04/21/21 Morning Report with @CPSolvers

Case Presenter: *Rafael Medina (@Rafameed), HDx case by Kevin Grudzinski* ***Case Discussants***: *Anusha Chidharla and Kirtan Patolia (@KirtanPatolia)*

CC: hypertension, episodic epigastric pain

HPI: 60 year old F presents w/ concerns of high BP, epigastric and LUQ pain radiate to L flank - pain worse 1 hour after eating. Also has nausea, bloating, urinary urgency. BP high for 2 months 190/100
2 weeks ago - PCP started on nitrofurantoin for suspected UTI, increased valsartan 80 to 160 mg
Unintentional 10lb weight loss over 1 month. Denies chest pain, SOB, lower extremity edema, headache, bruising, change in BM, hematochezia

PMH:
HTN - well controlled
Fe def anemia
HLD
Asthma
Hep C antibody +
C-section
Colonoscopy 12 years ago -

Meds:
Albuterol
Furosemide
Valsartan

Fam Hx: Mother - colorectal cancer, father - liver cancer

Soc Hx: No tobacco, alcohol, recreational drug use

Health-Related Behaviors:

Allergies:

Vitals: **T**:36.7 **HR**: 81 **BP**: 219/112 **RR**: 15 **SpO$_2$**: 100% on RA
Exam: **Gen**: awake, alert, oriented x3
HEENT: No icteric changes or conjunctival pallor. No supraclavicular lymphadenopathy
Abd: nontender to superficial and deep palpation, no suprapubic tenderness, no CVA tenderness, no masses, no hepatosplenomegaly
Neuro: CNII-XII intact, 5/5 strength all extremities, no motor or sensory deficits
Extremities/Skin: No bruising, petechiae, bleeding, jaundice, or rash

Notable Labs & Imaging:
Hematology: WBC: 6.04 Hgb: 11.2 MCV 91 Plt: 258
Chemistry:
Na: 140 K: 4.0 Cl: 107 CO2: 23 BUN: 14 Cr: 0.87 glucose: 83
AST: 11 ALT: 11Alk-P: 74 T. Bili: 0.4 Albumin: 3.4 TP: 7
INR 1.02
U/A - neg nitrites, leuk est, no bacteria, WBCs, RBCs
CEA 2 (L), AFP 4.5 (nl), CA 19-9 195 (H)

Imaging:
CT chest: borderline enlarged L supraclavicular lymph node
CT A/P: well-defined soft tissue density periportal, severe narrowing of portal vein that extends medially to encase the celiac and SMA origins.
MRI abdomen w/o contrast: large soft-tissue mass lesion centered within the portohepatic and suprapancreatic head with encasement of multiple vascular structures
Endoscopy, FNA biopsy - pancreatic adenocarcinoma
Final Diagnosis: pancreatic adenocarcinoma

Problem Representation: 60 year old F with hx of HLD, HTN presents with a month of post-prandial LUQ and epigastric pain in the setting of weight loss and worsening HTN.

Teaching Points (Sukriti):
Hypertension: Identify whether true true and related to the clinical syndrome
-Base rate favors Primary HTN; Important to consider social factors that may influence disease, however a sudden change in the course of a disease must prompt further investigation into additional etiologies at play.
-Secondary HTN: kidney: Vascular vs parenchymal (fibromuscular dysplasia, glomerular process, vasculitic, renal artery stenosis), Endocrinopathies (Thyroid, Hyperparathyroid, pheochromocytoma, Cushings), Meds (Steroids, OCP), Drugs (Alcohol, Cocaine), Thorax
-The absence of the acute worsening of HTN should not dissuade one from considering life threatening etiologies like dissection that may present chronically as a pseudoaneurysm -> mesenteric angina
- Asking "who is this patient" can help prioritise the differential Dx
Episodic epigastric pain
-Anatomical approach: Musculoskeletal, Visceral (stomach, pancreas, small bowel, liver, gallbladder, spleen), Vascular
-"Eating, the stress test of GI system": Pathologies of the pancreas, hepatobiliary, upper GI, abdominal wall, vascular
-Absence of tenderness prioritizes >> vascular, hepatobiliary causes
-It is helpful to revisit a diagnosis made in the past before incorporating it into the PR as it may falsely alter how you frame the clinical syndrome
- Tumor markers - Important to understand in the clinical context, may be helpful in monitoring response to malignancy not necessarily Dx one.