6/26/25 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Seeme Rukh* **Case Discussants**: *Rabih Geha and Zakariyya Gardee*

Scribing (Anmolpreet)
CC: 1 month of progressive abdominal pain, distension and LE edema
HPI: A 64 old woman p/w the complaints of progressive abdominal pain accompanied with distension and lower extremity edema. These symptoms started after receiving an EGD one month back. The patient never had these symptoms before.
Over the last week:
Developed dysuria and urinary frequency

ROS: no fever, chills, diarrhea, constipation, chest pain, dyspnea, rashes

PMH:
MASLD cirrhosis complicated by varices s/p banding
T2DM / dyslipidemia
HTN
Past surgical hx:
Cholecystectomy
Tubal ligation

Meds:
Atorvastatin
Carvedilol
Insulin glargine
Metformin

Fam Hx:
Mother: HTN, diabetes

Social Hx:
Originally from Mexico, Lived in Texas for 20 years

Health-Related Behaviors:
None

Vitals: T: 98.8 F **BP:** 120/72 mm Hg **HR**:79/min **RR:** 18/min **Sat:99%**
Exam: Gen: awake, oriented, no apparent distress
HEENT, CV, Pulm: NL, **Neuro:** NL, No asterixis
Abd: tense abdomen, distension, slightly tender in all quadrants
MSK: spider angiomata, palmar erythema

Notable Labs & Imaging:
Complete blood count: normal
Basic metabolic profile: normal
Liver function tests: Total serum protein : nl with hypoalbuminemia
AST: 65, ALT:nl, ALP:146, T.Bili:1.2, D.Bili:0.4, PT 16.1, INR nl, PTT nl
HIV and Hepatitis: NR
Urinalysis: cloudy appearance, inc WBCs, +ve nitrates, many bacteria
Urine culture: E.Coli → treated with antibiotics with resolution of urinary symptoms → persistent abdominal distension, pain and edema
IMAGING:
CXR: normal
USG Abdomen: moderate ascites, no e/o HCC
Paracentesis : 800 cc removed, Whitish , cloudy in appearance
700 WBC with lymphocytic predominance, High SAAG ascites
Total protein fluid: 2.2, albumin fluid:1.3
Fluid amylase: low (s. amylase:low), pH, LDH, glucose: low,
Cytology and flow cytometry: negative for malignancy; ADA: low
Quantiferon gold from serum: positive, s.AFP-nl
BNP, TTE - NL
Ascitic fluid culture : no growth
Fluid cholesterol: low (36) , elevated triglycerides (319); nl in serum

CT A&P: e/o varices and ascites, no acute pathology

***Dx* : CHYLOUS ASCITES 2/2 cirrhosis**

Problem Representation: A 64 years old woman with PMH of MASLD cirrhosis complicated by varices s/p banding came with symptoms of progressive fluid overload & dysuria. She had spider angiomas palmar erythema, found to have moderate high SAAG lymphocytic rich ascites with elevated triglycerides (>110)

Teaching Points (Masah):
Subacute Abdominal Pain: either progresses to chronic / smth more disastrous
Abdominal distension: Gas: → Bloating
Solid: Focal eg. Large spleen/liver/pelvic mass
Liquid: diffuse throughout
Elderly + Gender + Pelvic Symptoms → be weary
Naming the dysuria + urinary frequency as "pelvic symptoms" bc of fluid overload, which could be due to compression of her pelvic veins/iliac veins
Postmenopausal F: ddx: **UTI, Pelvic mass
H/o Cirrhosis + new onset abdominal swelling: decompensated cirrhosis. Have to think of SBP.; Is this decompensated cirrhosis? Or an independent condition?
Proof of decompensated cirrhosis: worsening hepatic synthetic function or worsening portal HTN
Absence of thrombocytopenia: decreased likelihood of cirrhosis, but with varices in the past and AST/ALT ratio suggests that she already has cirrhosis (there is small % of normal plt)
Lymphocytic predominance + High SAAG: Transudative + inflammation.
Ascites: Portal HTN vs nonportal HTN: Transudative or Exudate (inflammation)
Mixed picture eg. Disseminated TB in a patient with h/o cirrhosis.
Exception: Chyle: lymphocytic predominant process in transudative fluid (bc chyle is an albumin depleted fluid)
In this patient: Subacute peritonitis in a patient with cirrhosis/mimicker
Lymphocytosis but her ADA and LDH (lymphocytic enzymes) are wnl : lymphocytes Activated or inactivated(eg. chylous effusion)
High TG→ Chylous Ascites : trauma, venous HTN, inflammation