9/24/26 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Ethan (@e_chiu17) Case Discussants: Rabih (@rabihmgeha) & Javier (@javierperezn)

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

Scribing (Chris & CPS Team):

CC: 68 yo F N/V 10 days

HPI: 10 days post prandial vomiting and nausea and GERD. Symptoms persisted and pt presented to ED due to continuation of symptoms. Also recent weight loss of 3kg due to decreased intake and dizziness. EGD done at LMD showed LA grade D. Tarry stool and coffee ground emesis in ED with subsequent transfusion.

ROS: Recent 3kg weight loss

PMH: HTN, DM2,

Meds:

Fam Hx:

Social Hx:

Health-Related Behaviors:

Allergies:

Vitals: T 35.7: **HR**:104 **BP**:154/84 **RR**: 15 **Sat**:96% RA **BMI**:

Exam: Gen:

HEENT: Unremarkable **CV**: Unremarkable **Pulm**:Unremarkable **Abd**: Soft nontender **Neuro**: Alert x3

Notable Labs & Imaging:

Hematology:

WBC: 4.7 Hgb: 12 Plt:311 MCV:

Chemistry:

Na: 131 K: 4 Cl: HCO3: Ca: Mg: BUN: 34.9 Cr: 1.25 -> 3.99 Glu:

AST:112 ALT: ALP: T. Bili: T. protein: Alb:

ESR: CRP: 15.28 LDH:

NG Tube placed, NPO, PPI

Imaging:

ED got an KUB which was unremarkable.

EGD: Showing blood and clots, gastric ulcer 0.5cm, duodenum grossly normal, incomplete study due to retention of blood. Gastric ulcers, Forrest Ib and III, s/p endoscopic hemostasis

Follow up KUB => severely distended stomach

CT Abd: Distended stomach, partial obstruction caused by duodenitis. Bilateral hydronephrosis, left mild hydroureter with bilateral ureteral

wall thickening, liver hemangioma.

EUS: duodenum obstruction 3rd portion, thickening submucosa and mucosa layer but The MP layer beneath was of normal thickness and preserved layer structure; One 13.2 mm LN around the hilum

, pancreas unremarkable, kidney bilateral hydronephrosis with 32.9mm ill-defined hypoechoic lesion right kidney.

Sent multiple urine cytologies:

- first set of urine cytology from right PCN returned Suspicious for high-grade urothelial carcinoma (Suspicious). (Paris System)
- cytology obtained during left uteroscopy showed High-grade urothelial carcinoma (HGUC). (Paris System)
- left PCN cytology: Suspicious for high-grade urothelial carcinoma (Suspicious)
- subsequent right and left PCN cytologies: suspicious/atypical for HGUC in several samples

Ureter, right, biopsy ---- negative for malignancy

Final Diagnosis: High-grade urothelial carcinoma with presumed infiltrative periureteral/retroperitoneal spread causing bilateral ureteral obstruction and high-grade D3 obstruction

Problem Representation: 68 yo F presenting with 10 days N/V and decreased intake.

Teaching Points (Varsha, Javier and Ethan)

Differences between GERD/Reflux and vomiting, remember when you vomit you are refluxing. With vomiting what other symptoms are presents?

Difference b/w vomiting and GERD - things are moving in reverse direction from stomach to esophagus in both

- GERD - reflux of gastric content/acid contained to the lower esophageal tract → abnormal distal LES relaxation with normal stomach motility
- Vomiting - completely regurgitation → hypercontraction of stomach to force content up.

Isolated vomiting: Hidden structural cause - GI, Brain, Heart (MI) VS non- structural cause - substance (2Cs - Chemo/cannabis)

Ulcers develop in any area b/c of → **3 Is** → **inflammation** (infectious/drug induced), **ischemia** (dual blood supply of stomach makes it rare), **infiltration**
Eg: peptic ulcer disease, H.Pylori, NSAIDs, neoplasm (gastrinoma)

Whenever both ureters are dilated → bladder is probably involved → obstructed vs stiff bladder (infiltration) vs external compression

Disease encasing the duodenum and disease encasing the ureter → could have a much more diffuse/infiltrative disease process → MRI/ex lap/ high quality tissue sampling

Cytology - studies the overall appearance of a cell → might have malignant features → but aggressive inflammation can mimic cancer cells

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"One life, so many dreams" **Case Presenter**: (@Kyaw Thet) **Case Discussants**: (@Helen Shi) & (@Aye)

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Scribing (Hans):

CC: 76 y/0 m pw HA for 2 months right side headache, progressive in nature.

