9/11/25 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Vijay **Case Discussants**: Rabih @rabihmgeha) and Eugene (@EugeneBondzie)*
https://clinicalproblemsolving.com/present-a-case/

Scribing (Vini)
CC: 21 M presenting with abd pain for 2 years
HPI: The patient complains of a Dull, Aching, Mild, diffuse abd pain, 3/10 in intensity, persistent, increase on working/running, non radiation. 10kg weight loss over 2y.

Not related to meals/night time awakening, no relieving symptoms. Denies recent travel, fevers, N/V, or reduced oral intake, jaundice, pruritus, dark urine, melena, hematochezia, rash, arthralgia or mucosal ulcers.
Tx symptomatically for abd. pain

PMH: h/o incidental elevated Cr to 1.9 - Baseline 1.6. Urine 3+ protein
Renal amyloidosis.

Meds:
Short course steroid. Anti TB therapy - not confirmed.

Fam Hx, Social Hx, Health-Related Behaviors: non contributory

Allergies: none

Vitals: unremarkable **BP:** 130x80
Exam: Gen: Otherwise unremarkable except for:
Abd: Massive hepatosplenomegaly 16c m liver - spleen 14 cm

Notable Labs & Imaging:
Hematology:Hgb: 8,1 -baseline 8,4 WBC: 14 - N 80% L 11% M 7% Plt: 414 MCV: MCHC 28
Chemistry: Cr: 6,8 U: 98 Ca: 8 AST:21 ALT: 8 Alk-P: 316 high Phosp: 5.36 Bili: nl Albumin: 2,52 Total Protein:6,6. LDH: 97 Ferritin: 1255 tsat 10% PTH 240 ESR 120 CRP 65
HIV, Hep B and C neg
Imaging:
CT abd mesenteric lymphadenopathy - 2 cm
Renal Biopsy neg for immunoglobulins light chains. PET CT - multiple lymph nodes in the abdomen, low avidity LN (Abd, chest, hepatosplenomegaly).
Excisional LN Biopsy: Negative for AFB, Xpert. Mild plasmacytosis in interfollicular areas. No K/L restriction. No amyloid deposits. No evidence of lymphoma/atypical cells/granuloma/necrosis.
Repeat biopsy - confirmed amyloidosis - neg for IgG4. Infiltration of lymphocytes and plasma cells.
Pet - hypermetabolic mesenteric LN with heterogeneous enhancement of abdominal nodes. Hepatomegaly increased to 21 cm. Multiple hyperenhancement of bulky mesenteric lymphadenopathy.
Subcentimeter cervical, celiac and paraaortic LN.
FDG avidity in mesenteric, parotid, submandibular glands.
Heterogeneous enhancement of B/L kidney/liver/spleen: Amyloid deposition.
Repeated Excisional biopsy of LN: Features of castleman's disease, hyaline variant along with amyloidosis.

Dx: Multicentric castleman's disease w sec. amyloidosis

Problem Representation: 21yo M w PMHx of renal amyloidosis + proteinuria presents w chronic abd pain for 2 y. PE w hepatosplenomegaly. Labs w anemia, neutrophilia, h ferritin. Imaging reveals bulking abdominal and widespread lymphadenopathy. Final lymph node biopsy revealed **castleman's disease.**

Teaching Points (Seeme):
Approach to abdominal pain:
-diffuse abdominal pain makes it hard to find a focal point for pain, studying the nature of pain and aggravating and relieving factors can help us make progress
-we can look for consequences of chronic pain: look for anemia/kidney involvement/inflammation
-weight loss- we can see if it is related or not? If patient can still eat well the main function of bowel seems to have been preserved.
Approach to past medical history and exam findings:
-lymphadenopathy could be sign of inflammation
-three organs liver, spleen and kidney are involved. Renal amyloidosis can be systemic (chronic inflammation or light chain) or limited to kidney. Most common is amyloidosis with amyloid A (AA amyloidosis).
-Renal amyloidosis can be indicative of infection or chronic inflammation.
Approach to labs:
-having elevated inflammatory markers can be indicative of inflammation
-leukocytosis can be from blasts or reactive (usually when neutrophilic). ALP elevation, proteinuria may be consequence/cause.
-AA amyloidosis infiltrates liver, spleen and kidney
-we can look for signs of asymmetry- **(1)lymph nodes did not show amyloid** so could be a new issue (look for HIV, syphilis, ANA) **(2) plasmacytosis** (infections-syphilis/autoimmune disease-rheumatoid arthritis/malignancy-multiple myeloma/castleman disease)
-Chronic inflammation and neutrophilia- vasculitis and histiocytic diseases
-lymphadenopathy is usually associated with pancytopenia but we do not have that we have leukocytosis - a paradox which can be indicative of autoimmune disease
-histiocytic disease with bulky lymphadenopathy can be indicative of Rosai Dorfman disease
-enhancement of lymph nodes on CT is a vascular phenomenon