03/28/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Dr. William Lippert (@wclippertMD) Case Discussants: Rabih (@rabihmgeha) and Reza (@DxRxEdu)

Scribing (David)

CC: 65 year-old female with 8 week of abdominal pain, 20 pound weight gain, dyspnea on exertion with orthopnea

HPI: The abdominal pain was intermittent, dull, mostly in RUQ, but sometimes diffuse, not associated with food.
Her weight has been stable for 5 years (150 pounds), but in the last 8 weeks the abdomen has become more distended (170 pounds). Also endorses poor appetite and early satiety.
No changes in urination or bowel movements.
The reason to come now is that the dyspnea progressed to inability activities of daily live. She felt that CPAP may need to be adjusted.

PMH:
CAD, T2DM controlled with diet (HbA1c 5%), HLD,
OSA on CPAP
Cholecystectomy at 45

Meds: atorvastatin,

Fam Hx: HTN and MI in father part

Soc Hx: lives in North Carolina. Works at a furniture store.

Health-Related Behaviors: former smoker (quit 10 years prior), previously 1 pack-year.
No alcohol.

Vitals: T: 98.4 F **BP:** 132/85 **RR:** 16 **HR**: 90 **Sat:** 94% on RA **BMI:** 32
Exam: Gen: not in distress
CV: RRR, normal S1 and S2, no S3, no murmurs, no JVD,
Lung: normal
Abd: distended, positive bowel sounds, + fluid wave and shifting dullness
Neuro: no asterixis, no sensory deficit , no weakness
MSK: trace bilateral pitting edema
Skin: no rashes or stigmata of liver disease

Notable Labs & Imaging:
Hematology:
WBC: 9 Hgb: 12 Plt: 449k

Chemistry
Na: 138, K: 3.8, Cr: 0.4, Ca: 9, TP 7.0, Albumin 3.5, Br 0.7, AST 19, ALT 16, Alk Phos 137 (< 105) Lipase 18, BNP 24, INR 0.9
Paracentesis: 467 nucleated cells (24% PMN, 16% L, 57% Mono, , Eos 0%, Eos 0%), protein 4.5, albumin 3.9 (SAAG 0.4), cytology: , cultures:
CEA: 40 (high) CA19-9: >19.000 (high) CA-125: 668 (high)

Imaging:
EKG: normal SR without abnormalities
CXR: no evidence of cardiopulmonary disease
POCUS: large volume ascites
CT CAP: bilateral lung nodules. Ascites. Ovaries and uterus normal. Spleen normal. 2 cm mass in right lobe of the liver.
-> biopsy of liver lesion: moderately-poorly differentiated adenocarcinoma with mucinous features. Unknown primary.

Dx : Stage IV Adenocarcinoma

Problem Representation: 65 yo female with PMH of CAD, T2D and HLD presents with 8 weeks of abdominal distension, weight gain, DOE and orthopnea. Found to have ascites with low SAAG. CT revealed liver mass. Biopsy confirmed mucinous adenocarcinoma (unknown source).

Teaching Points (Minahil):
->**Abd pain:** localizing abd pain based on quadrants helps narrow DDx-RUQ-hepatobiliary , LLQ-diverticulitis
->**Wt gain:** 1.cal intake ,2.fluid retention (orthopnea-> suggesting thoracic pathology- lt sided heart dysfuncopd)
->CAD-HLD-T2DM-these conditions are components of **metabolic syndrome** assoc with non alcoholic fatty liver disease and Wt gain
->Fluid retention often correlates with HTN,but normal BP does not exclude CKD
->Ascites helps differentiate from other other causes of **abd distension** intraluminal process(bowel obstruction)or space occupying lesions in abdomen/peritoneal (tumor,cyst) or accumulation of solid/liquid
->A **mass effect** from focal lesion or excessive fluid can compress
1. stomach-early satiety , 2.diaphragm-resp compromise

Approach to Ascites
->**Examination:***Pos findings* rule in disease but *neg findings* do not rule out the disease
->Differentiating causes of Ascites
Peritoneal related or *organ* related → 1.Heart- JVD/S3 , GYN-Meigs syndrome,(*triad of ovarian fibroma,ascites,pleural effusion)*-ascites should resolve after tumor removal,or can be 3rd category where ascites is due to *leakage of fluid*-chile/urine/CSF
->**SAAG:** *high*(>1.1g/dl) suggest portal HTN,often assoc with wt gain *low*(<1.1) suggest non porta causes and often assoc with wt loss
->**Paracentesis:**Essential for diagnosing the cause of ascites, guiding management, and ruling out SBP-which can be asymptomatic in 25% of cases.