HPI: Right sided intermittent for 2 months
Gradual onset, right ear pain, right occipital pain,
Right hemicranial HA can not wear hat sometimes vomits, feels dizzy and sleepy and generalized weakness w/ tendency to fall backwards. Dysphagia solid>liquid, constipation with hard stool.
Loss of wt 120 lbs to 96 lbs
Denies cardiac and respiratory problems.

ROS:

PMH:
DM 2 HTN,
CKD, BPH
For 6 months tinnitus reduced hearing Foreign body removed
Sudden Right sided weakness removed w/ glucose.
Right facial palsy
Meds:
Atorvastatin

Fam Hx:

Social Hx:

Health-Related Behaviors:

Allergies:

Vitals: T: wnl **HR**:
BP: 171/81 **RR**: **Sat**:98% **BMI**: all normal
Exam: Gen: PERRLA
HEENT: facial asymmetry
Right temporal artery thickness
Right otitis media
Neuro: VII LMN lesion facial palsy on right side
Power 5/5, except ⅘ on hip and knee flexion
Reflexes normal
Hoffmann sign negative
Plantar response flexor
Finger to nose test ok
VIII reduced hearing on right side
I Hyposmia
II unable to reads w/o glasses
III, IV, VI normal
V Hyperesthesia on right side of face
CV: normal
Pulm: normal
Abd: normal
Extremities/skin: wnl

Hematology:
WBC: Hgb:7.9 Plt: MCV:
Fe low, TIBC low Transferrin normal
Microcytic hypochromic anemia of chronic dz.
Chemistry: normal
ESR: 120 CRP:113.9 D-dimer >3000
Imaging:
MRI: diffuse infiltrative scull based findings
Mastocytosis
Osteomyelitis
Nasoscopy no lesions, chronic inflammation negative for malignancy
ENT profile normal
US : temporal vessels findings consisten w/ gigant cell arteritis Artherosclerotic plague along frontal branch of right temporal artery

Hemogramm leukocytosis

BCX no growth Dx: B/L osteomyelitis w/ mastitis GCA can be excluded.

Problem Representation: Older male comorbid with new onset headache with red flags including constitutional syndrome and with associated lower cranial nerves compromised. The MRI showed B/L mastitis with osteomyelitis. US temporal US pointed to GCA.

Teaching Points (Javier)

First approach of headache

- **Primary** (Migrain, tension type headache, Trigeminal Autonomic)- *ICH3 classification gives specific criteria. Eg. Migraine : 3-72 hours, photophobia or phonophobia…*
  Trigeminal (Unilateral pain, red eye,e.g.) Subdivided based on duration.
- **Secondary** (Inmunologic, infections, bleeding, structural)

Look for red flags: Fever, Rapid onset, **systemic signs (**eg. weight loss), old age.

SNOOOP10

PEARLS

- Reproducible pain could be associated with **nerve irritation**
- Solid dysphagia can help go towards a structural cause. However, lower cranial nerves can explain sometimes **dysphagia**, thats why is always important to evaluate every cranial nerve.
- Any localizing symptoms is relevant in the context of headache.
  Eg. Contiguous mastoiditis. In this case right ear pain was revealing
- >50 years always considerate GCA.
- Jaw Claudication is not always painful, it's also ability to finish to feed due to tired jaw
- Cranial nerve VIII go through internal auditory canal (MRI would be the next step), also cranial nerve comes in around the same localization- Then **focality** around this skull base location could be the explanation of the full presentation.
- It's not unusual to find a **skull base osteomyelitis** that could be cause these multiple neuropathies, metagenomics sequencing is next step when empiric antibiotics don't work