4/21/20 Morning Report with @CPSolvers

Case Presenter: *Bryan Ulrich (@BryanCUlrich)* ***Case Discussants:*** *Bhavya Varma (@BhavyaVarma12) & Gregory Ow*

CC: Vomiting

HPI: 65 year old man presents with 2 weeks of vomiting. He was recently admitted for 3rd unprovoked DVT in 5 years. Hereditary thrombophilias ruled out.

1 week prior to presentation presented to clinic with trouble keeping food down, able to keep liquids down. Barium swallow "normal" given Zofran w/ mild relief.

Day prior to presentation, vomited 5X and presented to ED. Non-bloody emesis, some weight loss, no abdominal pain, fever/chills/headaches or changes to diet.

PMH:
Unprovoked DVT
Gout
T2DM
HTN
No surgical Hx

Meds:
Dabigatran
Zofran

Fam Hx:
Unprovoked DVTs
No cancer history

Soc Hx:
Recently retired
No recent travel or changes to diet.
10 pack-year smoking history, quit > 30 years ago
No alcohol or marijuana use
Monogamous with wife

Vitals: T: 36.9, HR:79, BP: 124/75 RR: 16, SpO_2: 97% on RA, weight down 10lb from 3 weeks prior
Exam:
Gen: well appearing, no acute distress
HEENT: anicteric, no adenopathy
CV: RRR, no m/r/g
Pulm: CTAB
Abd: slightly protuberant, non-tender, no rebound, guarding, masses, or organomegaly. Faint bowel sounds
Neuro: no deficits
Extremities/Skin: no rash, no swelling of lower extremities

Notable Labs & Imaging:
CBC: Hg 11.3, MCV 90, WBC 5.1 (ALC: 290, low CD4), Plt 239
CMP: Na 136, K 3.4, Cl 98, HCO3: 26, Cr 0.53, BUN 5
LCT: normal, **HIV negative**, ECG: normal
LDH 145, CEA/19-19 wnl, CA-125 310.3 (elevated)
Imaging:
CT A/P: severe confluent retroperitoneal, mesenteric adenopathy, duodenal mass (10.4 x 5.6), encasing aorta, SMA, renal vasculature. Confluent w/ uncinate process of pancreas.
CT Chest: unremarkable
FNA: acinar cells, periportal LN: c/f malignancy
Biopsy: histiocytic granulomas c/f mycobacteria
Cultures: grew mycobacterium avium

Problem Representation: Older gentleman with history of unprovoked VTE presents with subacute progressive vomiting found to have lymphopenia and a retroperitoneal duodenal mass diagnosed with MAC

Teaching Points (Jack):
Nausea + Vomiting: Focus on the company it keeps. Nausea + Chest pain is much different than Nausea + Headache. The accompanying symptoms help us localize the cause.
What if Nausea alone? Make sure there aren't lethal friends (a brain problem, cancer, or ACS) out of sight.
How to evaluate a prior DVT: Consider **Virchow's Triad:** [1] Stasis, [2] Endothelial Injury [3] Hypercoagulability. If [1] or [2] absent, start with age appropriate cancer screening. Consider hypercoagulable workup in patients with a strong family history OR patients who are young (<45), have recurrent VTE, or have unusual VTE (e.g., hepatic vein, mesenteric vein, etc.) It is rare that a hypercoag workup will change acute mgmt, and many coag factor tests will be altered by an active thrombus. Rethink sending the workup inpatient and defer if it is not crucial.
Ask where disease IS and where disease ISN'T: Intra-abdominal mass without liver metastases suggest a retroperitoneal malignancy.
- Metastatic disease from GI, GYN, GU.
- 1° RP Disease: Sarcoma, Neurogenic, Lymphoma.
- Non-Malignant RP mass: IgG4 disease, Granulomatous processes

Interpret Cancer markers in the setting of the pretest probability (e.g., a CA-125 can be elevated for reasons other than malignancy).