VCU Medical Center
Virginia Commonwealth University

Department of Internal Medicine
Clinicopathologic Conference

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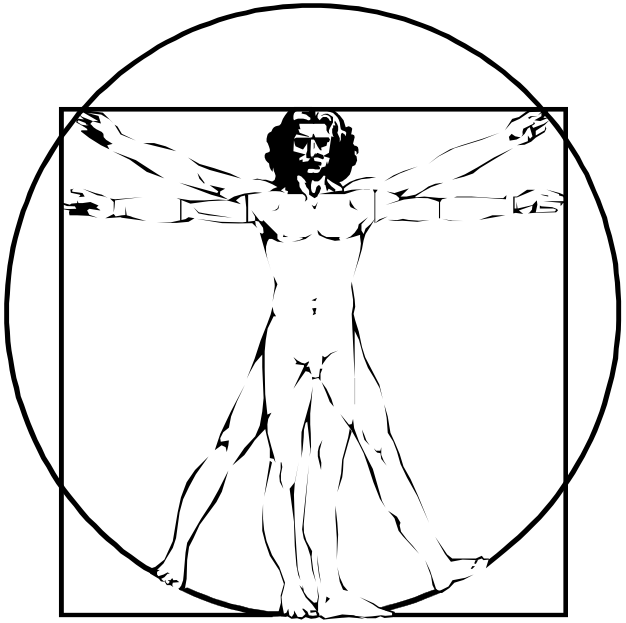
A 45 year old man with progressive abdominal swelling, constipation and vomiting



Case History

CC: Increasing abdominal swelling, pain, constipation
HPI:
A 45 year old gentleman presents to the emergency department for evaluation of three weeks of worsening abdominal pain, swelling and constipation. He describes the abdominal pain as generalized, pressure-like, no particular change with movement or eating. He reports that the abdominal swelling has occurred over the same three weeks; he cannot button pants on old clothes. Over this time, he states that he has lost approximately 20 pounds. He does report some fatigue, decreased appetite, and increasing abdominal size for the last year, but he states that this major change has occurred over the past three weeks.

He now has stopped eating completely and has developed decreased caliber stools and constipation. He has had some intermittent nausea and vomiting which has worsened over past day. Vomitus is clear/yellow, no blood noted. He denied fever, chills, and diarrhea. He denied hematemesis or hematochezia. He does not have a history of liver disease or kidney disease. He does have a history of binge drinking (reports last binge one month ago) and tobacco use (approximately 3 cigarettes per week for 15 years). There is no history of any other substance abuse or intravenous drug use.

He denies any chest pain, shortness of breath, or cough. He denies lower extremity swelling and sleeps on one pillow at night, denies episodes of PND. When asked, he does report night sweats but states that he has had these for years.

Past Medical History:
None

Past Surgical History:
Vasectomy 2009
Hernia repair 2012

Allergies: no known allergies

Family History: none

SH: married, lives with his wife and has one biological child, three step-children; tobacco and alcohol use as per HPI; no illicit drug use; worked in construction as a demolition worker and has worked at a concrete plant in the past; currently not working; no recent travel, no pets; he has no history of incarceration; hobbies are cooking and drag racing. He was in jail once for one day in past. He denies any travel.

Review of Systems:
Entirely negative except as noted in the HPI

Physical Exam

Blood Pressure 131/96 Heart Rate 118
Respiratory Rate 20 Pulse Oximetry 98% on RA
Temperature 37C

General: mild distress as he moves due to abdominal pain; alert and oriented
HEENT: bilateral temporal wasting, conjunctivae pink, sclera anicteric, mucosal membranes moist without lesions
Neck: supple, no jugular venous distension, no lymphadenopathy
Lungs: clear to ausculatation, no rales/rhonchi/wheezes, normal symmetrical expansion
No gynecomastia
CV: normal rate, regular rhythm, normal S1 and S2; no murmurs, no S3 or S4 noted, PMI nondisplaced
Abd: distended with bulging flanks, but soft; fluid wave and shifting dullness present; mildly tender to palpation over epigastric region, bowel sounds present; no organomegaly or masses noted
Ext: warm and well perfused, no edema, hypothenar and thenar wasting, no palmar erythema noted
GU – testes nl in size, no lesions/masses
Skin – no rash, no spider angiomata, normal color
Neuro – oriented to person, place, time, situation; no asterixis, normal strength, DTRs 2+ throughout, no abnormal cerebellar signs, normal gait

