6/11/20 Morning Report with @CPSolvers

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CC: 74M w/myelofibrosis admitted from Pulm clinic with **shortness of breath** and R- sided **pulmonary infiltrate**

HPI: **Increasing SOB** over 1-2 weeks, acutely worsening 4 days prior associated with **exertional chest tightness**, better with rest. Had GERD-like symptoms 6 days prior to pulm clinic visit.
Wife had fever/nausea/diarrhea 4 days prior
Came into Pulm Clinic for lung nodule screening -->found to have **fever** and **NEW right sided pulmonary infiltrate, with resolution of L sided infiltrate noted prior.**
Other history:
Seen in rural NC prior to COVID
L sided infiltrate - treated with Levofloxacin (Nov-Feb)
Hospital Course:
Improved O2 requirement, felt much better subjectively. Pt reported that he had more severe GERD symptoms prior to admission

PMH:
Myelofibrosis in 2015
CAD (CCTA dx, neg stress test)
Recurrent hemoptysis (s/p BAL - unrevealing)
Meds:
Ruxolitinib - stopped b/c pt preference
s/p Levofloxacin for “PNA”
Nexium
Losartan
Amlodipine
Statin

Fam Hx:
Noncontributory
Soc Hx:
Plumber - doing a lot of work under houses recently
Health-Related Behaviors:
1-3 shots of whiskey, a few times a week
Former smoker

Allergies:
Lisinopril

Vitals: **T**: **101.1, resolved on admission HR**: **77** **BP**: 131/58 **RR**: 16
SpO_2: 96% on 2L NC
Exam:
Gen: well appearing, NAD
HEENT:
CV: RRR, no MRGs, no JVD, no edema
Pulm: **crackles at R base**, normal WOB, left fields clear
Abd: NTND, **enlarged liver, spleen tip 10 cm below costal margin**
Neuro: AOx3
Extremities/Skin: **1 cm bruise under right thumbnail, nonpainful**

Notable Labs & Imaging:
Hematology:
WBC: 4 Hgb: 10.4 Plt: 96 (increased from prior 2 weeks ago)
48 segmented neutrophils, 16 lymphs, eos 1, baso 1, monos 4 . (+) schistos, teardrop cells, nucleated cells
Chemistry:
Na: 138 K: 3.8 Cl: 105 CO2: 23 BUN: 24 Cr: 0.92 glucose: Ca: Phos:
RF<10, ESR 44, ANCA neg, UA without hematuria, neg ANA, neg CCP ab (?)
Imaging:
CT chest: lung nodules unchanged, full resolution of L sided PNA, **large heterogeneous infiltrate of the posterior/lower middle lobes of R lung**
Bronchoscopy: **R upper lobe post segment showed blood**. Additional oozing from the post-segment, felt due to scope trauma. No other bleeding from any segment.
Quant: neg, KOH neg, 1+ normal flora, BCx NGTD, BAL insufficient sample

Problem Representation:
A 74 y/o M with PMHx of myelofibrosis not currently on therapy p/w subacute dyspnea, fevers, and GERD-like symptoms, found to have posterior RLL infiltrate with bronchial bleeding on BAL, thought to have recurrent aspiration w/ pneumonitis-related bleeding.

Teaching Points (Alex Horne):
-**Myelofibrosis**: myeloproliferative neoplasm w/ proliferation of mature myeloid cells -> fibrotic obliteration of BM, notable features include hepatosplenomegaly (extramedullary hematopoiesis) + constitutional symptoms + anemia + increased risk thrombosis/hemorrhage/infection!
- **Ruxolitinib:** JAK2 inhibitor, increased risk of infection d/t suppressive effect on natural killer and dendritic cells - must screen for TB; can see a withdrawal syndrome (ruxolitinib discontinuation syndrome) when stopped w/ full relapse of disease +/- ARDS, DIC
-**Lung nodules** -> Classify by imaging as **centrilobular** (many infections; also aspiration, HSP, endobronchial tumor), **random** (hematogenous infection - miliary TB, disseminated fungal, septic PE vs hematogenous malignancy - solid tumor mets), **perilymphatic** (sarcoid, pneumoconiosis, lymphangitis carcinomatosis, leukemia/lymphoma)
-**Ddx hemoptysis**: infections (TB, aspergillus, abscess/cavities, many others), autoimmune (vasculitis, SLE), bronchiectasis (CF), malignancy, PE, foreign body or trauma, mitral stenosis, bleeding disorders/abnormalities
- **Faget sign = increased temperature with paradoxical decreased pulse** (normally, for every 1 degree temp increase HR also increases by ~8): associated with BB but also intracellular organisms (legionella, mycoplasma, coxiella, brucella)