1/20/22 Morning Report with @CPSolvers

Case Presenters: *Ori Lieberman (@OriLieberman)****Case Discussants***: *Sharmin (@sharminzi) and Rabih (@rabihmgeha)*

CASE 1

Summary of the case:

- 47 y/o M two months of low back pain
- Three ED visits in the last three months. First visit 3 months ago, presented for N/V for 24 hours. Lipase just above upper limit of normal. US of abdomen showed fat stranding, presumed pancreatitis. Over last month two ED visits for back pain, normal labs, sent home with oral pain control. Now unable to get out of bed, diffuse weakness, weight loss. No bladder or bowel incontinence
- ROS: Neg
- PMHx: Neg, No meds
- Social Hx: born in Mexico, came to the US twenty years ago
  Lives with daughter son and wife

Important findings from exam:

- Vitals signs WNL
- Alert and oriented. Diffuse weakness. Tender spots midline over back. Neurological exam normal, weakness equal throughout with giveaway in UE and LE

Important labs/imaging:

-BMP: Creat 1.03 from 0.7. CBC WBC 7.1, Hgb 9.7 MCV 70, Plt 330.
-Albumin 3.2, Normal ALT/AST, Calcium of 12, Alk phos ofl 245, total protein 7.2, PG is 4
- CT: lytic osseous lesions throughout spine, ribs, sternum
- Bone Scan:
- PTH: low PTHrP was normal, SPEP: hypoalbuminemia
CT Abdomen pelvis: enlarged peritoneal lesions, normal liver
CEA was 3x ULN
CT chest shows 2 nodules 5mm in RLL with mediastinal and hilar lymphadenopathy
1,25 Vit D normal
Biopsy: Gastric Adenocarcinoma

Teaching points (Brodie):

-MSK apparatus (Resist the reflex), cord, retroperitoneal structures (aorta, pancreas(Lipase>Amylase sensitive), urinary system).
- Temporality, progression, other associated symptoms including signs of inflammation.
-Red flag signs: acute flare of chronic back pain
-Duration of pain in chronic back pain is not useful. PROGRESSIVE PAIN is a massive red flag. -CT results much faster, so go ahead and get it.
-A MCHC is iron deficiency anemia unless proven otherwise.
-Primary hyperparathyroidism can be aggressive.
-Lytic bone lesions: MM, Mets, Hyperparathyroidism, Infection (Brucella, Bovis), hemangioma, fibrous dysplasia, enchondroma, osteochondroma,
-MM very rarely causes ALP elevation.
-Three tumors from GI can bypass the liver- rectal, cancers of unknown primary,
-¾ bone mets: Breast, prostate, lung, kidney -mets or PTHrP related process (lung)
-CEA elevation: colorectal ca, primary ovarian carcinoma, breast, thyroid, NSCLC, **smoking,** append/chol/panc -itis, cirrhosis, orlistat
-Sarcoid can affect the GIT- 1,25 Vitamin D.
-Linitis plastica: The diffuse-type adenocarcinoma is typically found in women, often <50 years old. This form of adenocarcinoma is not associated with environmental factors. The diffuse-type adenocarcinoma has a worse prognosis than the intestinal-type adenocarcinoma. Spread of diffuse-type adenocarcinoma to the peritoneal cavity occurs frequently. Leather bottle appearance. E-cadherin mutation.