4/9/20 Morning Report with @CPSolvers

Case Presenter: *Charlotte S. (@tarheel_doctor)* ***Case Discussants:*** *Emma L. (@EmmaHLevine) and Sal K. (@SZKamal)*

CC: 50 F p/w fever + headache for 8 weeks

HPI:
2 mo - daily constant boring headache behind the eye, progressive & severe. No tearing, redness, vision changes, no jaw claudication.
Fever - comes on 11AM every day, takes tylenol.

ROS: + fatigue

PMH:
HTN
gunshot wound remote w/ bullet fragment (next to aorta)
no surgical Hx,

Meds:
HCTZ

Fam Hx:
mother: psoriatic arthritis
father: MI (age 55)

Soc Hx: no smoking, vaping, no recent travel. 2 male partners in last 6 mo w/ consistent condom use.

Vitals: T: 98.1, HR: 88, BP: 121/90, normal RR & SpO_2
Exam:
Gen: morbidly obese, non-toxic appearing
HEENT: normal conjunctiva, EOMI, normal visual fields. Tenderness to palpation of L. scalp "feels swollen", no lymphadenopathy
CV/Pulm/Neuro: normal
Extremities/Skin: no rash

Notable Labs & Imaging:
CBC/CMP: WBC 2.1, ANC 1.21, ALC: 1.35, no mono/eos, Hg 13.9, Plt 109, Cr: 1.28 BUN 17
AST: 217, ALT 114, AP: 82, Tbili: 0.6
LP: normal w/ normal opening pressure
Imaging: head CT no acute process. Pan-scan unrevealing
ID: Negative: viral (+HIV), endemic mycoses, tick-borne neg, CSF Cx neg
Rhum: neg: ANA, ANCA, SMA, mitochondrial, CCP, RF, ferritin 6900, CPK 636, LDH: 896, haptoglobin 46
Heme: PT/PTT/INR normal, fibrinogen 178, D-dimer 4, smear: big platelets, lipid: triglyceride 338
BMBx: frequent hemophagocytosis
PET-CT: numerous hypermetabolic intramuscular lesions diffusely.
Biopsy: peripheral T cell lymphoma

Problem Representation: 50F p/w subacute fever, headache and AKI found to have HLH 2/2 biopsy proven peripheral T cell lymphoma

Teaching Points:
Headache: Primary vs. Secondary
Important Headache Q:
- Is this new or old?
- What makes it better or worse? (exp: helps with raising/lowering suspicion for intracranial HTN)

Evaluating blood counts: look at the company it keeps. Multiple cell lines down, consider BM pathology
Very high ferritin: consider adult onset Still's, HLH, disseminated histoplasmosis
HLH pearls: can be primary or secondary
- DDx: ~50% Malignancy: liquid (exp T/NK cell lymphomas) > solid. ~30% Infection (EBV can serve as trigger). ~20% autoimmune (exp: SLE, Still's Vasculitis, IBD)
- Primary HLH can be caused by mutations in genes encoding mediators of cytotoxicity in lymphocytes (exp: perforin)
- Diagnostic criteria: either a molecular dx OR 5/8 criteria met.