07/24/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Luke Maillie (@)* ***Case Discussants****: Rabih Geha (@rabihmgeha) and Nikola (@VladicNikola)*

Scribing (Magnus)

CC: 66F with 3 weeks SOB with exertion and 2 month of intermittent diarrhea

HPI: 3 weeks ago slow onset worsening SOB. PCP prescribed allergy meds and albuterol with no improvement. Can barely climb stairs. No symptoms at rest. Also non-productive cough and weight loss 10 lbs.

Non-bloody diarrhea, started 2 months ago, 4 times daily. Fluctuating.

ROS: No fevers, chills, night sweats, rhinorrhea, sore throat, CP, palpitations, edema, rashes or joint pain

No melena, BRBPR, abdominal pain or N/V

PMH:
CKD stage 3
T2DM
HTN
Hyperlipidemia

PSH:
Lap-chole (1990)

Meds:
Lisinopril
HCTZ
Metformin
Atorvastatin
PPI

Fam Hx:
Father - pancreatic cancer
Mother - T2DM, HTN

Social Hx:
Lives alone with her cat
Retired librarian

Health-Related Behaviors:
No alcohol, tobacco or substance use
No recent travel

Vitals: T: 98 BP: 123/70 **HR:** 110 **RR:** 16 **Sat: 97% RA at rest, 85% walking**
Exam: Gen: Well appearing at rest, appears very short of breath on exertion
CV: Tachycardic, but RRR no MRG
Pulm: Dullness to percussion on R posterior lung. Decreased breath sounds R lung. No crackles or wheezing.
MSK: No edema

Notable Labs & Imaging:
Hematology:
WBC: 7 Hgb: 11 Plt: 550 MCV: 92
Chemistry
Na: 131 K: Cr: 1.3 (baseline 1.1-1.3) Alb: 3.2 (other LFTs wnl) LDH 248
total-protein 6.9
proBNP 97
TSH wnl
Imaging:
EKG: Sinus tach
CT-PE: No PE, but large R pleural effusion with adjacent atelectasis and mild pleural thickening
TTE: EF 61%, no abnormalities
Thoracentesis: 1.3L hazy, yellow. RBC 643. TNC 555. 71% lymph, 22% mono, 6% other, 1% neutro. LDH 187, TP 5.3. Glucose 156. pH 7.9. Culture without growth, AFB negative.
S-osm 280, U-osm 657, U-Na 68
ID studies: HIV and HBV negative.
ANA, ANCA, RF negative.
Diarrhea studies: Legionella, EPP, O&P, calprotectin, H. pylory Ag, Celiac panel negative.
Repeat CT after thoracentesis: Extensive nodular thickening. Also some R diaphragmatic LAD.
Undergoes VATS with pleural biopsy

Dx : High-grade neuroendocrine carcinoma of pleural origin

Problem Representation: 66F with CKD and T2DM presents with subacute progressive SOB and chronic diarrhea found to have R pleural exudate and extensive nodular pleural thickening. Biopsy reveals neuroendocrine carcinoma.

Teaching Points (Anmolpreet):
I] **Exertional shortness of breath**: dyspnea pyramid (heart,lungs,blood-anemia, acidosis) can even represent MI especially in the setting of T2DM (pain absent)
Lungs: loud dyspnea- cough, stridor, wheeze; Heart/blood: quite dyspnea
Connection: cardiogenic pulmonary edema (heart + lungs)
Dyspnea exacerbated by exertion: angina equivalent (issue with coronary circulation) vs cardiovascular circuit issue (eg: mitral stenosis, pulmonary hypertension) vs anemia vs issue with alveolar capillary membrane
SpO2 plays a major role in differentiating:
Hypoxia with exertion:- alveolar vascular membrane (exudate-blood)
Normal sat with exertion:- anemia
II] **Chronic intermittent diarrhea**: evaluate what intermittent means; does she have healthy bowel days as well; to evaluate if these 2 symptoms at different geographical locations are related or not.
Inflammatory vs non-inflammatory (stool osmotic gap)
III] **Dullness on percussion-** increased density - (lungs)- pleural effusion, alveoli
IV] **Sinus tachycardia**: needed by this patient to maintain cardiovascular circulation; ?HF+normal BNP+sinus tachy:- obstructive ds
V] **Exudative right pleural effusion**: infection, malignancy, autoimmune
Tension pleural effusion(increased pleural pressure)- cardiovascular compromise (tachy)- likely slowly developing confined to a space. Send cytology.
Taking into consideration diarrhea and thrombocytosis:-->
Possible DDx⟶ Malignancy: mesothelioma, carcinoid; Others: Whipple
Typical exudative effusion:- Fluid rich in proteins and LDH:- leaky cell junctions
Different etiology: eg:- 1. pancreaticopleural fistula [pancreatic duct <-> pleural space] (fluid anyways rich in proteins and LDH, essentially testing pancreatic fluid in pleural tap); 2. Chylous ascites: fluid rich in TG looks like TG rich effusion
VI] Isolated right pleural effusion : autoimmune less likely, Infection: TB/Nocardia, Malignancy: Pleural lymphoma – pleural biopsy