



# 6/24/25 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Anmol (@anugrewal19) Case Discussants: Dr. Ravi (@rav7ks) and Kirtan (@KirtanPatolia)

<p>Scribing (Lera)  <b>CC:</b> fever for 4 days  <b>HPI:</b> 74 y/o M presented to ED due to low grade fever for 4 days. Also noticed <b>decreased appetite</b> for 3-4 months, generalized body weakness and nausea. Unintentional <b>weight loss</b> of 20 kg / 6-8 months.</p> <p><b>ROS (-):</b> No abdominal pain, cough, night sweats, no loose stools, no dysuria, no rashes.</p>	<p><b>PMH:</b>  T2DM  HTN  CAD -&gt; MI managed medically (2022)  post-COVID</p> <p><b>Meds:</b>  Rosuvastatin  Sapitrin  Bisoprolol  Isosorbide dinitrate  Hydralazine  Omeprazol  Gliclazide</p>	<p><b>Vitals:</b> T: afebrile <b>BP:</b> 130/80 <b>HR:</b> 90 <b>RR:</b> 22 <b>Sat:</b> 96% on RA  <b>Exam:</b> <b>Gen:</b> conscious, AO x 3  <b>HEENT:</b> PERRLA <b>CV:</b> no JVD, unremarkable <b>Pulm:</b> unremarkable  <b>Abd:</b> soft, distended w/ shifting dullness, non tender <b>Neuro:</b> nl <b>MSK:</b> nl</p> <p><b>Notable Labs &amp; Imaging:</b>  <b>Hematology:</b> WBC: 7600 (neutrophils 80.7) Hgb: 12.8 Plt: 174K MCV: 89</p> <p><b>Chemistry:</b> Na: 133 K: 4.9 Cr: 1 BUN: 45 Ca: 8.6 Ph: 2.6 Mg: 1.9 <b>CRP:</b> 122.7 <b>ESR:</b> 55 <b>LDH:</b> 327 <b>AST:</b> 113 <b>ALT:</b> 42 <b>ALP:</b> 292 <b>Bili:</b> 2.7 (direct 0.9) <b>Procalc:</b> 0.41  T. prot: 7.3 Albumin: 3.2 Vit B12: 182, <b>Vit D:</b> 2.68 (low) TSH: 3.15 A1c: 7.8%  <b>UA:</b> trace protein <b>BCx:</b> negative <b>PSA:</b> 0.19 <b>Cholesterol:</b> 194  <b>Echo:</b> regional wall motion abnormalities with mild aortic regurg, EF 46%</p> <p><b>Hapto:</b> 140.8 (nl) <b>PBS:</b> no evidence of hemolysis, WBC and plt nl in size and morphology, no parasites seen. <b>G6PD:</b> normal. <b>CEA:</b> nl. <b>CA19-9:</b> 32.4  <b>ID workup:</b> IgM Dengue, Leptospira, Scrub Typhus negative. IGRA negative. HIV, HCV, HBV negative. P. falciparum and vivax negative. <b>Ascitic tap:</b> MNC 90%, neutrophils 10%. TLC 45, RBCs 0, amylase 50, lipase 138. Glucose 222. Protein 0.5, LDH 29. Fungal, AFB and Gram smears neg. ADA 2.49. SAAG 1.1</p> <p><b>US abdomen:</b> irregular liver outline, coarse echotexture, <b>heterogeneously hyperechoic lesion</b> 6.7 x 6.1 cm in segment VII of right lobe. Bile ducts not dilated, <b>echogenic contents in portal vein</b> (thrombotic likely), pancreas nl, spleen nl, both kidneys nl, omentum thickened with evidence of <b>omental caking</b>, a lot of free fluid.</p> <p><b>AFP:</b> 150K. PIVKA-2: 2K (both high). <b>Triphasic CT:</b> liver shrunken, dysmorphic, irregular. <b>Lesion 7 x 6 x 7 cm</b> in VII, VIII segments, arterially enhancing with washout on delayed phase seen, <b>extension to portal vein</b>, hypodense filling defect in splenic vein. Multiple dilated collaterals. Gallbladder, spleen, pancreas looked nl. Free fluid in abdomen and bl pleural effusions. LI-RADS V. <b>EGD:</b> varices.</p> <p><b>Dx:</b> angioinvasive HCC 2/2 cirrhosis and portal hypertension.</p>	<p><b>Problem Representation:</b> A 74 y/o gentleman presented with acute fever on the background of subacute anorexia and weight loss. Was found to have ascites with borderline SAAG. Imaging showed cirrhotic liver with single lesion consisted with HCC complicated by PV invasion.</p> <p><b>Teaching Points (Krihika):</b>  Causes of fevers- Pneumonia, UTI, Skin/soft tissue, GI causes M/C- could be Bacterial, Viral, If long term fever-Malignancy, Endocrinopathy, Vasculitis  Unifying diagnosis or complication  Chest X Ray, CBC, U/R/M  Cytokines- TNF Alpha, IL-6-affects Hypothalamus- Malaise, loss of appetite  ?Indolent neoplasm- Solid/Hematological  Loss of appetite- GI tract abnormalities, Obstruction, Compression-due to liver infiltration, motility disorders  Acute on Chronic picture- Immune system affected  Weight loss- 2 key aspects- due to decreased appetite or decreased absorption  Any inflammatory process like malignancy- normal appetite but increased catabolism; Any dysphagia, poor dentition- decreased appetite  Poor absorption- Malabsorptive disorder  Immunocompromised, Any occupational exposure- risk for Malignancy  Distention of abdomen- fluid, faeces, malignancy, obstruction  Non Malignant- Cirrhosis, Ascites  Malignancy(solid)- Malignant ascites, lymphomas, splenomegaly, hepatomegaly  Hematological- Myeloproliferative disorders causing organomegaly  Leukemias- CLL likely at this age, AML if leucocytosis+  ?Occult Hemolysis- indirect bilirubin high- if not could also be liver dysfunction- failure to conjugate  Portal HTN- Hepatobiliary or pancreatic malignancy, ?metastatic- gastric, pancreatic, Cirrhosis from metabolic risk factors-could be cause for HCC  Increased vit d- granulomatous disease- sarcoidosis, fungal, lymphomas  Exogenous vit d excess.  IGRA- could have false positives and negatives- needs definitive testing- ascitic fluid analysis, CA 19-9- Marker of pancreatic CA- non specific, ALP high- affected biliary canaliculi  Echogenic content in portal vein-? foreign body, thrombus, parasites, tumor extension  HCC mostly occurs in the background of cirrhosis, could also be de novo  Triple Phase contrast CT- HCC, Metastasis, benign liver tumor  Portal vein thrombosis- M/C/C- cirrhosis, tumor thrombus  Omental lesions need to be evaluated- exploratory lap- to know content- primary or mets  Triple phase CT- liver normally enhances in the venous phase whereas the tumor will enhance in the late venous phase as it derives its blood supply from artery.</p>
--	--	--	--