



7/20/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Shreyaa Rajpal (@) Case Discussants: Julia (@) and Ethan (@)



| | | | |
|--|---|--|--|
| <p>Scribing (Marcela) CC: 56yo female presenting with fever and abdominal pain HPI: 3 month hx of intermittent low grade fevers, generalized weakness, vague abdominal discomfort predominantly in the RUQ and weight loss of 6kg. She reported dry cough that was non-productive, more pronounced at night and not associated with wheezing or hemoptysis. Last 1 month appetite decreased significantly. Denies jaundice, hematemesis, melena.</p> | <p>Vitals: T: 100.8 BP: wnl HR: wnl RR: wnl Sat: wnl BMI: Exam: Gen: pale, ill appearing, HEENT: no lymph nodes, no jaundice CV: normal Pulm: Reduced breath sounds at right lower lobe, no crackles or wheezing Abd: soft, mild distended abdomen, normal bowel sounds, tenderness RUQ, liver mildly enlarged on percussion</p> | <p>Problem Representation: 56yo F with hx of abdominal surgery and DM presenting with fevers, weight loss and abdominal pain. Work up remarkable for renal injury, transudative ascites and liver mass.</p> | |
| <p>PMH: T2DM, hx of ampullary mass s/p Whipple's surgery 1 year ago (Bx neg for malignancy marked fibrosis and inflammation). Meds: Metformin</p> | <p>Social Hx: no hx of recent exposure to sick contact, no recent travel Health-Related Behaviors: no drugs, smoking or alcohol Allergies: no allergies</p> | <p>Notable Labs & Imaging: Hematology: WBC: 11,8 Hgb:9 Plt: 180k Chemistry Cr:2 AST: 46 ALT: 28 ALP: 183 GGT:30 Bili: 0.7 Total pr: Alb:2.7 Ca19-9 141 AFP 2.6 (normal) PIVKA 86.8 Peritoneal fluid: Cell 60 Protein 1.1 SAAG 1.6 ADA 5.3 GeneXpert negative, Cytology neg</p> <p>Imaging: CT 7.3x5cm left liver lesion with left hepatic vein occlusion PET CT - left lobe of liver lesion (6.8x4.7x5cm), abdominal lymphadenopathy, multiple ill defined nodular opacities in both lungs, mediastinal lymphadenopathy</p> <p>Biopsy: inflammatory lesion with focal histiocytes and show focal filamentous bacterial colonies (suggestive of Actinomyces) Patient was started on high-dose IV penicillin G and planned for long term therapy. Patient had clinical improvement with resolution of fevers and weight stabilization.</p> <p>Dx : Actinomyces</p> | <p>Teaching Points (Masah): - CC: Abdominal pain: localize it anatomically depending on quadrant and whether it's diffuse or localized, and explore any accompanying symptoms. + fever: infectious causes, malignancy, or vascular cause. - HPI: 3 months: subacute-chronic. Decreases likelihood of acute cholecystitis/acute hepatitis. RUQ localizes to hepatobiliary system. + weight loss: why? Decreased appetite/functional issue/absorption issue/Catabolic process. Dry cough: nonspecific but resp system involvement could be possible. Absence of jaundice doesn't exclude posthepatic causes. - PMD: Post Whipple complications biliary infection, pseudocyst, abscess or fistula formation, pancreatic insufficiency. Fibrosis & inflammation →systemic disease eg. IgG4 disease. - PE: Febrile: patient is inflamed. RUQ tenderness → liver capsule stretched. Hepatomegaly: Biliary obstruction, portal HTN, Space occupying lesion, Endemic causes like TB. Reduced breath sounds at RLL→ Hepatic hydrothorax. - Labs & imaging: SAAG>1.1 →transudative → portal HTN. Elevated ALP: no GB but could be intrahepatic bile ducts involvement. AFP made in the liver. PIVKA→ more specific for HCC if both positive highly specific for HCC. Lesion in Hepatic V: lymphoma, metastasis, vascular invasion is highly specific to HCC. Actinomyces: G+ve filamentous anaerobic bacteria. Hepatic actinomyces can occur after abdominal surgeries. Slow nature and can be mistaken for neoplastic disease</p> |