8/11/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Sudarshan* ***Case Discussants****: Ravi & Kirtan*

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

Scribing (Eyron):

CC:

60/F lives in group home presenting to ED with right sided chest pain

HPI:

Reports right sided chest and abdominal pain, nausea, vomiting, and cough for several days. Denies shortness of breath, fevers, chills, and trauma.

Not reliable historian - HPI limited

PMH:

Paranoid schizophrenia
Intellectual disability
MDD
HLD

Meds:

Aripiprazole
Fluoxetine
Benztropine
Atorvastatin

Fam Hx: Unknown

Social Hx:

Lives in group home
Denies EtOH/substance/tobacco use

Health-Related Behaviors:

Allergies: NKDA

Vitals: BP: 133/83, otherwise stable
Exam: Gen: NAD
CV: Murmur heard best at RUSB |**Pulm**: Decreased BS on right
Abd: Soft, mildly tender on R, non-distended
Neuro: Non-focal | **Psych**: poor insight into clinical condition
Extremities/skin: warm, good turgor

Notable Labs & Imaging:

Hematology:
WBC: 6.5 (N78) Hgb: 12.7 Plt: 439
Chemistry:
Electrolytes: nl | Cr: 0.8 Glu: 108 | LFTs wnl | Alb: 3.9 |PT 13.4 INR 1.16 aPTT 30.8
UA: Trace protein and ketones, unremarkable | Trop: 45 (mildly elevated) | EKG: nl
Imaging:
CT Head: No acute intracranial hemorrhage or lesion
CTPE: No PE, obstruction seen at the right mainstem bronchus with near complete atelectasis of the right lung and moderate to large right pleural effusion
CTA/P: 6.9 cm peripherally calcified cystic lesion in the anterior pelvis, likely ovarian, moderate stool burden in colon
Pelvic US: 7.5 cm complex cystic right adnexal mass with solid components and minimal vascularity
Bronchoscopy: Right mainstem bronchus >90% obstructed by endobronchial lesion, separate lesion noted in RML and an additional endobronchial lesion in the L mainstem bronchus
Endobronchial biopsy: AdenoCA with mucinous and signet-ring cell features
Immunostaining: Pos for CDX2 CK20 CK7 ; neg for TTF1 Napsin PAX8 ER GATA3- suggestive of GI/biliary source | **Tumor markers**: **CA125** 49 **AFP** 2 **bHCG** 4 **CEA** 6.2 **CA 19-9** 289
MRCP: no pancreaticobiliary abnormality, T8 compression fracture
EGD: Gastric lesion near pylorus with central depression
Colonoscopy: prolapsed rectrum and internal hemorrhoids, no polyps or lesions
Repeat CT A/P: interval increase in b/l pulmonary nodules, bulky R hilar mediastinal mass, 7.2 cm mass along superior bladder in region of the urachal remnant

Dx: Widely metastatic mucinous/signet ring cell adenocarcinoma of uncertain primary (urachal remnant vs. GI)

Problem Representation:
60/F p/w right sided chest pain and abdominal pain, found to have obstruction at the right mainstem bronchus. Biopsy of endobronchial lesion revealed mucinous/signet ring cell adenocarcinoma with immunostaining suggesting GI/biliary source. EGD/colonoscopy negative for source and repeat abdominal imaging showed a mass in the region of the urachal remnant.suggesting primary source.

Teaching Points (Varsha)

Chest pain → 1st priority → CAD/ ACS
Anatomical involvement: **Anterior contents of thorax**: Coronary arteries, aorta, pulmonary vessels, pleura, pericardium Vs **posterior contents**: - spine, posterior mediastinal structures
Left sided chest pain - most common; embryological development → nerve shared with left shoulder, neck and jaw (classic presentation)
Right sided chest pain - ACS (atypical presentation in females) → correlate with HPI (dyspnea, palpitations), PMHx, RF, Physical exam, investigations (EKG, troponin)

In an unreliable historian: Rely on labs (CBC, CMP, HIV/Hep B, C syphilis, TSH, vit B12, ferritin, drug screen) / imaging/ investigations to make progress. (X Ray preferred when you know what you're looking for Vs CT & if no time crunch CT >> X Ray. consider IV thiamine

Right sided abdominal pain: Hepatobiliary system, hepatic flexure of bowel, pancreas, part of stomach. Review medication (nausea/vomiting)

Pleural effusion: exudative unless proven otherwise
-Catastrophic vascular pathology → PE → CTPE
-Infections (parapneumonic) → usually parenchymal signs + (could be associated with fever, chills) Vs rarely without parenchymal signs - TB of pleura
-Neoplasm → is the primary in Thorax (lung/lymphoma/ mesothelioma) → imaging or is it a a secondary deposit

Atelectasis: **Resorptive** or Obstructive (lumen or bronchial wall)- Mucus plugs/foreign body infection/ tumor Vs **Compressive** (outside the bronchus - Lymph node/ mass)
-Mediastinal shift: **Push and Pull phenomenon** (Pleural effusion and concomitant atelectasis)

-Signs of malignancy: increased size/ complex nature of mass
-Chances of ovarian primary to affect only bronchial wall and not parenchyma is less likely Vs Ovary and lung could both be a secondary to another primary tumor
-Sites of mucinous tumor - Ovary, GI: appendiceal, gastrial, pancreas (peritoneal metastasis Vs Signet ring cell - Lymphatic spread more common)

Tumor Markers: TTF and Napsin - lung/PAx8: Mullerian tumor/GATA3 - breast/CDX and CK 20- GI