4/9/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Lukas Wohnrath* ***Case Discussants****: Rabih & Siva (@siva11r (IG))*

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

Scribing (Magnus)

CC: 75M with CP and vomiting

HPI:

Reflux and involuntary hiccups. No triggers. For the past year more and more hiccups.

1 day prior more worsening and has had 8 episodes of non-bloody non-bilious emesis

Son persuaded him to go to ED. Family worried for the patient, has noted anorexia and weight loss over 6 month.

ROS: No fever, chills, SOB, cough, nausea, dysphagia, abd pain, heachahce, dysuria

PMH:
HTN
Gout

Meds:
Enalapril
HCTZ
Allopurinol

Fam Hx:
Non-contributory

Social Hx:
Retired truck driver

Health-Related Behaviors:
No travel
3 pack year smoking, quit many yrs ago
No alcohol or illicit drugs

Allergies:

Vitals: T: afebril **HR**: 80 **BP**: 118/61 **RR**: nl **Sat**: 97 RA **BMI**: 24

Exam: Gen: NAD. Hiccups noted. **HEENT**: No LAD. **CV**: Systolic murmur loudest at R upper sternal border and L 5th IC space mid-clavicular. No radiation. No JVD. **Pulm**: CTAB **Abd**: Sparse bowel sounds. Visible mass in RUQ. Firm, painless, no skin changes. Rest of abd soft, non-tender, non-distended. No guarding, but intermittent contractions. No CVA tenderness. **Neuro**: nl **Extremities/skin**: No edema.

Notable Labs & Imaging:

Hematology:

WBC: 18.8 Hgb: 11.5 Plt: 696 MCV: nl

Ferritin 696 TSAT 10.9 B12 nl Folate 4.2

Chemistry:

Na: 135 K: 5 Cl: nl Cr: 2.4 (baseline 0.8) Glucose: 165 Ca: nl

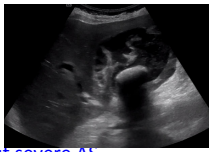
AST: 90s ALT: 90s Alk-P: 193 GGT 184 Bili: nl Albumin: 39.3 TProtein: 59

CRP: 181 LDH: 259

Trope 43 CK normal

TSH normal Lipase nl UA nl

Imaging:



EKG: SR with LBBB no ST-changes CXR: nl

TTE: LVH, normal LVEF, severe aortic sclerosis without severe AS

Abd US: Conglomerate 7x7 cm with liquid components and 3 cm calculus 5mm CBD

Started on Zosyn and IV fluids. Renal function improved. Remained stable.

CT: Gallbladder no longer clearly identifiable. A lobulated multi-septated conglomerate within the gallbladder fossa, extending into liver. Measures 9x9 cm and contains calculus.

CT-guided drain placement. Cultures grew E. coli, Klebsiella, E. faecium.

Cholecystectomy without evidence of malignancy.

Dx: Acute-on-chronic xanthogranulomatous cholecystitis

Problem Representation:

75 yo male presents with vomiting, singultus and a 6 month history of weight loss was found to have signs of subacute hepatobiliary inflammation (shown by Leukocytosis, Thrombocytosis and elevated ALP) and a calcified liver mass.

Teaching Points (Julia) →

Substance (diffuse symptoms) **S**tructural issue (pinpoint the lesion)

- Singultus: N.phrenicus/diaphragma vs GI → > structural

US > CT? IF high suspicion for Cholecystitis and ovarian tortion

Distinguishing noise from important clues:

I) Clues/Signal

Mass (benign or malignant)

Study internal and external consequences!

External: no overlaying skin findings (ulceration/bleeding) ->

Internal: Singultus w/ irritation of diaphragm/N.phrenicus?

Inflammation (Leukos↑ PLUS Thrombos↑)

labs can be used as a marker of chronicity

-> subacute infection vs cancer vs hidden infection (abcess/granuloma)

Calcification liver mass:

Infections

Echinococcus / Entamoebia infection R > L liver lobe

Abcess / xanthogranulomatous reaction

Cancer

Cholangiocarcinoma 2/2 hepatolithiasis

HCC (w/ calcification) (cirrhotic morphology present?)

II) Noise/Consequence

Wide pulse pressure (high cardiac output OR normal cardiac output w/ stiff vessel) hint: chronic hypertension and calcific AS (systolic murmor) -> noise

Struvit stone -> xanthogranulkomatosus PN (macrophages)