10/20/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter***: *Praveen (@)* ***Case Discussants***: *Ravi (@rav7ks) & Kirtan (@KirtanPatolia)*

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

Scribing (Meghna):

CC: 78 y/o presents with black, tarry stools for 1 week

HPI: A 78 y/o male presents with a week long history of melena. He reports 2 episodes over the past week. It is associated with mild abdominal discomfort. Denies hematochezia, hematemesis, vomiting, or fever. No obvious bleed from other sites.

ROS: No chest pain/ SOB/ fever/ vomiting/ dysuria

PMH:
DM
HTN
Hypothyroidism
Parkinson
BPH
CABG done a year ago

Meds:
Aspirin + Ticagrelor
Atorvastatin
Linagliptin
Levothyroxine
Levodopa/Carbidopa
Amantadine
Silodosin

Fam Hx: -

Social Hx: Retired from public work.

Health-Related Behaviors: No h/o smoking/alcohol/drug use

Allergies: Denied

Vitals: T: Afebrile **HR**: 78 **BP**: 100/60 **RR**: - **Sat**: 98% **BMI**: -
Exam: Gen: Alert, oriented **HEENT**:
CV: No murmurs, S1 S2 +
Pulm: B/L air entry +, no added sounds
Abd: Soft, diffuse tenderness, no guarding, no rigidity or organomegaly
Neuro: no FND
MSK/skin: -
Digital rectal exam: melena in stools (+)

Notable Labs & Imaging:
Hematology:
WBC: 10.3K -> 4.9K Hgb: 8.8-> 5.9 Plt: 372K -> 305K MCV: 81.2
Reticulocyte: 1.2 -> 0.75 (corrected)
Chemistry: Ca: 8.4 Mg: BUN: 36 Cr: 0.93 Glu: 170
ESR: 69 CRP: LDH:142 A1c: 5.5 PT: 13s INR: 1.12
TSH, T3 T4 - normal
LFTs normal, except low normal protein and albumin
Imaging:
Echo: 60% EF, mild MR, AR, mild elevated PA pressure
CECT: Cholelithiasis, B/L simple renal cortical cysts; Polypoidal lesions in cecum and sigmoid, largest measuring 6x5 mm
EGD: normal study, no source of bleeding
Colonoscopy: Polypoidal lesions in caecum and sigmoid colon. No active bleeding source identified
CEA: 5.57ng (positive) CA 19-9: 31.2 AFP: N EPO: 22.84
Bone marrow aspirate: hypercellular marrow, normal erythropoiesis, morphologically abnormal megakaryocytes - Myelodysplastic Neoplasm (MDS)
Trephine Biopsy: Hypercellular, dysmegakaryopoiesis. Consistent with MDS and low blasts
Polyp Biopsy: Villous adenoma with high grade dysplasia of the cecal polyp

Dx: Myelodysplastic neoplasm with low blasts

Problem Representation: 78 y/o M with DM, HTN S/P CABG who presented with black, tarry stools, low hemoglobin level, low reticulocyte count and cecal/sigmoidal polyps on colonoscopy

Teaching Points (Ramaswamy)

Approach to tarry stools - Subclinical bleeding vs acute; time course is hard to rely on unlike chest pain; Upper GI vs lower GI - greater index of suspicion for upper GI; how long, how severe; Tar - consistency -> digested Hb; pseudo tarry - Fe, Bi.
UGI vs LGI - UGI can be more dangerous sometimes if it is a brisk bleed
Localizing UGI bleed - Esophagus vs gastric vs duodenal bleed
No hematemesis => slow bleeding => digestion => lower GI => tarry stools
Approach to GI bleed overall => NPO; hemodynamic instability[2 large bore IV needles for fluids preemptively even if BP normal], medication reconciliation, labs; stop antiplatelet agents and reverse them; ask about NSAIDS; PMHx bleeding diathesis/liver Dz; visualization is important; check structure - mass, ulcer, varices; consider Pantoprazole -> gastric acid is erosive so worth suppressing acid secretion
UGI bleed in the context of portal HTN -> octreotide => EGD; **BUN/Cr =>** 30-> GI b
Vitals -> normal HR/BP can be misleading; hypotension is a better signal
Labs - > reconcile low normal Hb; hemo conc. dehydration can lead to this
MGMT -> *Treat the immediate issue; stabilize the patient; proactive vs reactive*
EGD (N) -> focus on lower GI -> colonoscopy - > **Step 2 :**repeat everything (lesions may be missed) -> small bowel evaluation (capsule or push enteroscopy); DDx - dieulafoy lesions, AVM, ulcers; Rx - check iron studies -> IV iron if low
Polypoid lesions in colon => biopsy => neoplastic potential => unlikely to cause this => can one be cancerous => bleeding; Acquired => hyperplastic, tubulovillous (may bleed), Genetic -> PJ syndrome (likely in young) ; rarely Amyloidosis of the GI tract => fragile blood vessels => bleeding; cecum vs sigmoid -> cecum more likely given this is digested blood (more transit time) => black tarry stools
Pseudo UGI bleed => nasal, pancreas, biliary tree => bleeding => melena
MGMT -> when Hb continues to decline -> repeat all studies to identify source; tumor markers -> prognosis >> diagnosis
MDS -> pre leukemic state -> esp with age