9/30/20 Morning Report with @CPSolvers

Case Presenter: *Alec Rezigh (@ABRezMed)* ***Case Discussants***:*Meret Bauer and Chen Hochman*

CC: Dyspnea, abdominal distension
HPI: 60 M p/w dyspnea + abd distension. Worsening SOB for a few days (at rest and exertion). No CP, n/v, diarrhea, fevers/chills. Requires paracentesis every 3-5 days (previously monthly). Dyspnea improves after paracentesis, but globally worsening over the past few months
+ LE edema, No orthopnea, cough, sputum production

PMH:
Cirrhosis (2/2 EtOh)
HTN, HLD, Benign Prostatic Hyperplasia
Iron Deficiency Anemia
Hepatorenal Syndrome, Dilated Cardiomyopathy (HFpEF) s/p TIPS (10 years ago)

Meds:
Bumex 1mg qd
Spironolactone 50mg qd, Atorvastatin
Lactulose

Fam Hx:
None
Soc Hx:
Lives in Houston, born in Mexico
Health-Related Behaviors:
Prior alcohol use (last 25 years ago)
Allergies:
None

Vitals: **T**: **AF HR**: 91 **BP**: 165/74 **RR**: **28 SpO_2**: 96% on RA
Exam:
Gen: cachectic with temporal wasting
HEENT: conjunctival pallor
CV and Neuro: Normal
Pulm: decreased breath sounds at R base, no wheezes or rales
Abd: VERY distended, + fluid wave. Non-tender to palpation
Extremities/Skin: 3+ LE edema to thighs

Notable Labs & Imaging:
Hematology: WBC: 10.4 (normal diff) Hgb: 8.3 (baseline) Plt: 141 (baseline)
Chemistry:
Na: 138 K: 4.1 Cl: 110 CO2: 20 BUN: 57 Cr: 1.9 (baseline 2) Ca: 7.4 AST: 48 ALT: 52 Alk-P: 227 T. Bili: 0.8 Albumin: 2.8 T Protein: 5.1 INR 1.4 LDH 300 BNP 1200
Thoracentesis: pH 7.4, WBC 275 (40% PMNs), 20,000 RBCs, LDH 132, Protein 2.2, Glucose 122
Paracentesis: WBC (100 PMNs), Albumin 0.4 (SAAG 2.4), Protein 2.5
Culture, gram stain, cytology negative from chest/ascitic fluid
UA specific gravity 1.014, 3+ protein, 1+ blood, 10 RBCs (no dysmorphic RBCs), no casts. Urine Pr/Cr 13.5
Imaging:
CXR: enlarged cardiac silhouette, bilateral airspace opacities (suggestive of pulmonary edema), moderate R pleural effusion
Abd US with doppler: +cirrhosis, large ascites, decreased velocities with bidirectional flow in TIPS (suggestive of partial occlusion). No PVT, HVT
TTE (unchanged from prior): EF 55%, severe LV dilation, moderate MR, normal RV EF, RVSP 30 , LA presure 0-5 TIPS gradient 10 (normal <12)

Clinical Course: worsening Cr despite treatment for HRS. Additional labs sent: SPEP, UPEP, serum free light chains, HIV, Hep B/C, PLA2 Ab, ds-DNA, C3, C4, cryoglobulins, HbA1c normal
Renal biopsy: IgA nephropathy

Problem Representation:
60 yo M with a h/o cirrhosis s/p TIPS, HFpEF presenting with worsening dyspnea and abdominal distension found to have new mixed nephrotic syndrome.

Teaching Points (Andrea):
- Dyspnea: PE, ascites pushed the diaphragm, portal hypertension, portal pulmonary hypotension, alcohol cardiomyopathy, hepatocellular carcinoma
- 6F of abdominal distensions: Fluid, Flatus, Feces, Fetus, Fatal growth, Fat
- SAAG = serum albumin concentration minus ascitic fluid albumin concentration. SAAG correlates directly with portal pressure for SAAG ≥ 1.1 g/dL suspect portal hypertension, most likely due to cirrhosis
  -Low protein (< 1) chronic liver disease massive hepatic metastasis
  -N to high (> 2) cardiac disease, Budd-Chiari syndrome, veno-occlusive disease and myxedema
- Transjugular intrahepatic portosystemic shunt (TIPS) for patients with cirrhosis and refractory ascites
- Cirrhotic patients tend to have low BP
- Hepatic hydrothorax:Presence of a pleural effusion (usually >500 mL) in a patient with cirrhosis who does not have other reasons to have a pleural effusion 5 to 15 % of pts with cirrhosis. Pleural effusion of ascitic fluid. Most common in the RIGHT side
- Liver disease is the leading cause of secondary IgA Nephropathy. Immunoglobulin A nephropathy secondary to chronic liver disease is more often reported in adults with liver cirrhosis and portal hypertension.