5/22/20 Morning Report with @CPSolvers

***Case Presenter**: Bryan Franco (@franklyBryan) **Case Discussants**: RLR (@DxRxEdu & @rabihmgeha)*

CC: dysphagia

HPI: 54 yo F with 1 year history of progressive dysphagia
- Started with solids, progressed to liquids
- No identifiable trigger
- No odynophagia, halitosis, regurgitation, change in voice, n/v, hematemesis, diarrhea, constipation
- ROS +: fatigue, generalized weakness, drenching night sweats, 20kg weight loss, dizziness (?orthostasis), heartburn
- ROS -: No fevers, chills, orthopnea
- 3 weeks ago seen in ED for dizziness: started on iron supplement for anemia
- LMP 3 weeks ago

PMH:
GERD
Hemorrhagic shock during delivery

Meds:
PPI
Ranitidine previously
Ferrous gluconate

Fam Hx:
Non-contributory

Soc Hx:
Immigrated from Italy to Toronto
Worked as secretary

Health-Related Behaviors:
No smoking, alcohol use, drug use

Allergies:
NKDA

Vitals: **T**: 37.5 **HR**: 80 **BP**: 124/80 **RR**: 12 **SpO_2**: 98%
Exam:
Gen: no acute distress, tired-appearing, overweight
HEENT: no scleral icterus, no cervical LAD, oropharynx clear, conjunctival pallor
CV: RRR, normal volume exam
Pulm: clear bilaterally
Abd: soft, non-tender, non-distended
Neuro: 5/5 strength throughout, normal sensation, 2+ reflexes throughout, CN intact
Extremities/Skin: no muscular atrophy

Notable Labs & Imaging:
Hematology:
WBC: 7.4 (normal diff) Hgb: 8.1 (MCV 75) Plt: 323
Reticulocytes 1%, Ferritin 7, Serum iron 34, TIBC 255

Chemistry:
Na: 139 K: 4.1 Cl: 100 CO2: 24 BUN: 10 Cr: wnl
glucose: 150 Ca: Phos: Mag:
AST: 13 ALT: 10 Alk-P 25: T. Bili: 1.0 Albumin: 3.1
INR 1.0, TSH 4.5, B-hcg neg

Imaging:
Endoscopy: mild gastritis (biopsy: H pylori), normal colo

CT Enterography: no mass, intra-abdominal calcified lymph nodes

Barium swallow: esophageal web causing stenosis with cervical osteophytes protruding into the esophagus

Problem Representation:
54 yo woman with a history of GERD p/w 1 year of progressive dysphagia to solids and liquids, a/w weight loss, night sweats and IDA without mass on EGD/colonoscopy, found to have esophageal web and stenosis on barium swallow consistent with diagnosis of Plummer Vinson syndrome (courtesy of Gurleen Kaur)

Teaching Points (Alex Horne):
Approach to Dysphagia: oropharyngeal vs esophageal
- **Oropharyngeal**: difficulty initiating swallow with food bolus stuck in mouth with nasal regurgitation, +cough, choking
  - Ex. Motility (dementia, stroke, Parkinsons, ALS), Structural (Zenker, malignancy, cervical osteophytes)

- **Esophageal:** sense of fullness neck/chest
  - Ex. Motility (spasm, achalasia, scleroderma), structural (extrinsic compression 2/2 to increased LA size, mediastinal mass vs intrinsic such as rings/strictures/malignancy, Plummer Vinson)

A few disease associations with dysphagia
- Halitosis -> Zenker
- Pain + dysphagia -> esophagitis (eg, pill, drug, infectious)
- Weakness + dysphagia -> CVA, MG, muscular dystrophy, others

-Solid dysphagia followed by liquid later in disease course suggests a structural cause; with a motility issue, more likely to have solid/liquid dysphagia onset from the start
-Negative EGD with esophageal dysphagia -> think about motility issues (consider manometry), external compression (vascular malformations, mediastinal mass, enlarged LA, etc), very upper pathology such as a web
- Linking GERD with esophageal dysphagia may be due to: 1) stricture formation, 2) development of esophageal adenocarcinoma

Anemia Pearls
-IDA typically microcytic (can be normo) with low ferritin and low % sat; may also see associated increase in RDW and thrombocytosis
-Palmar crease pallor = sign of anemia (LR 7.9, R Manesh)