Laboratory and Imaging Studies

CBC:
WBC 11.3 (81.9% PMN), Hgb 15 (MCV 80), Plt 384

Basic Metabolic Panel
Sodium 133 mmol/L
Potassium 4.2mmol/L
Chloride 101mmol/L
Carbon Dioxide 21mmol/L
Glucose 100mg/dL
BUN 15mg/dL
Creatinine 1.06mg/dL
Calcium 9.5mg/dL

Hepatic Panel:
AST 30units/L
ALT 39 units/L
Alk Phos 125units/L
Total Bilirubin 0.8mg/dL
Conjugated Bilirubin 0.3mg/dL
Albumin 3.5g/dL

Lipase 38 units/L
BNP 3pg/mL
AFP 4.5ng/mL

Diagnostic Paracentesis:
Yellow/Hazy
Albumin 3.1g/dL
Amylase 38 units/L

Cell Count:
RBC <10,000/mm3
WBC 571/mm3
Poly 19%, Lymph 28%, Eos 1%, Baso 1%, Macrophage 50%, Mesothelial 1%
Glucose 68 mg/dL

LDH 229 units/dL
Bacterial Culture: negative
Protein 5.2g/dL
AFB Culture: negative

Cytology: negative for malignant cells reactive mesothelial cells; acute and chronic inflammation

Imaging studies:
Abdominal KUB:
1. No evidence of obstruction. Only a minimal amount of colonic stool. The colon is collapsed.
2. Suggestion of thick-walled small bowel in the left mid-abdomen.
3. Significant ascites.
4. Bibasilar atelectasis and small bilateral pleural effusions.

CT scan abdomen/pelvis:
1. Massive ascites. Slight suggestion of peritoneal enhancement in the pelvis but no peritoneal nodules are seen.
2. Thick walled loops of distal jejunum are seen in the floating mid abdominal; small bowel with mild proximal jejunal dilatation and distal small bowel collapse.
3. No lymphadenopathy.
4. Mild to moderate colonic diverticulosis, no diverticulitis.
5. 1.3 cm hemangioma in the inferior liver. Otherwise, normal appearing liver. No splenomegaly. Portal venous system normal.
6. Bilateral renal cortical cysts. Kidneys otherwise unremarkable.
7. Pericardial effusion, bilateral pleural effusions and compressive atelectasis at both lung bases.
8. Minimal atherosclerosis.

Upper GI:
1. Multifocal intestinal and gastric fold thickening. Speckled appearance of proximal jejunal folds. Findings are concerning for multifocal serosal process, such as tumor implants.
2. Partial small bowel obstruction at the level of the mid small bowel.
3. Long length of mid to distal small bowel demonstrate luminal narrowing with fold thickening. Luminal irregularity is concerning for serosal process such as infection or neoplasm / carcinomatosis. Luminal narrowing differential considerations include prior radiation therapy to lower abdomen and pelvis, infectious processes, ischemia including ischemia due to vasculitis, medications/drugs and possibly the peritoneal.
4. Esophageal dysmotility. Small hiatal hernia.

Endoscopy:
Upper:
A non-obstructing Schatzki ring (acquired) was found in the lower third of the esophagus. A medium-sized hiatus hernia was present. Bilious fluid was found in the gastric body. Fluid aspiration was performed. Patchy mildly erythematous mucosa without active bleeding and with no
stigmata of bleeding was found in the duodenal bulb. The 2nd part of the duodenum was normal.

Lower:
The perianal and digital rectal examinations were normal. A sessile polyp was found in the cecum. The polyp was 3 mm in size. Biopsies were taken with a cold forceps for histology. A sessile polyp was found in the transverse
colon. The polyp was 7 mm in size. The polyp was removed with a cold snare. Resection and retrieval were complete. An area of mildly congested mucosa was found in the rectum. This was biopsied with a cold forceps for histology. Multiple small-mouthed diverticula were found in the sigmoid colon and in the descending colon. Internal hemorrhoids were found during retroflexion and were medium-sized.

Colon Polyp Biopsy Pathology: tubular adenoma

Rectal Biopsy Pathology: active proctitis with acute cryptitis, no significant chronic inflammation or crypt disruption

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A consultation and procedure were performed to arrive at the definitive diagnosis.