6/19/20 Morning Report with @CPSolvers

Case Presenter:*Travis Smith (@RosenelliEM)* ***Case Discussants:*** *Robert Thiel (@) and Chioma Ndukwe (@chioma_ndukweau)*

CC: chest pain

HPI: 29 M presented with chest pain for 2 days, describes it as sharp pain, anterior chest, does not radiate. No exacerbating or relieving factors. Some episodes of tachycardia, SOB, x1 episode syncope 1 day prior
ROS: intermittent fevers, chills, drenching night sweats, loss of appetite, weight loss 4-5 kg, and swollen LN in neck over 3 mo, denies sore throat/oral ulcers, intermittent diarrhea, denies GU Sx, denies abdominal pain

PMH:
none

Meds:

Fam Hx:
DM, HTN, heart disease

Soc Hx: works as as server
No travel

Health-Related Behaviors:
Syphilis pos 2.5 years ago
Sexually active with 1 partner
Other STI tests at the time neg

Allergies:

Vitals: **T**: 37 **HR**: 118 **BP**: 133/86 **RR**: 18 **SpO_2**: 99
Exam:
Gen: NAD, alert
Lymph: palpable cervical and inguinal LN
CV: no PAD, no m/r/g
Pulm: CABL
Abd: soft, non tender, non distended, no organomegaly
Neuro: nl
Extremities/Skin: seborrheic dermatitis on face, hyperpigmented patches over chest/back (new)

Notable Labs & Imaging:
Hematology:
WBC: 9.1 (46% seg neut, 37% lymph, 17% mono), Hgb: 8.3 Plt: 350
Peripheral smear- rare smudge cells, slight anisocytosis, rare monocytes, rare stomatocytes

Chemistry:
Na: 133 K: 5 Cl: 99 CO2: BUN: 10 Cr: 1 glucose: 121
Ca: Phos: Mag:
AST: 22 ALT: 15 Alk-P: T. Bili: 0.6 Albumin: 2.4 TP: 8.7
D-dimer: 43.44 Trop: <0.01
HIV ab - pos ; HIV 1 ab - pos ; HIV 2 ab- non reactive
Flow: no evidence of a lymphoproliferative disorder or leukemia
Imaging:
EKG: sinus tachycardia with no ST changes
CXR: no acute infiltrates, normal heart size
CTA chest: no evidence of PE; lungs clear; no infiltrates. B/L mediastinal axillary/hilar LAD
Core Bx of R inguinal LN- atrophic germinal centers + strong plasma cells
Special stains: CD 23 w/ residual atretic germinal centers; BCL-2 outlining atretic germinal centers; CD 34- strong vascular background, CD 138- numerous plasma cells; Kappa/ Lambda light chains- numerous plasma cells
HHV 8- focally positive in spindled areas

Dx: HIV and HHV-8 associated multicentric Castleman's disease; outpatient Ritux/ HIV tx

Problem Representation: 29yo man presenting with several months of constitutional symptoms, weight loss, chest pain, generalized LAD, and new skin findings with anemia and protein gap. The patient was ultimately diagnosed with HIV-associated, HHV8-associated, multicentric Castleman's disease

Teaching Points (Anand):
Chest Pain: outside-in approach → skin, musculoskeletal, lungs, heart, GI, and other
Lymphadenopathy w/fevers, sweats (code as inflammation): infection, malignancy, or autoimmune buckets are the most common; also remember drugs, DVTs, and endocrinopathies
Syphilis pearl: untreated syphilis can become latent, and then progress to secondary syphilis
Inflammation workup: are there localized sites we can hone in on from the physical exam?
Lymph node red flags: firm/matted, non-tender; Generalized LAD → higher concern for malignancy
Anemia pearls: anemia in a young patient → hard to attribute it to a chronic inflammatory condition; is there blood loss? Is there a hemolytic process? Is there a primary bone marrow process? Smudge cells on a smear → think CLL or mononucleosis
Protein Gap: There is excess paraprotein (from a polyclonal process like inflammation or a monoclonal process like myeloma)
HIV pearls: HIV+ patients are not just at risk of concurrent infection, but also at risk of malignancy (lymphoproliferative diseases (lymphoma, Castleman's), kaposi sarcoma)
When plasma cells and B-lymphocytes mix →think lymphoplasmacytic lymphoma or Castleman's disease
Castleman's Disease pearls: can be unicentric (one lymph node region) or multicentric (generalized LAD, associated with HIV and HHV8)