12/18/25 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Youssef (@saklawiMD) **Case Discussants**: Dr. Conan Liu (@EGSuppy)

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

Scribing (Lera)

CC: 35F with **10 days of abdominal pain and swelling**, associated with nausea, diarrhea.

ROS: Weight loss and night sweats for past month.

PMH: none

Meds: none

Fam Hx: —

Social Hx: lives w spouse, mail-woman From Mexico originally, Now lives in Atlanta

Health-Related Behaviors: none

Allergies: —

Vitals: normal **Exam:** **Gen**: not in acute distress
CV, Pulm, Neuro: nl
Abd: distended, non tender, pos fluid wave -> **ascites** on POCUS
Extremities/skin: no rashes or cirrhosis stigmata

Notable Labs & Imaging:
Hematology: WBC: 4.3 **Hgb**: 11.3 Plt: 387 MCV: nl
Chemistry: RFTs and LFTs: nl, both aPTT and INR: nl
HIV screen: negative

US abdomen: moderate ascites, LLQ cystic lesion [L adnexa?]
CT C/A/P: large volume ascites, prominent celiac / ileocolic LN, peritoneal thickening, ovarian cystic lesion -> *findings concerning for omental caking*
Para: SAAG < 1.1, total protein 5.5, WBC 1900 [PMN 95, Lymphocytes 1710]

CT chest: normal. **Tumor markers**: **CA125**: 573 [very high]. AFP, CEA, bHCG: nl
TB workup: Peritoneal TB PCR: neg. IGRA +. Sputum AFB x3, TB PCR: neg
Ascites cytology: neg. **EGD**: normal.

-> patient discharged, then represented 3 weeks later with worsening ascites.

Peritoneal Bx: non caseating granulomas. AFB: neg.
Laparoscopy: peritoneal miliary nodularity, omental caking with adhesions.
Bx: **non caseating and caseating granulomas**, cytology and AFB stains neg. AFB remains neg. ADA sample lost. **CT**: ovarian cyst gone.
ID: cocci, ellas, RPR, fungal Cx, crypto negative. **AI**: ANCA neg.

Dx: TB peritonitis.
-> initiated on RIPE therapy with improvement.

Problem Representation: A 35 y/o lady from Mexico presented with abdominal pain and ascites in the context of subacute inflammation. Para revealed low SAAG ascites associated with peritoneal thickening on imaging. Bx showed granulomas with positive response to TB Rx despite persistently negative TB workup.

Teaching Points (Siva)

1. generally younger pts tend not to come to hospital until they have unbearable sx.
abd pain -intraintestinal and extraintestinal(ovary,soft tissue etc)
Check for Cirrhotic signs-spider angioma,caput medusae
Endemic area-TB should be ruled out(can present with no lung manifestation).
SAAG<1.1- no Portal HTN.
Rule out SBP due to its high morbidity .
high lymphocyte count in ascitic fluid -TB,malignancy ??
MEIG syndrome(ovarian cancer, ascitic fluid ,pleural effusions)?
CA 125-ovarian Cancer /non specific.
PPD ,quantiferon sensitivity drops in active TB .
TB vs ovarian CA?
Caseating granulomas -classically TB,
non caseating -endemic mycoses,autoimmune.
TB can present with non caseating granulomas as well(which is the case here)
Granuloma-IMAD(infections(TB,endemic mycoses,malignancy,autoimmune(sarcoid,IBD),drugs).
Go for Omental AFB culture rather than ASCITIC FLUID TB PCR (as sensitivity drops in Tb peritonitis)in abdominal TB suspicion.

DX-TB peritonitis.