9/5/24 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Ryan Salemme (@) **Case Discussants**: Rabih(@rabihmgeha) and Debora(@deboracloureiro)*

CC: 26 y female **postprandial epigastric pain** following a meal for **2 weeks**, worse w/ solid food, **stabbing** in nature, radiates to her back

HPI: Presented to urgent care clinic earlier, where she was started on **pantoprazole w/ no relief. H pylori** urea test pos. - no treatment started yet

Decreased BM but no diarrhea or constipation. Denies hematochezia or melena. Denies fevers, chills, weight loss, or night sweats

started on IV pantoprazole (**quadruple therapy** for H pylori)

PMH: no

Meds:

Fam Hx: CLL paternal grandmother & dad

Soc Hx: works at an office job, travelled to central america and Europe

Health-Related Behaviors: **smokes marihuana,** alcohol rarely

Allergies: no

Vitals: T: nl **HR:** 122 **BP:**121/81

Exam:

Gen: comfortable, well nourished, no toxic apparent, no fever/chills

HEENT: anicteric sclera, mucus membrane **dry**, no LAD

CV: tachycardic, no murmurs gallops, no LEE

Pulm: nl

Abd: soft non distended, **mild tenderness** epigastric, no rebound, garding, no organomegaly, decreased bowel movement, no hematochezia

Neuro: nl

Extremities/skin: nl

Notable Labs & Imaging:

Hematology:

WBC: 9.23, neutrophilic predominance, Plt 409

Chemistry:

Na: 147K: 4.4 Ca 9.3 BUN: 10 Cr: 0.9

LFTs: wnl, Lipase 3755, Lk 7.9

Urine: Protein and trace ketones, no pyuria

Imaging:

CT: large invasive infiltrative mass: 14.3cm, invades left hepatic lobe, spleen and pancreas, peritoneal metastatic disease

upper endoscopy tumor from cardia w/ biopsy, mass in lesser curve duodenal bulb nl

Biopsy : monoclonal B lymphocytes CD 19 CD 20, neg. H pylori

Dx: high grade large B cell lymphoma, germ centre subtype

Problem Representation: young female presents with transient epigastric pain associated w/ sinus tachycardia and decreased bowel movement was found to have a pos H pylori test w/ no relieve on pantoprazole. Labs were notable for elevated Lipase, Lactate and Calcium

Teaching Points (Sohil):

I) Clarify if really postprandial pain, which is strictly defined as "pain after eating." Is her pain strictly postprandial or not? True postprandial: r/o ectopic pregnancy, VIPO (vascular, ischemia, perforation, obstruction). Common causes of postprandial: gallbladder, stomach, pancreas. "Radiating to back": pancreas

II) Whenever pain is triggered by something (exertion, eating, etc.), there is no fingerprint when no trigger is present. Tachycardia = suspicion for non-trigger-induced pain.

III) H. pylori: most asymptomatic, although associated w/ 2 cancers: MALT lymphoma and GI adenocarcinoma. Decreased BM most probably noise but c/f space-occupying lesion d/t gastrocolic reflex

IV): Elevated lipase. Lipase can be falsely elevated in 2 K's (urine ketones, kidney injury), but 2 wk time course is not c/w pancreatitis.

V) Pancreatitis: Common causes (think 2 S'): substance (alcohol) or structural (gallstone, mass). CT scan for diagnosis (atypical presentation) or etiology/ consequence. Here, 2 of 3 diagnostics positive (epi+back pain and +lipase). Management: fluids, fluids, FLUIDS (in first 24 hrs) and gradual intro of diet and pain control (keep NPO initially)

VI) Malignancy: GI adeno (most common), MALT, or GIST (GIST does not spread typically). Large size, locally invasive (not hematogenous), and well-appearing more c/w GIST

VII) Large B-cell lymphoma also associated with H pylori