11/4/20 Morning Report with @CPSolvers

***Case Presenter**: Brianna Coogle (@Breezy_Coogs) **Case Discussants**: Jessica Morales (@JessieMoralesM) and Dhruv Srinivasachar (@TheRealDSrini)*

CC: worsening abdominal pain for 4 weeks

HPI: 59 F presented with persistent L upper quad abd pain, L flank pain. Progressively worsened for 3 weeks. Dull, non radiating, 6/7 out of 10, worse with touch/movement of body. Could localize specifically to LUQ.
ROS: + nausea, - for all others (fevers, chills, CP, dysuria, melena, diarrhea)

2 wks prior, presented to ED for same CC. CT showed omental fat stranding and cholelithiasis. Surg did not rec surgery at the time

PMH:
- Heterozygous for prothrombin mutation, Dx during PE s/p 2 mo AC
- 15y ago gastric bypass (Roux-en-Y), B12 def, GERD
- Anxiety/Depression

Meds:
Omeprazole
B12 inj monthly
Fluoxetine
Ondansetron/Tramadol PRN

Fam Hx:
Brother- AFib
Daughter- NHL @24yo
Mother/Father- CA of unknown type

Soc Hx:reception

Health-Related Behaviors: smokes 1ppd x30y, no EtOH, no drug use

Allergies:none

Vitals: **T**: 37.3 **HR**: 61 **BP**: **146/84** **RR** 18: **SpO_2**: 98% RA
Exam:
Gen: nl / **HEENT**: nl / **CV**: nl
Pulm:nl
Abd: soft, non distended abd TTP in LUQ with mild guarding, no rebound. + BS throughout
Neuro: nl
Extremities/Skin: nl

Notable Labs & Imaging:
Hematology:
WBC: 4.3 Hgb: 14.7 Plt: 213
Chemistry:
CMP- nl / Trop: 0 ; CRP 1.32; D dimer 1163; lactic acid: 0.9
UA: nl; SARsCoV2- neg
Imaging:
CT A/P w and w/o contrast: area of linear soft tissue density that extended from the inferior aspect of the greater curvature of the stomach to an area of ill defined fat stranding in the L anterior omentum, w/ characteristic features of omental panniculitis
Enteroscopy/colonoscopy- no marginal ulcer, all anastamosis intact, gastric pouch not visualized, 5 colonic polyps removed, no inflammation/masses
Laparoscopy: extensive adhesions, omental lesion in location of pain
Omental Bx- poorly diff adenocarcinoma, signet ring cell features
Gallbladder Bx: focal serosal involvement by poorly diff adenocarcinoma
PET Scan- thickening of gastric pylorus, with periportal involvement
Final Dx: primary gastric adenocarcinoma with mets to omentum and gastric pylorus

Problem Representation: 59F w/ pmh gastric bypass Roux-en-Y, heterozygous prothrombin mutation p/w subacute, progressively worsening LUQ pain with laparoscopy notable for omental lesion and biopsy consistent with poorly differentiated gastric adenocarcinoma.

Teaching Points (Elena):
- **Approach to Abdominal Pain:** First think - is this life-threatening? (1) Anatomical location (using the four quadrants) (2) time course (3) Extra-peritoneal vs intraperitoneal (4) Quality of pain: visceral (luminal structures are stretched/ischemic) vs peritoneal/somatic (lining related, localized, sharp such as inflammation, mechanical) (5) "Exposures" - always consider meds, prior surgeries, hypercoag states
- **Blood clots+Abdominal Pain:** (A) Consider "Where" - arterial vs venous sides and (B) Consider "How" - (1) embolization: clots move from one place to another (2) in situ thrombosis such as acute ischemic colitis from spontaneous clot formation in a vessel
- **D-dimer:** inflammation or vascular insult? Can be helpful but also can be noise
- **Interpreting "fat stranding" and "soft tissue density" on CTAP:** Sterile inflammation, infectious inflammation or malignancy. Also considering atypical infections such as mycobacteria, prior anastamosis from surgery, lymphoma. Is there communication from the lumen to the extraintestinal space? Always feel free to talk with your radiologist!
- **Differential Diagnosis for Omental Lesions:** fat, lymph node and vessels as well as sites of metastases.
- In every patient, be aware of altered anatomy and how it might change their presentation