectum and cramping in his lower abdomen. Over the next two days he described further rectal bleeding with maroon colored stools and presented to the outlying hospital where he was found to have a guaiac positive stool and a hematocrit of 37 that dropped to 34 the following day.

In the outlying hospital he had a temperature of 101^{o}F (38.4^{o} C) and a white count of 17 X 10^{9}/L with 83% neutrophils. His colonoscopy showed blood throughout the colon and in the terminal ileum. The mucosa appeared normal. Upper endoscopy showed mild gastritis but no source of bleeding. He had an echocardiogram which revealed a thickened aortic valve with severe aortic stenosis, mild aortic insufficiency and concentric left ventricular hypertrophy. He had a tagged red blood cell scan that was negative. He was transferred to this hospital for further evaluation.

Medication History: He denied alcohol use and smoking. He had taken an over-the-counter analgesic (containing aspirin, acetominophen, and caffeine) during the past couple of weeks.

Physical Examination: The exam was notable for a pulse of 84 and blood pressure of 138/80 with no orthostatic changes. His temperature was 100.4^{o} F (38^{o}C) and respiratory rate 20. He appeared as a well developed, well nourished black male in no distress. His pupils were equally round, reactive to light, and accommodation. The tympanic membranes were normal. Mucus membranes were normal and the oropharynx was clear. He had no thyromegaly. There was no lymphadenopathy. He had a V/VI systolic crescendo decrescendo murmur heard best over the left sternal border. There was a II/VI early diastolic blowing

murmur also at the left sternal border. He had a thrill over the upper sternum and visible pulsations in the neck. The murmur radiated into his carotids bilaterally. He had normal bowel sounds. There was no abdominal organomegaly. He had tenderness and guarding in the right mid-abdomen. There was no rebound or percussion tenderness. His stool was guaiac positive. The prostate was normal. He had good peripheral pulses and no peripheral edema. The musculoskeletal exam was normal. His deep tendon reflexes were equal bilaterally and strength was good bilaterally.

Laboratory Data:

			Normal
CBC	Hct	36	*40-54%*
	Hgb	12	*13.4-17.4 g/dl.*
	WBC	8.4	*4-12 X $10^{9/L}$*
	Neut	71	*40-70 %*
	lymph's	18	*20-50 %*
	mono	8	*2-10%*
	platelet count	372	*150-440 X 10^{9}/l*
Chemistries	sodium	139	*135-145 mmol/l*
	potassium	4.1	*3.5-5.0 mmol/l*
	chloride	103	*100-111 mmol/l*
	CO2	25	*24-30 mmol/l*
	creatinine	normal	*0.8-1.5 mg/dl*
	BUN	normal	*8-20 mg/dl*
	bilirubin, total	.4	*0-1.2 mg/dl*
	AST (SGOT)	15	*11-40 U/L*
	ALT (SGPT)	11	*10-52 U/L*
	LDH	193	*108-215 U/L*
	PT	normal	*10-13 sec.*
	APTT	normal	*21.5-31.9 sec.*
	Sed rate	78	*0-15 mm/hr*

Chest X-ray : no abnormalities

EKG: normal sinus rhythm with evidence of LVH.

Meckel's scan: negative

Abdominal CT: inflammatory changes around the small bowel in the right lower quadrant and thickening of the terminal ileum.

Upper GI with small bowel follow-through: mass effect with displacement of the cecum and terminal ileum. Mild nodularity of the mucosa of the terminal ileum.