5/15/25 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Anna Jarvis MD (@) **Case Discussants**: Gregory Kirshen MD PhD (@) and Bobby Brar (@)*

Scribing (SEEME)

CC: 30yo G3P0111 at 10w0d presented to L&D triage for lower abdominal pain and dysuria for 2 days.

HPI:
Benign exam. BSUS performed at visit demonstrated singleton pregnancy with FHR 170 bpm and large volume, simple-appearing ascitic fluid throughout her abdomen with floating loops of bowel.

ROS: normal

PMH:
-1 prior C-section (midline vertical incision)
-Right oophorectomy after ovarian cyst (benign)

Meds:

Fam Hx:
non-significant

Social Hx:
non-significant

Health-Related Behaviors:
non-significant

Allergies:
NKDA

Vitals: T:nl BP: nl **HR**: nl **RR:** nl **Sat:** nl **BMI:** nl
Exam: Gen: well oriented
HEENT: nl
CV: no murmurs, normal rate and rhythm
Pulm: nl
Abd: nl
Neuro: nl
MSK: nl

Notable Labs & Imaging:

Hematology:
WBC:nl Hgb: nl Plt:nl MCV:nl
UA: consistent with UTI, 1+ protein
Chemistry
Electrolytes normal
Imaging:
TTE: normal
CXR: mild cardiomegaly
Abdominal US:
moderate volume of simple appearing ascites in the right greater than left lower quadrant, otherwise normal liver size (14.8 cm) and echogenicity, normal gallbladder and CBD, and patent main portal vein.
Paracentesis: SAAG <1.1 and total protein 5.4 (exudative ascites)
Culture: gram positive cocci (suspect skin contamination)
Fluid cytology, CEA and AFB tests: negative
TVUS: ascites, absence of right ovary, cfDNA: negative for malignancy
CTAP:bilateral corpus luteum cysts, presence of ascites, mild pleural effusion
Pregnancy was uncomplicated with recurrent UTI. She presented at 39w3d with painful contractions and cervical change.Decision was made to proceed with delivery via CS and was uncomplicated.
CS Operative findings: small yellow serous ascites, red pinpoint lesions on uterus indicative of endometriosis, left ovary with 2 cm cystic structure.
Ascites resolved after surgery.

Dx : Ovarian cyst with ascites of unknown origin

Problem Representation: 30 yo G3P0111 at 10 weeks presented with abdominal pain and dysuria. Abdominal US and paracentesis showed low SAAG ascites. Corpus luteum cyst was found.

Teaching Points (Sawsan):

Approach to CC:
- Think obstetric & non obstetric causes
- Dysuria + abdominal pain make us prioritize GU over upper Gi causes.
- OB causes of abdominal pain: threatened misscaarriage , uterine cramping,.... Ask about associated bleeding, nature of the pain? Similar like period cramping?
- Also rule out ectopic pregnancy
- Recent surgery + ascites + dysuria = possible bladder injury causing urinary ascites .
- Objective data can help you narrow your ddx on whether its a obstetric vs non obstetric cause.

Ascites :
- Low SAAG <1.1: points **away** from portal htn / making malignancy or infections like TB more likely.
- Ascites can be seen in pregnancy in pre eclampsia
- This patient's ascites was at its worse during the peak of b-hcg, so this could be an explanation especially after it resolved after pregnancy .

Corpus luteal cyst:
- Expected to be seen in pregnancy .
- Usually revolve around 12 weeks, its there to support the development of pregnancy.
- Having bilateral corpus luteal cysts with hx of oophorectomy should raise suspicion for having ovary remnants, a newly growing mass,..?

cfDNA:
Most likely malignancies that are picked up on are lymphomas and leukemias rather than solid tumors.

Take home message:
Never assume anything , always double check, confirm , and exclude.