7/21/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Kuchal Lambal (@AgadiKuchal) **Case Discussants**: Ravi (@rav7ks) & John(@calicocapybara)

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

Scribing (Renzo)

CC:

HPI: A 71-year-old woman presents with **1 week of fatigue shortness of breath and lower abdominal fullness/pain**.

Apparently normal a week ago. Then she started having shortness of breath, positional; Her shortness of breath increases when she lies down in supine position, and relieved when she lies in the Right lateral or left lateral position

She describes her abdominal fullness as feeling like *"air moving."* Over the last day it worsened, now with nausea and two episodes of non-bloody, non-bilious emesis containing recently ingested food. No bowel habit change.
She also reports **increased urination and increased thirst all through the night**, with poor sleep, and woke up too fatigued to function — prompting her family to bring her in.

ROS: **6 lb weight loss over 3 months**, increased sweating, heat intolerance. Denies cough or anorexia.

PMH: of HLD and GERD

Meds:

Fam Hx:

Social Hx:
Independent in ADLs, non-smoker, occasional ETOH.

Health-Related Behaviors:

Allergies:

Vitals: BP 85/32, HR 86, RR 40, T 101.9°F, SpO2 100% on room air (later requiring a simple mask at 10L to maintain saturation).

Exam: Gen not ill-appearing, no acute distress (deceptively reassuring)
HEENT:
CV: Normal
Pulm: normal

Abd: **distended, soft, with a palpable mass and diffuse tenderness with guarding, no rebound**
Neuro: Neuro: alert and oriented x3, no focal deficit
Extremities/skin:

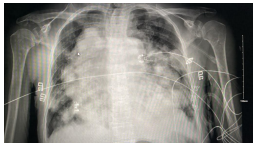
Notable Labs & Imaging:

Hematology:

CBC: WBC 15.84 (neutrophil-predominant), Hgb 10.9, **MCV 78.6** (microcytic), Plt 126
BMP: Na 135, Cr 1.3, eGFR 43, glucose 256, **anion gap 18**
VBG (initial): pH 7.22, pCO2 50, HCO3 20, **lactate 5.2**
VBG (repeat, ~2.5h later): pH 7.16, pCO2 44, HCO3 16, **lactate 7.2**, Hct dropped from 34 → 27
VBG (repeat again): pH 7.26, lactate 4.0, Hct now 23
AST 40/ALT 16 (mild transaminase pattern), troponin <0.010, lipase normal
UA: trace blood, 100 protein, WBC 10.9, RBC 8.3, numerous granular/hyaline casts EKG: NSR, **new(?) RBB**

Imaging: **CT chest (no contrast):** 5.5 x 8.5 x 10.6 cm **anterior mediastinal mass** abutting the ascending aorta and main PA, extending along the right atrial border — "highly concerning for malignancy, probably lymphoma." Two LLL soft tissue masses (1.6, 1.5 cm) and multiple sub-centimeter bilateral pulmonary nodules. Small right pleural effusion.
CT A/P: 13.2 x 6.4 x 9.7 cm heterogeneous **retroperitoneal mass** inferior to the right kidney, encasing the perirenal space, displacing duodenum, **inseparable from the IVC**, encasing the cecum/ascending colon, extending into the pelvis with deposits in the cul-de-sac and mesorectum. Differential given: **retroperitoneal sarcoma, lymphoma, or metastasis**. Pancreatic hypodensities. Ascites with peritoneal deposits. Pericardial effusion.

CXR: :



Dx: Thymic Carcinoma

Problem Representation: 71-year-old woman with months of constitutional symptoms followed by acute orthopnea, abdominal distension, and shock, ultimately found to have disseminated malignancy characterized by bulky anterior mediastinal and retroperitoneal masses with pulmonary and peritoneal metastases.

Teaching Points (Gillian)

Multiple chief complaints:
- Determine the threshold event
- Don't assume they will all tie together
- Prioritize most urgent ddx
- Gathering data before representing the problem
- Define chronicity (last known well; look for sx of chronicity like weight loss)

Symptom-base
Abdominal Fullness + dyspnea consider volume overload
Orthopnea: classically heart failure, but anything pressing on diaphragm (ascites, obesity, bilateral diaphragmatic paralysis, hypo/hyperthyroidism, COPD, URTI)
Polyuria, polydipsia point to endocrine cause/osmotic diuresis
Weight loss, night sweats point to chronic inflammatory process

Physical Exam localization
Prominent veins: intrinsic compromise fibrosis, thrombosis; extrinsic: tumor/mass, lymphadenopathy
Palpable abdominal mass: enlarged organ (liver, spleen), fluid (massive bladder, ascites), hollow viscus, mass (ovarian colon, retroperitoneal, lymphoma) → Imaging
Hypotension without tachycardia: sick sinus, beta blocker, conduction disease

Laboratory data
Hgb dropping: is there continued bleeding, hemolysis
Lactate: local hypoperfusion, poor clearance, excess production from cancer, global hypoperfusion (shock)
White count: infection, inflammation,malignancy, stress
New RBBB: ischemia, stretch (PE most often)
Lymphoma: Hodgkin vs Non-hodgkin→ indolent vs aggressive
- Aggressive: DLBCL is most common
- mimics: IgG4 related disease, tuberculosis/fungal infections