8/4/20 Morning Report with @CPSolvers

Case Presenter: *Fernand Bteich (@fernandbteich)* ***Case Discussants***: *Maria Jimena Aleman (@mariamjaleman) and Max Klesten (@Maxkelsten)*

CC: Found down

HPI: 70M brought in by EMS after being found down. No eye witness to describe the event. Patient awoke en route to the hospital with limited recollection of what happened.

Had a similar episode one month ago. Denied palpitations, chest pain, DOE, and lower extremity edema.

On arrival to the hospital, he noted tingling and decreased sensation in his fingers and toes (chronic for 15 years).

PMH:
Burkitt's lymphoma (cervical LNs, treated w/ chemo, relapsed, received auto HCT 12 years ago)
Peripheral neuropathy
Prostate CA s/p robotic resection 16 years ago

Meds: Multivitamin
Occasionally omeprazole

Fam Hx:
Son with lupus

Soc Hx:
Lives independently

Health-Related Behaviors:
No EtOH use, no recreational drug use

Allergies:
No known

Vitals: **T**: 98 **HR**: 71 **BP**: 161/78 → 154/61 on standing **RR**: 16 **SpO_2**: 98% RA
BMI: 26

Exam:
Gen: Alert
HEENT: Pale, with clear conjunctiva. No icterus or cervical LAD
CV: Regular, normal S1 and S2, no murmur. JVP was not elevated
Pulm: Bibasilar crackles
Abd: Soft, non-tender, no mass or HSM
Neuro: Normal strength, tone, and reflexes. Normal gait.
Extremities: No edema. No axillary or inguinal LAD
Skin: Ecchymosis on R forearm (from prior IV)

Notable Labs & Imaging:

Hematology:
WBC: 5.3 (ANC 4.5) Hgb: 5.1 MCV: 132.5 Plt: 112
LDH: 676. Retic: 2.2%, Haptoglobin < 8, Ferritin: 311, TSat: 13.6%, Coombs: Negative.
Smear: Ovalocytes, macrocytes, no schistocytes or hypersegmented neutrophils.

Chemistry:
Na: 134 K: 4.2 Cl: CO2: BUN: 27 Cr: 1.5 → 1.1 glucose: 113 Ca: 8.2 Phos: 3.0
Mag: 2.0 AST: 71 ALT: 51 Alk-P: 80 T. Bili: 2.0 Albumin: 4.0
INR and PTT: Normal
TSH: 3.11 FT4: 0.9, PSA: <0.1
Folate: 16 (normal), B12: 6 (very low). Anti-Intrinsic Factor Abs: Positive

Imaging:
EKG: NSR with HR of 72 bpm, no T-wave of ST-segment abnormalities
CT-Head: Unremarkable
CT C/A/P: Nodular, heterogeneous thyroid, multiple low density liver lesions (up to 2 cm), 1.5cm complex cystic lesion in the right kidney. No LAD or splenomegaly

Problem Representation: 70M with a history of Burkitt's lymphoma s/p chemotherapy and auto HCT and peripheral neuropathy, presented with recurrent transient LOC, was found to have a severe macrocytic anemia, and diagnosed with B12 deficiency due to pernicious anemia.

Teaching Points (Andrea):

- Fall down: seizure (previous feeling, after feel tired, in clonic type the bite is in the side of tongue) vs cardiogenic syncope (sudden, go back to normal after syncope, patient falls face first, bite in the tip of tongue).
  Always checkout stroke, hypoglycemia,
- To assess episode: Find trace of problem, fingerprints of risk factor and wait for episode to occur or make it happen again (ie. methacholine for asthma)
- Brain metastases can cause seizure
- Older adult fall: look for fracture, hemorrhage
- Orthostatic hypotension (postural): The drop in blood pressure may be sudden (vasovagal orthostatic hypotension), within 3 minutes (classic orthostatic hypotension) or gradual (delayed orthostatic hypotension). Fall in systolic BP of at least 20 mm Hg or diastolic BP of at least 10 mm Hg. It can be due to old age
- Macrocytic anemia: megaloblastic (B12, folate deficiency), liver dz, thyroid dz , renal dz
- Acute anemia: bleeding, hemolysis (Like in immune we use haptoglobin, LDH, smear, coombs test), AML
- Acute macrocytosis anemia: reticulocitosis
- Microangiopathic hemolytic anemia: schistocytes
- Hemolysis with low BM response: B12 deficiency, invasion of BM by lymphomas, PNH. However, Sometimes reticulocytes take time to respond