9/14/20 Morning Report with @CPSolvers

Case Presenter: *Tara Ahmadi (@tara_ahmadi)* ***Case Discussants***: *Lindsay Haselden (@hazelnutmed) and Mike Rose(@MikeRoseMdMPH)*

CC: Dizziness

HPI: 98F w/ h/o HTN and essential thrombocytosis Tx hydroxyurea, p/w 2 days dizziness. It is associated with standing and relieved on sitting down. No history suggestive of palpitations, SOB, LOC or Afib.

She also reports 1 episode of diarrhea -- watery and dark brown, w/ no blood or mucus and 1 episode of Vomiting dark brown, no blood

No fever, chills or urinary Sx.

Vitals: T: Afebrile **HR:** 97 **BP:** 166/78 **RR: 20** **SpO_2:** 98% RA
BMI 29.39

Exam:
Gen: Sitting comfortably, no acute distress.
HEENT: Moist mucous membranes, no LAD.
CV: Regular rhythm, slightly tachycardic.
Pulm: Clear to auscultation.
Abd: No tenderness or palpable organomegaly, BS +
Neuro: Alert, no nystagmus, CN I- XII intact, motor exam normal, finger- nose intact, no pronator drift, no sensory deficits. Gait not assessed.
Extremities/Skin: Peripheral pulses felt b/l, extremities well perfused.

PMH:
Breast Ca, lumbar disc herniation (1960s)
SHx - carpal tunnel release, cataract removal, total knee arthroplasty, lumpectomy

Meds:
Iron supplements
Tylenol
Aspirin 81mg
Vit D, hydroxyurea 500 mg, HCTZ, metoprolol 25mg, melatonin

Fam Hx: Pancreatic ca (father), parkinson's and stomach Ca (mother), dementia (sister)

Soc Hx: Lives by herself, currently living w/ grandchildren. No sick contacts

Health-Related Behaviors:
Not a smoker, occasionally consumes alcohol, occasionally, active, no drugs

Allergies:
Penicillin, ampicillin

Notable Labs & Imaging:
Hematology:
WBC: 8.68 HgB 8.2 (3 weeks before → 10.8) MCV: 101.2 HCT: 25.3 Plt: 560 (baseline)
Chemistry:
Na: 141 K: 3.7 Cl: 101 CO2: 29 BUN: 30 Cr: 0.81 glucose: 109
Ca: WNL AST: 42 ALT: 38 Alk-P: 132 T. Bili: 1.1 Albumin: 5

Iron studies: Fe: 38 TIBC: 400 Ferritin: 12
Imaging:
EKG: Normal sinus rhythm, sinus arrhythmia + RBBB, no ischemic changes
CXR: No evidence of pneumonia, R paratracheal opacity unclear etiology
CT Head: no visible acute process
CT Abd and pelvis: stranding of omental fat
Fecal occult blood +
EGD: **Dx Dieulafoy lesion**

Problem Representation: 98yo female presents with orthostatic hypotension and a PMHx of essential thrombocytosis. Labs showed an iron deficiency anemia with a sudden hemoglobin drop. EGD ultimately revealed Dieulafoy lesion.

Teaching Points (Maria):

- **Dizziness:**
  - What do they mean? Spinning room → vertigo (central vs peripheral); lightheaded → orthostatic hypotension.
  - What's the time frame? Acute vs chronic
  - Episodic vs continuous? Episodic → Think about possible triggers (Mov of head → BPPV; standing up→ ortho) Continuous → think meds, vestibular neuronitis, stroke.
  - Associated symptoms? Vomiting and diarrhea → Think volume depletion.
  - Targeted exam: HINTS (Head impulse, Nystagmus, Test of Skew)Dix Hallpike
  - Don't miss sinister causes: posterior stroke, SAH.
- **Things happening in a hot shower:** PV (mass cell mediated pruritus), MS exacerbations (Uhthoff's phenomenon)
- **Myeloproliferative disorders Complications** (PV, ET, Primary Myelofibrosis, CML): Clotting disorder, Bleeding disorder. Malignancy transformation → AML. Hyperviscosity syndrome. Gout. Massive Splenomegaly.
- **Orthostatic hypotension:** Think meds, volume depletion, sympathetic dysfunction. → Try to find clues in Hx+exam
- **Law of Relativity:** Everybody has different normals!
- **Hydroxyurea:** Macrocytosis can show compliance.
- **Iron deficiency + age:** Low grade bleeding. + Fast Hb drop: Acute/Subacute on Chronic Process.
- **High Plt count doesn't mean Plt's are working:** Plt chew VW factor. Consider other factors (ASA use, age) to worry about CNS bleed.
- **BUN/Cr>35** ratio consistent with UGI Bleed.