6/8/20 Morning Report with @CPSolvers

Case Presenter: *Anand Patel (@anand_88_patel)* ***Case Discussants****: Amr Mousa (@amrmousa96) Elizabeth Evans (@Elizabe19893579)*

CC: Fatigue (feeling tired, worsens with activity)

HPI: 56F
3 months of fatigue, gradual worsening with walking. No dyspnea, no chest pain
Last 6 months: lost 15 pounds with active interventions then 20 pounds unintentional
2 months ago: early satiety (feeling hungry wanting to eat but feeling full after eating half of she normally eat)
2 days ago: she had vomiting after eating
No abdominal pain, no fever, no chills, no diarrhea, no night sweats

Sarcoid 5 years ago, dx via hilar node bx. Pulm/Abd LAD, salivary involvement

PMH:
Sarcoidosis
OSA, Unproc DVT (10 mo ago)

Meds:
-Rivaroxaban
-Was on 10mg prednisone and weekly methotrexate for sarcoidosis, hasn't taken in 4 mon

Fam Hx:
Non contributory

Soc Hx:
Works in Retail

Health-Related Behaviors:
5 year- pack history
No smoke for 15 years
No ETOH no drugs

Allergies: none

Vitals: **T**: afebrile 97.6 **HR**: 96 **BP**: 101/76 **RR**: 16 **SpO_2**: 97%
Exam:
Gen: No acute distress
HEENT: No scleral icterus, enlarged submandibular glands, no cervical LAD
CV: RRR no m/r/g
Pulm: CTAB
Abd: Soft, non tender, non distended, no hepatosplenomegaly
Neuro: mentating well, no focal deficit, CN II-XII intact
Extremities/Skin: no rashes or lesions, no edema

Notable Labs & Imaging:
Hematology:
WBC: 2.7 (59% PMN, 30% lymph 8% monos 3% eosinophils) Hgb: 6.9
MCV 85 Plt 65
LDH: 486 Haptoglobin 286 retic index 0.7
Normal iron, ferritin 550 Normal folate
Blood smear: normocytic anemia adequate neutrophils w/ megakaryocytes
Chemistry:
Na: 136 K: 3.5 Cl: 103 CO2: 24 BUN: 36 Cr: 4.16 (1.5 base) glucose: wnl
Ca, Phos, Mag, LCT: wnl Albumin: 3. 7 (T Protein 8.4)
UA: SG: 1.013 color yellow No turbidity, no casts, 0-5 wbc 0-5 rbc
Protein negative
Imaging/Additional Workup:
CT Chest-ABD, pelv: diffuse lymphadenopathy neck, ab, pelvis, Splenomegaly. Mass effect from lymphadenopathy in 3rd portion of duodenum
Renal ultrasound: no hydronephrosis
SPEP: small M spike 0.5, monoclonal IgM kappa
BM biopsy: small monoclonal B cell population
PET Scan: diffuse positivity and involving parenchyma of the kidneys
Excisional node biopsy: mantle cell lymphoma (MCL)

Problem Representation: 56F w/ hx of sarcoidosis and unprovoked DVT p/w early satiety, fatigue and involuntary weight loss. Exam notable for enlarged submandibular glands, and labs for pancytopenia, AKI on CKD, with a small IgM kappa M spike. Imaging with diffuse LAD and PET avidity, diagnosed with mantle cell lymphoma via excisional node biopsy. Also with likely renal involvement based on PET scan.

Teaching Points: (Moses):
Early satiety: *think stomach problem*
- External compression exp: splenomegaly
- Luminal: PUD, malignancy (linitis plastica, neoplasm invading wall of stomach)
- Motility issues (exp: gastroparesis)
- In vasculopath: chronic mesenteric ischemia

Weight loss + DVT → may be connected by cancer or AI process.
CR pearl: some dx benefit from tissue assessment. Cancer, sarcoid, IBD etc.
Submandibular glands: malignancy, obstructive stones, autoimmune (exp: Sjogren's)
CR pearl: the more cell lines are down, the suspicion rises for a BM process. Pit-stops before the BM peripheral process: infection (tick-borne), AI (SLE), malignancy (CLL), big spleen
Bone marrow:
- Stem cell problem?
- Nutrient problem? (B12, folate, iron, hormones)
- Infiltrative (sarcoid, malignancy, lymphoma etc.) + Alcohol

High morbidity AKI + Ca: TLS & RP obstruction, think of hypercalcemia
Sjogren's a/w increased risk for lymphoma
Sarcoid affecting:
- Cell counts: more commonly isolated leukopenia
- Kidney: granulomatous interstitial nephritis, hypercalcemia

Mantle Cell Lymphoma: classically a/w t(11;14) translocation. ~30% of B-cell lymphoma will have a M-spike