7/3/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Julia Zanco (@) Case Discussants: Rabih (@) and Seeme (@)

Scribing (Lera)

CC: 79F with progressive **SOB, pleuritic chest pain, increasing orthopnea.**

HPI: Presented to the ED. Been sleeping with 3 pillows for 14 days. Was hospitalized 1 month earlier for **pericardial effusion** and new onset HFpEF -> pericardiocentesis with Sx relief. Since then – progressive SOB and GI Sx.

ROS (+): PND, early satiety, postprandial fullness, N/V, poor appetite for the past months

PMH: T2DM, HTN, HLD, HFpEF
L subclavian v thrombosis (unprovoked)

Meds:
Insulin
Metformin
Losartan
Amlodipine
Simvastatin
Furosemide
Rivaroxaban
Omeprazole

Fam Hx: TB in daughter, father. No Hx of cancer.

Social Hx: Retired, lives in Brazil.
No recent travel.

Health-Related Behaviors:
no smoking, alcohol use.

Allergies:
dimenhydrinate

Vitals: T: afebrile **BP:** 120/70 **HR**: 110 **RR:** 18 **Sat:** 89% (placed on 4L O2)
Exam: Gen: weak, pale, AO x 3
CV: no JVD, unremarkable, no rubs
Pulm: bl crackles, decreased breath sounds at bases
Abd: globose, soft, non tender, no organomegaly
Neuro: no focal deficits
MSK: bl LE edema, no calf tenderness

Notable Labs & Imaging:
Hematology: WBC: 8 (neutrophil-predominant) **Hgb**: 11 **Plt**: 96

ABG: pH 7.52, pCO2 38, pO2 49, HCO3 26, **Sat** 89% (on 4L O2)
Chemistry: Na: nl **K:** 3.1 Cr: 1.3 BUN: 36 Ca: 1.33 (ionized) **Glu**: 54 CRP: 3.57 ESR: 15 LDH: 330

EKG: sinus rhythm, otherwise unremarkable
POC US: pericardial effusion
-> non-purulent fluid, glucose 86, protein 5, 84% lymph
TB negative (AFB and Cx done)

-> Clinically deteriorated -> hypoxia -> started on empiric ABx

CT chest: no PE, bl pleural effusions (R>L), reticular opacities, GGOs, bronchial wall thickening, cardiomegaly.
TTE: LVH with EF 58%, **persistent effusion**, moderate pulmonary HTN.

EGD: gastric ulcer.
Biopsy -> poorly differentiated diffuse-type gastric signet-ring adenocarcinoma.

Dx: metastatic gastric adenocarcinoma with pericardial and pleural carcinomatosis

Problem Representation: A 79 y/o female presented with progressive SOB superimposed on subacute early satiety, unexplained pericardial effusion and unprovoked UE DVT. Was found to have worsening hypoxia, and persistent pericardial / pleural effusions. EGD with Bx showed signet ring gastric cancer

Teaching Points (Parisa):

Pleuritic chest pain → central (pericarditis) vs peripheral (pleuritis)
SOB + orthopnea (Base rate) → congestive HF → physical examination (JVD, edema, crackles) is helping us to frame our working diagnosis but remain open to unusual features HF as Pleuritic chest pain is uncommon in classic HF, prompting considering pericardial diseases.
Pericardial effusion etiology: MCC idiopathic (no clue; never recur) secondary (cancer >> TB> AI> post injury (MI surgery: Dressler syn))
Clue toward malignancy: secondary pericarditis spontaneous thrombosis; location thrombosis; **early satiety**!!! (primary GI cancer vs edema d/t HF)
ascites precox: In pericardial dx abdominal congestion + GI sx; GI sx should improve after pericardial effusion drainage
Peripheral thrombosis (below knees or elbows): age > 50 is a major risk factor;
Central thrombosis (proximal to knees/elbows) are much likely to be secondary.
Sinus tachycardia is uncommon ADHF we need to prioritize obstructive causes like pericardial dx.
Thrombocytopenia: hematological usually causes wide spread presentation vs focal problem (hypoxemia) →**extra vascular fingerprint** 1. PBS 2. Imaging (mass forming)
Lymphocytes predominant: TB endemic fungal
TB does not infect fluid infects lining visceral pleura pericardium → never able to rule out TB by fluid sampling only → tissue biopsy is needed
pulmonary pressure pericardium does not encase pulmonary artery so pericardial pressure does not directly affect pulmonary artery → then pulmonary HTN in this case a strong is clue → High risk cancer w pulmonary HTN: 1. Breast cancer 2. metastatic gastric cancer 3. Ovarian cancer.
ILD is the main alveolar cause of PH, develops over months! Tempo!
GGO in this patient: pulmonary edema pulmonary tumor thrombotic microangiopathy (PTTM)
Final frame = Pulmonary HTN + GGO + pericardial effusion + unexplained thrombosis→ malignancy