5/3/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: *Javiér(@javierperezn)* **Case Discussants**: *(noah @) & (kirtan@KirtanPatolia)*

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

Scribing (Lukas)

CC: 62 y o male heartburn, nausea, progressive inability to tolerate solid and liquid foods

HPI: GERD, since years controlled with omeprazole. 11 months prior developed postprandial nausea + heartburn despite med.therapy. Progression over 9 months gradually. Diet modification from solids to liquids. 2 months prior to admission he transitioned from soft solids to blended softs. 2 weeks ago, prior to admission he tolerated mainly liquids. He reported epigastric burning and postprandial nausea. Weight loss 13.6 kg over 1 year, 5.4 kg in the last 2 weeks.

ROS (-): vomiting, odynophagia, abd.pain, hematemesis, hematochezia, melena, no b-symptoms

PMH:
GERD
DM
HTN
Dyslipidemia
Glaucoma
Basalcell Carcinoma (resected)
EGD 5 years ago: Schatzki ring with irregular Z-line + few gastric polyps

Meds:
Omeprazole

Fam Hx:
- Mother with colon cancer in the 70s
- Paternal aunt with colon cancer
- sister healthy

Social Hx:

Health-Related Behaviors:
No smoking
drinks 1 glass of wine on most nights

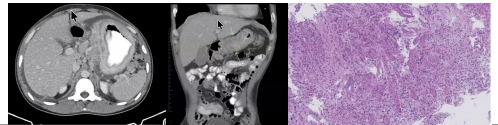
Allergies:

Vitals: T: - **HR**: - **BP**: - **RR**: - **Sat**: - **BMI**: -
Exam: Gen: mildly cachectic
HEENT: - **CV**: - **Pulm**: -
Abd: mild epigastric tenderness, no guarding or rebound, no palpable mass, no hepatosplenomegaly
Neuro: - **Extremities/skin**: -
Nasogastric tube was placed draining bilious fluid

Notable Labs & Imaging:

Hematology:
WBC: 9,2 Hgb: 10,6 Plt: 388 MCV:
Neutrophils: 72%, 18% lymphocytes, 8% monocytes, 1% eosinophils
Chemistry:
Na: 134 K: 3,1 Cl: 92 HCO3: 32 Cr: 1,1 BUN: 28 Glucose: 94 Ca: 8,2 Mg: 1,5 P: 2,3 AST: 26 ALT: 20 Alk-P: 104 gGT: 48 Bili: Albumin: 2,6 Total Protein: 5,6 INR: 1,2 PT: 14,8s aPTT: 30 s
LDH: 212 U/L CRP: 18 mg/L HbA1c: 6,1% Iron: 44 TIBC: 228 Ferritin 168 ng/ml Vitamin B12: 342l
Upper endoscopy: 2 months prior; fasting for 24 hours but much residues, but no intraluminal mass seen, mucosa biopsies negative for malignancies
emptying scintigraphy: prolonged gastrointestinal passage time 86% remained after 4 hours (normal < 10%)
Preliminary Dx: idiopathic gastroparesis; Rx -> ondansetron, erythromycin, MCP, scopolamin. No improvement.
CT: abnormal circumferential wall thickening up to 20 mm; prominent at the antrum, and pyloric canal. The antrum appears decomprssed and non-expansive. Proximal stomach distended with retained material. No discrete intraluminal mass was identified -> Decompression with NGT
repeat EGD: Grade C reflux esophagitis; stomach with diffuse nodularity of the mucosa along the anterior gastric body and the antrum. The pylorus appeared narrowed. Endoscopic ultrasound with patchy wall thickening 20 mm involving lesser curvature involving the deep mucosa.
Biopsy: poorly differentiated adeno-ca; mismatch repair protein preserved, pdl1 negative; FISH shows no amplification

Dx: diffuse infiltrative poorly differentiated gastric adenocarcinoma



Problem Representation: 62 yo male with long standing GERD presents with progressive difficulty swallowing foods/liquids with heartburn and consecutive 14 kg of weightloss within 1 year while CT and ultrasound showed gastric wall thickening with biopsy revealing poorly differentiated gastric adenocarcinoma.

Teaching Points (Siva/Ramaswamy)

Approach to nausea, inability to tolerate solid and liquid foods -
Non specific; obtaining baseline is crucial, if intake is altered
Dysphagia vs inability
Pace - **1 hr - SBO; over few weeks to months - pathology -> critical point**
Inability to tolerate liquid and solid foods
- can be secondary to - obstruction - SBO/LBO/Achalasia ;
- Motility - gastroperesis
- extraluminal - large mediastinal mass or hepatosplenomegaly

Workup **- worth including ACS workup - EKG, troponins; EGD**
GERD of new onset can be analogous to asthma of new onset
- Solids -> liquids - s/o potential growing obstruction
- GERD - > clinical diagnosis > lab/ EGD diagnosis

Motility disorder -> solids + liquids
Structural -> progressive dysphagia
- Abscence of N,V does not rule out obstruction

*- **Progressive dysphagia + postprandial nausea -> diagnostic uncertainty for esophageal vs elsewhere in the GI tract***
Weight loss - > cause vs consequence
-Malignant process RF -> male, exposure to carcinogens, family history of Ca,
Early onset and close relative with CA - > increased risk
-Polyps -> >number s/o potential CA vs syndrome
Colon CA - polygenic (KRAS) vs Lynch syndrome/ FAP
CA predisposition in LGI increases risk for UGI malignancies
-NG tube - to tolerate feeds vs concern for obstruction
-PPIs -> good for GI tract not for electrolytes like Ca2+ and Mg2+
-Imaging approach -> Worth imaging greater than a single area of focus to define the extent.
- CT pearl - Lumen is not visible in CT. Further Bronch, EGD needed.
- Erythromycin prior to EGD to improve gastric motility, nuclear scinitgraphy
- *Gastroparesis causes* - DM, paraprotenmia, Severe B12 deficiency;
- *Infiltrative disorders* - Sarcoidosis, lymphoma, amyloidosis, scleroderma - worth considering when lumen and EGD show no clear pathology; Gastric CA - signet ring adenoCA - ECadherin mutation - requires deep biopsy; Infiltrative disorders in general - difficult to Dx.
- ***premature labeling as idiopathic - dangerous - requires further workup***
- *Non neoplastic infiltrative diseases* - TB, histo, HES, mastocytosis, hypertrophic gastropathy (Menetrier disease)
- Stomach analogous to heart - cardiac amyloidosis analogous to infiltrative disorder of the GI