



# 10/7/24 Morning Report with @CPSolvers



“One life, so many dreams” Case Presenter: Mark Heslin (@Mark\_Heslin) Case Discussants: Maddy (@MadellenaC) and Youssef (@saklawiMD)

**CC:** 68 yo female 2 month of abdominal distension and 1 day of generalized weakness

**HPI:** ED: abdominal distension developed slowly progressed over time, whole body weakness even at rest, known dyspnea on exertion (duration unknown), pertinent negatives: no dyspnea at rest, no PO intake problems, bowel movement regular, no bleeding, hematochezia, hematemesis, no weight gain

**PMH:** ESRD w/ intermittent dialysis TTS, HFrEF (EF 30-40% w/ severe TR 2 mo ago), AFIB, HT, preDM

**Meds:** Apixaban 5 BID, Calcium supplement, Lisinopril, Metoprolol

Transfusion of 1 unit blood; Andexanet alfa

**Fam Hx:** no

**Soc Hx:** has a dog  
No smoking, drinking

**Health-Related Behaviors:**

**Allergies:** no

**Vitals:** T: afebrile HR: 69 -> 110s BP 117/80 RR: 99% on Ra  
**Exam:**

**Gen:** tired appearing, eyes closed, little somnolent

**HEENT:** significant conjunctival pallor

**CV:** tachycardic, irregular regular, no murmurs

**Pulm:** normal effort, thin crackles at the basis

**Abd:** tense and hard, no pain, ascites, no organomegaly

**Neuro:** oriented 2x, no focal neurological deficits

**Extremities/skin:** warm well perfused, no edema

### Notable Labs & Imaging:

#### Hematology:

WBC: 5.2 Hgb: 4.3 (baseline 11) Plt: 175 MCV 102 (baseline 84)

Ret. count: abs. 123,000, rel. 8.8%; Ferritin 1140, Transat 15%,

VitB12 962, Haptoglobin 105, LDH 274, D-dimer >20, INR 1.9,

#### Chemistry:

Na: 137 K: 4 Cl: 94 HCO3: 19 BUN: 35 Cr: glucose: Ca: 9.9 Mag:

AST: 52 ALT: 14 Alk-P: Albumin: 3.8 bili total 1, protein 8

#### Imaging:

**EKG:** Irregularly irregular rhythm

**CXR:** bibasilar atelectasis

**CT abdomen.** large volume ascites, higher density, mildly dysmorphic liver (no clear signs of cirrhosis), hyperattenuation liver- mass 8.5 x 8.2 cm

**CTA triple phase:** highly suspicious for HCC w/bleeding into the peritoneum

**Dx:** HCC w/ Hemoperitoneum

-> Transarterial chemoembolization (TACE procedure)

**Problem Representation:** A 68 yo female w/ESRD on intermittent dialysis, HFrEF and Afib on Apixaban p/w a 2 month history of abdominal distention and generalized weakness. The patient was afebrile, tachycardia and somnolent on exam. No pain, weight changes, hematochezia or changes in bowel movement. Labs revealed a severe macrocytic anemia w/ elevated LDH, d-dimers and reticulocyte count. A CTA was performed and revealed large volume ascites and a hyperattenuated liver mass.

### Teaching Points (Parisa):

**Abdominal distention** → liquid (ascites/blood hemoperitoneum/urinary retention; solid organomegaly; gas obstruction) → bladder scan; signs of chronic liver dx; ultrasound looking for fluid → Most common subacute picture: cirrhosis portal HTN vs non Portal HTN; HF worsening dyspnea on exertion and weight gain/ No miss: obstruction

**Differentiating weakness** → asthenia vs neurological lesion

**Anemia:** bleeding (GI tract/internal bleeding); hemolysis (low haptoglobin elevated LDH elevated indirect bilirubin); underproduction (BM involvement → multiple cell lines are low) → rate of drop is important → Smear; retic count/percent; ferritin could help us framing

Markers of cirrhosis: low (Plt/ Albumin/ haptoglobin)

Actively hemorrhage is accompanied by tachycardia

**ESRD** elevates the risk of erythropoietin deficiency and underproduction. Peritoneal dialysis might lead to abdominal distention.

**Macrocytic anemia:** megaloblastic impaired DNA synthesis (B12 folate deficiency) vs non megaloblastic alcohol; liver dx; hypothyroidism. Up to 20% of Myeloma cases could present with macrocytic anemia.

Copper deficiency can manifest microcytic macrocytic normocytic anemia.

**Ferritin** cut off for patients with HF & dialysis is higher.

High ferritin plus low transferrin saturation → anemia of chronic disease

Low ferritin plus low transferrin saturation → Iron deficiency anemia

**The most common causes of ascites** → cirrhosis; cancer; CHF

**Liver mass** → malignancy (hepatocellular carcinoma; even w/o cirrhosis no need to bx imaging would be enough); benign focal nodular hyperplasia; metastasis; hemangiomas; bacterial abscess bartonella; giant cell arteritis

Hepatitis could convert HCC w/o intermediate step of cirrhosis.

Reverse apixaban: andexanet alfa