5/25/22 Morning Report with @CPSolvers

Case Presenter: *Kevin Grudzinski (@Alert_Oriented3)* ***Case Discussants***: *Jack Penner (@jackpenner) and Sharmin Shekarchian (@Sharminzi)*

CC: 78 y/o male 7 weeks abdominal pain and distension

HPI:

- Denied confusion, new medication, any skin change, hematemesis, melena,

PMH:
Alcohol use disorder started at 20 years stopped 2 months ago, HTN
DBT 2
Appendectomy 2 years ago

Meds:
None

Fam Hx:
None

Soc Hx: Lived in US but currently lives in Guatemala

Health-Related Behaviors:
Stopped drinking 2 months ago

Allergies:
None

Vitals: **T**: **98.8 F** **HR**: 93 **BP**: 129/78 **RR**: 18 **SpO_2**: 99%l
Exam:
Gen: Awake, alert, Anicteric sclera
HEENT, CV, Pulm: Normal
Abd: Distended, non tender, + fluid wave, no mass, no stigmata of cirrhosis
Neuro: AOx4, no focal deficits, no asterixis
Extremities/Skin: No lower extremity edema

Notable Labs & Imaging:
Hematology:
WBC: 7.71 Hgb: 12 (L) Plt: 362
Chemistry:
Na: 138 K: 3.7 Cl: 102 CO2: 27 BUN: 9 Cr: 0.73 glucose: 178 Ca: PT-INR 1.08 AST: 17 ALT: 11 Albumin: 3 Protein 7.1
Imaging:
CT abd w/ contrast: Cirrhotic liver with sequelae Portal Hypertension, including as ascites/ splenic varices and large volume abdominopelvic ascites. Loculated cystic lesion measuring up 13.6 cm in the left lower quadrant and extending into the pelvis. This lesion abuts bothe the sigmoid colon and the posterior aspect of the urinary bladder.
Paracentesis: The patient underwent IR paracentesis w/ 400 cc extremely thick gelatinous fluid aspirated from the LLQ loculated collection. 40 cc of similar fluid was aspirated from RLD free peritoneal collection. There was extreme acellularity in the cytology report and thus no conclusive interpretation could be drawn. Color fluid: Slt Xantho. Clarity Fluid: Cloudy. Gross blood fluid: Slight. WBC 400 RBC 1078 Seg fluid 22 Lymphocytes 14 MONONUCL flui 64 F/ MISC cells: 100
CA19 54 **CEA** 24.4
Colonoscopy: Normal. **Liver Biopsy** Portal and peritoneal fibrosis, no cirrhosis. **Peritoneal biopsy** 4.5l mucinous ascites. **Pathology:** extravasated acellular mucin. **Appendix:** low grade appendiceal mucinous neoplasm with acute perforated appendicitis, the margins appeared clear.
Dx: **Pseudomyxoma peritonitis due adenocarcinoma**

Problem Representation: 78 y/o male present w/ chronic abdominal pain and distension. PMH: Alcohol use disorder. Abd examen + fluid wave. CT: ascites/ splenic varices and a cystic of 13.6 cm in the LLQ. Paracentesis: 400 cc of gelatinous fluid. CA19 and CEA elevated.. Appendix: Mucinous neoplasm and perforated.

Teaching Points (Alaa):
- **Distention** -> think about phases of matter is it **solids** (masses, constipation), **liquids**(ascites) or **gases** (IBD, IBS)?
- **Abd pain** -> 2 things to think about (*time course - location*)
- **Don't forget neighbours** -> **thorax** (pulmonary and cardiac) and **genitourinary**
- **Don't forget the never miss diagnoses VIPO+ectopic**
  - **Vascular** -> eg, mesenteric ischemia, inferior MI
  - **-itits** -> eg. pancreatitis, cholecystitis, etc
  - **Perforation** -> eg from PUD
  - **Obstruction** -> eg. SBO, LBO
- **DM** -> increased risk of *microvascular disease*, think about *gastroparesis*
- **Don't forget surgical complications like adhesions**
- ascites findings -> positive fluid wave on exam, confirm with imaging (eg, bedside US)
- **is ascites portal HTN related or not? Measure SAAG**
  - **Cirrhosis stigmata** -> **Portal HTN** (ascites) **hyperestrogenism** (palmar erythema, gynaecomastia) **coagulopathy** (easy bruising)
- **Chronic Alcohol use** think about alcohol related liver disease, pancreatitis
- **Early lab findings of cirrhosis** -> **thrombocytopenia** due to thrombopoietin deficiency, splenomegaly causing sequestration
- **Normal platelets and normal INR makes cirrhosis less likely**
- is the portal HTN **intrahepatic** (eg. shistomasiasis) **pre hepatic** (portal vein thrombosis) **post hepatic** (budd-chiari, constrictive pericarditis)
- Mass or cystic lesions -> cancer or infection?
- ***tumor markers like CA 19 helps to monitor cancer rather than diagnose it as many things that happen within the abdomen can raise it***
- In this patient -> risk for cancer (age, alcohol) risk for infections (epidemiology, DM)
- **what things can make their way from peritoneum to liver? - malignancy and infection**
  - infection -> you expect to see **evidence of infection** on biopsy (eg. granulomas with TB)
  - malignancy -> **abnormal fibrosis and mucin** that could be *mucinous adenocarcinoma* (ovarian and lung but also intestinal epithelium)
- **Gelatinous ascites -> mucinous material accumulation with pseudomyxoma peritonei**
- **framework -> low grade neoplasm that transformed to worse grade -> mets to liver**