8/7/20 Morning Report with @CPSolvers

Case Presenter: *Colin Pierce and Joseph Rencic (@JRencic)* ***Case Discussants***: *Reza Manesh (@DxRxEdu) and Rabih Geha (@rabihmgeha)*

CC: abdominal pain
HPI: 49M in usual state of health 8 months prior, p/w diffuse abdominal pain with eating drinking
Denied assoc N/v/d/satiety/decr appetite / no other const Sx. Sx persisted 1-2 months prior to presentation, increased thirst, fatigue, polyuria, abd pain worsened during this period, 40lb WL, down to 190 lb

- DOE assoc w lower leg swelling, could not walk 8-10 steps without SOB, previously could walk more steps, denied PND/CP/palp
- White plaque on tongue assoc with mild/mod pain 6 days prior to presentation

PMH: HLD, DM2, venous insuff
Meds: Atorva Metformin Low dose furosemide
PSH: chole in 1993

Fam Hx: CA in 2 cousins and 1 aunt - type unknown
Soc Hx: Delivery driver in NE
Health-Related Behaviors: Drank heavily for 20 years, abstained since 4 y . No Tob, other drug use
Allergies:none

Vitals: **T**: AF **HR**: 103 **BP**: 154/108 **RR**: 18 **SpO_2**: 97% on RA BMI 30.67
Exam:
Gen: central obesity, mildly uncomfortable
HEENT: prom supraclav fat pads b.l. White plaque on tongue that could be removed
CV, Neuro and **Pulm**: nl
Abd: soft, abdominal tenderness in RUQ without RT or guarding. **HM,** liver 6 cm below R costal margin. No SM.
Extremities/Skin: +2 b/l pitting edema to knees. Dark skin with hyperpigmentation in lateral/post folds of the neck.

Notable Labs & Imaging:
Hematology:
WBC: 20.7 (72% poly, 14% L, 10% M, 0 Eos, 0 Baso) Hgb: 16.8 Hct: 49.5 Plt: 283
Chemistry:
Na: 143 K: 3.1 Cl: 94 CO2: 32 BUN: 13 Cr: 0.64 glucose: 273 Ca: Phos: Mag:
AST: 117 ALT: 341 Alk-P: 244 T. Bili: 2.1 D Bili: 1.2 Albumin:
INR 0.98 PT 11.7/ Lipase 33. A1c 9.2% / Lactate 5.1
VBG 7.57/42
Ca 19-9: 6 / CEA: 621.1 (nl <4.9)
PSA 0.4 / AFP 4.4 (nl). Ferritin >4000, Fe TIBC 214. Repeat Lac s/p IVF - 4.6?
HIV neg , quant gold neg, AM cortisol 36.7 (nl <2)
AM cortisol 22 (s/p dex stress test) / ACTH 267 (nl 6-50)
Free urine cortisol 4039.9 (nl 4-50)

Imaging:
CT AP: innum hypodense liver lesions, mult LN conglomerations adjacent to pancreas, abuttted stomach pylorus, first portion of duod, and panc head.
Adrenal glands nl
CT Chest: No suspicious masses
Elliptical Needle bx- metastatic small cell carcinoma of unknown primary
Final Dx: Paraneoplastic syndrome 2/2 ACTH producing metastatic carcinoma of unknown primary

Problem Representation: 49M p/w chronic post-prandial pain exams/labs consistent with excess cortisol with CTAP showing mult liver lesions, CT chest neg for malignancy concerning for paraneoplastic syndrome 2/2 ACTH producing met CA of unknown primary.

Teaching Points (Andrea):
- Abdominal pain: in ED context we question CT scan or not?
- Abd pain that can be seen without CT pancreatitis, hernia, zoster, rectal hematoma
- Pain dependent of food: stress test for GI: Postprandial pain: worsening with food: abdominal wall sindromes (intracutaneous entrapment of nerve),stomach duodenum, gallbladder, pancreas vasculature, intestines
- Weight loss and volume overload: hint to malignancy
- Polyuria: common etiologies (caffeine, alcohol, hypokalemia, hypercalcemia, Diabetes insipidus), Chronic Kidney disease, nephrotic syndrome,
- THRUSH: candida in immunocompromised
- Pancreatic disease: hyperglycemia, polyuria,
- DM I: Young and low body mass
- Medic causes of DM2: Cyclosporine, sirolimus
- Supraclavicular fat pads and white place: hypercortisolemia
- High steroids: make skin thin Pinch with skinfold caliper
- Eosinophils apoptosis due to increased steroids
- HSD11B: enz involved in steroid hormone physiology
- Cortisol excess: mainly extern use, if inside in the brain. Pituitary adenoma (80%) Adrenal causes (10%) ectopic source (10%)
- Small CC: majority of ectopic tumors creating cortisol excess
- Elevated Ferritin: any cause of inflammation. Histoplasmosis, heterochromatic, HLH
- MEN I: almost all have hyperparathyroidism (hypercalcemia)
- Liver lessionscan be due to GI malignancy