4/21/26 Morning Report with @CPSolvers

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

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

Scribing (Lukas)

CC: 45 y o male right sided abdominal pain

HPI: 1 week of RUQ abdominal pain radiating across right flank, 6/10 on painscale; no aggravating or relieving factors; no pain meds so far; no similar episodes.

ROS: no fevers , no chills,no nausea, no vomiting diarrhea or chest pain

PMH: none

Meds: none

PSH: appendectomy

Fam Hx: non contributory

Social Hx: -

Health-Related Behaviors: -

Allergies:

Vitals: T: 36,2°C **HR**: 62 **BP**: 184/82 **RR**: 20 **Sat**: 100% room air **BMI**:

Exam: Gen: wnl **HEENT**: wnl **CV**: wnl **Pulm**: wnl

Abd: soft nondistended, tender to palpation RUQ and epigastric area; epigastric 4x3 cm non tender mass

Neuro: wnl **Extremities/skin**: wnl

Notable Labs & Imaging:

Hematology: WBC: 10,7 Hgb: 13,9 Plt: 225 MCV:82

Chemistry: Na: 141 K: 3,6 Cl: 104 HCO3: 25 Cr: 1,69 BUN: 17

Glucose: 229 Ca: 9 AST: 17 ALT: 35 Alk-P: 73 tBili: 0,2

Albumin: 4.5 Total Protein:7,4 Lipase: 913; lipid panel normal

UA: wnl

EKG: Sinus rhythm

CT A/P: ill defined 7,4x7,1 cm head of **pancreas mass** with encasement of the SMA, subtle, cystic changes. Elevation of superior mesenteric vein(?) Retroperitoneal adenopathy. Benign renal cysts

Course: GI consult; endoscopic ultrasound

48x48 multicystic lesion in pancreatic head, probably microcystic cystadenoma; pancreatic tail and body free. Portal vein and superior mesenteric vein normal, as abdominal aorta and celiac trunk. SMA not seen.

Biopsy: diffuse large b cell lymphoma; oncology outpatient service; R-CHOP regiment started

Dx: diffuse large b cell lymphoma

Problem Representation:

45 yo male prior healthy patient presents with 1 week of RUQ abdominal pain with right flank radiation and elevated lipase turned out to have DLBCL mimicking pancreatic head tumors.

Teaching Points (Eugene)

Abdominal pain:

-What is the clinical context of the host? (PMHx, duration, characteristics).
-Meds being taken, similar symptoms in the past
-Separate direct pain from radiating pain (from structures in thorax, spine, pelvis)
-Hypothesis derived physical exams (deduce differentials from problem and narrow down)
-Anatomic structures for RUQ pain radiating to flank: Kidney, adrenal, ureter, ascending colon. Epigastric: Pancreas, transverse bowel, aorta

Palpable Adominal Mass

-Palpable intra-abdominal mass on exams warrants imaging
-Physiologic (distended bowel, fluid, stool) vrs pathologic (tumour, aneurysm from aorta, cyst, abscess, enlarged organ)

Labs and Imaging

-High lipase: not specific to only pancreas. Other causes: Kidney failure, bowel wall injury, cholecystitis, sphincter of Oddi dysfxn, DKA, microliposemia,
-Mass in pancreas on imaging: Neoplasm: solid(adenocarcinoma, neuroendocrine, solid pseudopapillary, acinar, sarcoma, lymphoma) vrs cystic (serous cystic, mucinous cystic, intraductal papilalary mucinous, pseudocyst) or inflammatory.
-Tunour markers for Ca pancreas diagnosis not sensitive, rather good for monitoring