



# 11/01/24 Morning Report with @CPSolvers



“One life, so many dreams” Case Presenter: Umbish Dino (@UmbishD) Case Discussants: Rabih (@rabihmgeha) and Reza (@DxRxEdu)

**CC:** 44 y/o male w/ 2 month history of nausea vomiting and weight loss

**HPI:** 2 month ago, sudden onset daily severe nausea and vomiting which progressed to abdominal distention (dx as ascites of unknown origin in outside hospital, no improvement of symptoms after discharge). Developed solid food intolerance as disease progressed. ROS: persistent nausea and vomiting with developing intolerance to fluids after a while, weakness and lethargy, severe functional impairment. Abdominal distention, no fever, no chills, etc.

**PMH:** No pertinent PMH

**Meds:** Furosemide  
Ondansetron  
Spironolactone

**Fam Hx:** Uncle with alcoholic cirrhosis  
**Soc Hx:** Moderate drinking history, some history of smoking and marijuana.  
Stopped all with beginning of illness  
**Health-Related Behaviors:** No recent travel history, has worked in roofing for many years  
**Allergies:** Denied

**Vitals:** T: afebrile overall HR: 104 BP: 120/84 RR: 16 sat 99% RA  
**Exam:** BMI 18  
**Gen:** severe temporal wasting, marked muscle wasting, cachectic  
**HEENT:** no LAD CV: normal  
**Pulm:** lungs clear no wheezes  
**Abd:** diffusely stiff abdomen, rigid abdomen, active bowel sounds, no distention, no tenderness or rebound  
**Neuro:** normal  
**Extremities/skin:** severe muscle wasting in upper and lower extremities

**Notable Labs & Imaging:**  
**Hematology:** WBC: Hgb: 11.9-12.9 hct 36 Plt: 217k  
**Chemistry:**  
Na: fluctuating 127 - 137 K: 2.8-4 BUN: 32 Cr: stable glucose: stable  
AST: nl ALT: nl Alk-P: ~230s Albumin: 3.5 Bili nl  
Hep panel, TB, and HIV all neg  
Ceruloplasmin high (37), tumor markers CEA 7.7 CA-125 high C19-9 high  
Iron 38, TIBC 215, Iron sat 14%  
Ascitic fluid tap -> protein 3.3, LD 223, Albumin 2.0 SAAG ratio 1.2

**Imaging:**  
**Echocardiogram:** nl  
**CTAB with IV contrast:** Diffuse small bowel and stomach wall thickening, bowel wall edema, ascites  
**Endoscopic sono:** esophagitis, hiatal hernia, chronic gastritis, edema prevented proper imaging, diffuse abnormal echotexture of liver  
**EGD:** inflammatory gastropathy, no evidence of malignancy and no H. pylori, gastric heterotopia  
**liver biopsy:** Unremarkable, **MRI head:** unremarkable  
**PET-CT:** suspicion of GI malignancy, abdominal cocooning, encapsulating peritonitis  
**Biopsy:** gastric signet ring adenocarcinoma

**Dx:** abdominal cocoon syndrome 2/2 signet ring adenocarcinoma

**Problem Representation:** 44yo male who presented with 2month history of nausea, vomiting, weight loss and abdominal distention which lead to the final diagnosis of abdominal cocoon syndrome secondary to gastric signet ring adenocarcinoma

**Teaching Points (Ethan):**  
Nausea is a nonspecific symptoms and prompts us to look for more specific symptoms, when combined with vomiting it points to gastrointestinal pathology but should consider broadly until a pivot point emerges.  
Ascites: consider mechanism. 1) leakage from vessels due to elevated hydrostatic pressure/decreased oncotic pressure (transudate) 2) leakage of inflammatory exudate. The former causes weight gain (volume overload state, e.g., cirrhosis, HF), and the weight loss here points the underlying inflammatory nature and suggests the ascites to be exudate. -> look for SAAG, neutrophil counts and culture of ascites fluid. (Could use I-made mnemonic for helping ddx)  
\*\* Before starting diuretics need to figure out the underlying disease process (not effective for exudative ascites)  
The significant weight loss points to severe disease process. The relatively normal BP suggests against portal hypertension. Diffuse abdominal disease => luminal disease/peritoneal disease. Subacute peritonitis? Alk-p-> needs to correlate with GGT for its origin. Could represents of infiltration in liver.  
DDx for isolated diffuse bowel wall thickening => very rare, usually there are extra-GI signatures, e.g., eosinophilic gastroenteritis, lymphoma, infiltrative disease like IgG4-RD, etc. Also needs to consider nephrotic syndrome manifesting as bowel wall edema.  
Consider subserosal/peritoneal pathology with the negative EGD and luminal studies -> MRI, exploratory laparotomy  
Abdominal cocoon syndrome (ACS), also known as sclerosing encapsulating peritonitis (SEP), is a rare condition that causes intestinal obstruction by encasing the small bowel in a fibrocollagenous membrane.