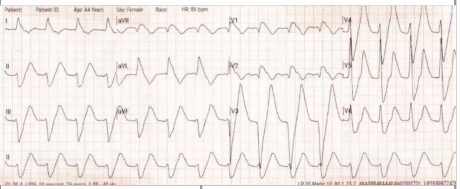
12/20/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter:*Wash Univ IM Residency (@@WashUMedIMRes)* ***Case Discussants***: *Rabih (@rabihmgeha) & Khashayar*
https://clinicalproblemsolving.com/present-a-case/

Scribing (Siva)

CC: 44 female with **fever, LLQ abdominal pain**

HPI: Also noticed decreased urine output. Pain had no irradiation, now pain become more persistent and DOE with NBNB emesis appeared. Progressed to SOB with minimal exertion -> ED presentation.



PMH: HTN, fentanyl use, Opioid use disorder

Meds: lisinopril

Fam Hx: Not significant

Social Hx:

Health-Related Behaviors: 4-6 cigarettes/day

Allergies:

Vitals: T: 96 **HR**: 77 **BP**: 156/102 **RR**: **Sat**: 76 -> 99% on O2
Exam: Pulm: B/l wheezing
Abd: soft,tender LLQ,mild distended
Extremities/skin: 1+ edema to mid shin bl

Notable Labs & Imaging:
Hematology: WBC: 12 Hgb: 7.3 Plt: 603

Chemistry: Na: 132 **K**: 12 **HCO3**: 8 **Cr**: 25 **BUN**: 130 Glucose: 135
AST: 15 ALT: 13 Alk-P: 111 Bili: 0.2 Albumin:3.7 Total Protein:6.7
LDH: 321 INR: 1.28, PTT: 30 Lactate -
VBG: pH 6.94 CO2 30 Trops BNP-21k, HCG 11.3
U/A-2+leukocyte esterase,RBC positive
Management: Foley placed, Ca and insulin given.
Serology: HIV,hepatitis-negative BCx and UCx neg C3 and C4 nl
Urine protein-30 mg/dl, no urine output in the last day.
Imaging:
Echo: Normal EF, no valvulopathy
CT: Mild pulmonary edema, b/l hydronephrosis, moderate ascites
Trans ABD USG- B/L enlarged ovaries
B/l urinary stents placed by surgery team -urine output +ve.
GYN-cervix enlarged (irregular and firm) .
Imaging-5.5 cm fungating post cervical mass eroding into posterior vagina.
Biopsy-HPV 16 SCC of cervix.
CEA 9.7,CA 125-77.

Dx: Squamous cell carcinoma of cervix due to HPV 16 with peritoneal carcinomatosis complicated by postrenal AKI.

Problem Representation: Premenopausal woman with a history of hypertension and cigarette smoking presenting with focal abdominal pain, dyspnea on exertion, and decreased urine output, found to have post-renal acute kidney injury with bilateral hydronephrosis and ascites on imaging, and an enlarged cervix with a cervical mass on gynecologic exam and imaging, concerning for advanced gynecologic malignancy causing obstructive uropathy.

Teaching Points (Manaswini)

Approach when we see multiple concerns: We do not have to come to conclusions quickly when we experience a broad problem. First let's stabilise the patient if needed, then let's zoom in and clarify each component.

Approach to Abdominal and thoracic syndromes:

- Abdominal pain:Perform EKG, post void bladder scan, think do we scan or not? →Important to study the landscape! Here, exclude gynecological pathologies in a perimenopausal woman.

Extremely Crucial to compare morbidity and mortality of the differentials we think of!
i.e GI(Diverticulitis and IBD) VS Pelvic diseases(Ovarian torsion, Tubo Ovarian abscess, ectopic pregnancy).
Pelvic diseases are more morbid and warrant TV-USG!
In this case: 1st Transvaginal-USG & beta HCG→ then perform CT scan

- For thoracic syndromes- 1st EKG, CXR→ if no answer, then perform CT chest with contrast

Can be Kidney disease radiating to chest -Seen in nephrogenic pulm edema/ toxicity from kidney dysfunction

Approach to EKG-: Wide QRS: We think of Intrinsic heart disease: i.e like V.Tach
But 3 Reflex NO miss DDx to think of: 1.Acute ischemia, Electrolyte abnormalities 2.Hyperkalemia, 3.TCA toxicity(blocking Na channels)

- Is it RBBB or LBBB?: Dr. Rabih's Trick:How much time is the QRS up or down? (V1- Taking forever to go positive to a right sided lead & V6- taking forever to go opposite of a left sided lead) → RBBB

Approach to Labs: High creatinine(>10-15): 1st think Post renal causes (Diseases increasing pressure-i.e obstructive causes)- Pain supports this concern
- Pressure causes increased Creatinine: does not have to be Macroscopic- Can be at microscopic tubules- tumour lysis, rhabdomyolysis, TMA
- Where is the obstruction?- lower it is, more bilateral involvement.
- POCUS→ if we see B/L hydro → Insert foley to see how much fluid comes out

Let's talk Bladder involvement: Why don't we create a schema: Analogy with the heart!
Most common 1. Outflow tract obstruction(Like Aortic stenosis), 2. Loss of contractility:Neurogenic bladder(like HFrEF), 3.restrictive cardiomyopathy pattern-unable to dilate/relax- Ketamine related bladder(hypertrophy seen), 4. Pericardial disease equivalent-high pressure external compression from retroperitoneum (cancer, IgG4)

- If [1,2]→ lot of fluid will come out on foley insertion VS [3,4]→ Not much fluid comes out of the Foley (do another pocus to see bladder hypertrophy etc)

Pathophysiology of 3rd spacing-Renal vs Heart: Why do patients who need dialysis rarely have intra abd fluid?-->Renal disease rarely causes extravasc volume overload outside of *nephrotic syndrome*. When kidneys fail→ volume failed to be excreted builds up in the *arteries* (Also, why they eventually become hypertensive)
In contrast, heart failure causes extravascular fluid overload due to *venous* congestion.

SOLVING ASCITES: Could it be [Tamponade of Bladder from something in the peritoneum] OR [Bursting of bladder]:
-What is the fluid causing the ascites ? →Hemorrhage from ruptured ovarian cyst or gynec malignancy(cervical cancer), or is it urine
-If gushing of urine seen after stenting the patient → Obstruction NOT at the bladder (seen at B/L ureter) → Cancer progressed to the retroperitoneum

This case highlights the Importance of a Gynecological Exam!