11/24/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Hee Mun* ***Case Discussants****: Alec (@ABRezMed) & Austin (@RezidentMD)*

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

Scribing (Magnus)

CC: 37F with severe, progressive LUQ pain radiating to the back for 1 week

HPI:

Worsened by deep breathing. Associated with nausea, vomiting and early satiety. Loose stools. Mild fever and chills.

No history of animal exposure or tick bites.

ROS:

Denied trauma. No jaundice, constipation, urinary symptoms or hematuria.

PMH:

None

Fam Hx:

Social Hx:

2 children

Health-Related Behaviors:

No travel hx.

Allergies:

Vitals: Stable **Exam:** **Gen**: Alert. NAD.

HEENT: No scleral icterus. No LAD. No oral thrush.

CV: RRR no murmurs

Pulm: CTAB

Abd: LUQ fullness and tender to palpation. Spleen palpable. No rebound or guarding. No hepatomegaly.

Neuro: AOx4

Extremities/skin: No edema, cyanosis or clubbing. No rash.

Notable Labs & Imaging:

Labs:

CBC, LFTs, RFTs, UA were all normal. Eosinophilia 10.9%.

ID:

Stool exam: no ova and parasites

HIV, HBV, HCV negative

Imaging:

EKG: nl

CXR: nl

USG: Spleen 13 cm with a solitary anechoic cyst

CT: Splenomegaly (14.7 cm) and single cyst (9.8 x 7.8 cm) with no calcification or solid parts

Later informed that she lived on a farm in India 7 years ago.

CE1 active hydatid cyst

Serology: IgG 1.07 IgE 593

Dx: Primary splenic hydatid cyst

Problem Representation: 37 year old woman with no PMH presented with severe LUQ pain for 1 week found to have a large splenic cyst and eosinophilia. USG and serology ultimately diagnosed the patient with primary splenic hydatid cyst.

Teaching Points (Sarah B)

1. Using an anatomic approach for abdominal pain, consideration of both the organs as well as the layers you pass through in each quadrant can help. LUQ also may also include the diaphragm, lung, and pleura. Radiation to the back may indicate a peritoneal component.
2. Severe pain does not necessarily mean acute pain. Rather than asking about a pain scale, asking about limitations on normal ADLs can be a more helpful metric of severity.
3. Systemic symptoms can be helpful for identifying whether autoimmune, infectious, or malignant (e.g. lymphoma) processes are involved.
4. A trend in a CBC can be more helpful than a single CBC in one time point. The differential can point towards malignancy, parasites, bacterial, or viral origin.
5. Evaluation of the spleen may require cross sectional imaging both due to limitations of the physical exam and to rule out conditions requiring intervention. Potential findings include fat stranding, masses/malignancies/cysts, infarctions, and splenic vasculature abnormalities. Radiology can be helpful in deciding who to consult next.
6. If a patient presents with LUQ fullness and tenderness, we should assess rashes, lymph nodes, and in the mouth. Often the CBC/diff can be revealing of the primary cause (e.g. undiagnosed thalassemias). Granulomatous diseases and HIV are on the differential with conditions resulting in activation of the reticuloendothelial system.
7. Benign growths can cause pain by irritation of surrounding structures (e.g. capsule) and mass effect. Blood or secondary infections can also cause irritation resulting in pain. Formation of a fistulization would likely result in a more inflammatory syndrome. In this case, the spleen parenchyma was not enlarged, but a cyst resulted in physical exam pertinent for splenomegaly.