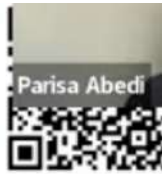
11/20/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Oye Abioye* ***Case Discussants****: Rabih (@rabihmgeha) & Umbish (@UmbishD (X) @umbishfromthe90s (IG))*

https://clinicalproblemsolving.com/present-a-case/



Scribing (Magnus)

CC: 70M with scrotal swelling and pain for a few months

HPI: No trauma or preceding illness. Progressively worsening. USG 1 mo ago with signs of epididymo- orchitis. Did not improve with cipro or doxycycline.

ROS: No hematuria, dysuria or other urinary symptoms. Otherwise negative.

PMH:
HFpEF
CAD (s/p CABG)
Afib
CKD stage 4
PAD
HTN
HLD
T2DM

Meds:
Eliquis
Aspirin
Atorvastatin
Clopidogrel
Furosemide
Sacubitril/ valsartan
Semaglutide

Fam Hx:
Heart disease in father and brother

Social Hx:
Retired. Lives with wife.

Health-Related Behaviors:
Former smoker (25 pack yr)
Uses marijuana multiple times per week.

Allergies:
None

Vitals: T: afebrile **HR**: 92 **BP**: 158/97 **RR**: 16 **Sat**:97 RA **BMI**: 34
Exam: Gen: Uncomfortable. In pain. Diaphoretic.
HEENT: nl **CV**: nl **Pulm**: nl **Abd**: nl **GU**: Enlargement of L hemiscrotum. Mass felt.
Neuro: nl **Extremities/skin**: No edema. No bleeding or bruising.

Notable Labs & Imaging:

Hematology:
WBC: 10.2 (neutro predominant) Hgb: 9.9 Plt: 202

Chemistry:
Na: 133 K: 5.0 Cr: 3.75 (baseline)
AST: 16 ALT: 9 LDH: 403
UA: nl AFP negative betaHCG negative

Imaging:
EKG: nl
USG: Enlarged and heterogeneous left testis and epididymis with a complex left hydrocele, suspicious for epididymo-orchitis. No discrete testicular mass.
CT AP: Diffuse retroperitoneal and pelvic adenopathy. Left gonadal vein thrombosis.
Urology consulted, underwent orchiectomy + ureteral stent placement. Cord stood out to the surgeon as being very thick and hardened.
1 week later: Chest pain, SOB, severe ankle pain with no pulse on doppler.
Repeat CBC: WBC 64 (blasts 24%) and uptrending -> 113
LDH > 2500
CT AP progression of an infiltrative process in left anterolateral pelvis extending into inguinal and anterior pelvic regions.
Pathology of testicle returned and showed: 5.4 cm left testicular mass, with morphology supporting cancer of myeloid blasts.

Dx: Acute myeloid sarcoma with monocytic differentiation of the testis
Complicated by acute limb ischemia

Problem Representation: 70 year old man presented with scrotal swelling and pain for months, found to have a left testicular mass and diffuse retroperitoneal and pelvic lymphadenopathy, later developed severe leukocytosis with blasts, ultimately diagnosed with acute myeloid sarcoma

Teaching Points (Parisa):

Scrotal swelling/pain → unilateral (epididymal, inguinal hernia, testicular torsion) vs bilateral (systemic decompensated CHF, rarely focal bl) → Physical exam helps differentiate

Testicular mass → Mass transilluminate (fluid/hydrocele) → Hematoma; abscess; cancer → US diagnostic confirmation; low test probability for malignancy, diffuse testicular enlargement reflect venous hypertension, ipsilateral venous pathology is often under appreciated.
Anatomy → left gondola vein drains perpendicular into left renal vein (prone to congestion) same as left LE iliac vein is compresses (May-Thurner physiology) Scrotal venous congestion: venous stasis/ hypercoagulability

Testicular cancer → Men (Germ cell tumors 20s 30s >> testicular lymphoma older) vs ovarian tumors epithelial older. → lab

Retroperitoneal LN → 1. Local tumor met (GI rectal; GU prostate bladder testicular) 2. gynecologic; 3. lymphoid malignancies → tissue

Lymphoma (mature body B/T cells, LN but not BM; 1. most common LN swelling DLBC 2. tissue mass/extranodal GI lymphoma 3. Mature lymphocyte in blood / marrow involvement (advanced) hodgkin
leukemia (stem cell inside BM) → spills over into blood
Leukemia (immature stem cells BM) → myeloid sarcoma
myeloid sarcoma stem cells convert outside BM concurrent or impending blood involvement plasma cell myeloma