5/4/20 Morning Report with @CPSolvers

***Case Presenter**: W. Scott Richardson* ***Case Discussants**: Mohit Harsh (@MohitHarshMD) & Hannah Abrams (@HannahRAbrams)*

CC: Dizziness

HPI: 81 presenting to the ED with dizziness

- 2 months of reduced solid+liquid PO intake and weight loss (134 lb → 120 lb)
- 2 days ago presented to ED dizzy upon standing.
- Day of presentation: same symptoms, admitted

Dizziness: "lightheaded on standing" last few days
Diet: unchanged in composition, less of an appetite. No pain or trouble w/ swallowing, abnormal taste, trouble with teeth, or fear of eating

ROS: nightmares (chronic in setting of traumatic experiences). No hallucinations, nothing neurologic
Last contact w/ health-system: a decade ago

PMH:
PTSD
No MDD

Meds: none

Fam Hx: none

Soc Hx:
Cambodian background (came to US 1980s)
Wife passed away 70s
Shopkeeper, teacher

Vitals: **T**: *37.8C* **HR**: 92 → 122 **BP**: 118/78 → 88/64 **RR**: 16 **SpO_2**: 96% **height:** 5'6 **weight:** 120. IVF **transiently** made orthostatic hypotension better

Exam:
Gen: very thin, wasted, in good spirits
HEENT/CV/Pulm/Abd: unremarkable, no lymphadenopathy or masses
Extremities/Skin: no signs of inflammation. Symmetric global reduced muscle bulk and "extra skin". No localized tenderness of any arteries

Notable Labs & Imaging:

Hematology:
WBC: 11.2 (8% mono) Hgb: 11.1, smear: normocytic, normochromic, no dysmorphic cells Plt: 470

Chemistry:
Na: 134, K: 4.7, Cl: 99 CO2: 24 BUN: 22, Cr: 1.2, glucose 87
AST/ALT/AP: normal, T. Bili: 0.9, albumin: 1.9
ESR: 118
UA: normal
PPD: negative, TSH 2.3 (wnl)
ACTH stim test: < 6 increase in cortisol

Imaging:
EKG: normal, CXR: normal
CT-chest/abd: negative → thin adrenal with calcifications
BMBx: caseating granulomas with acid fast bacillus

Problem Representation:
Older gentleman presents with chronic anorexia and weight loss, found to have sarcopenia, e/o inflammation and an inadequate response to ACTH stim diagnosed w/ disseminated TB with TB adrenalitis

Teaching Points (Smitha):
Weight loss is complex a math problem of energy intake/burn: 1) Reduced intake/access/desire to eat (e.g., untreated depression, elder abuse, odynophagia), 2) Reduced absorption, 3) Excess catabolism (e.g., malignancy, chronic infection, autoimmune causes). 1lb of weight loss = deficit of 3500 calories. Ask "Am I in the right schema." How to confirm: 1) Is weight loss verified? 2) Is it pathologic? Are you high-fiving your pt?
Orthostasis Ddx: 1) preload-dependent cardiac causes (e.g., tamponade, AS), 2) Autonomic (Prazosin, Parkinson's, DM, amyloid) 3) Hypovolemia. HR increase may mean 2<1,3. Base rate of 3>>>1,2, so trial fluids first to use treatment as a diagnostic test.
Weight loss → less fat → less fat stranding → less sensitivity of inflammation on imaging.
Inflammation of unknown origin → infection, malignancy, autoimmune, drugs, endocrinopathy. In elderly pt, need to consider giant cell arteritis and absence of headache, jaw claudication cannot r/o GCA → start with advanced imaging
Thrombocytosis makes chronic infection more likely than acute, solid cancer more likely than hematologic (e.g., GI)
Poor ACTH stim test: primary vs. secondary adrenal insufficiency. Prominent orthostasis helps point to primary. Step 2) Check ACTH. Ddx includes TB adrenalitis.