04/26/21 Morning Report with @CPSolvers

Case Presenter: *Jordyn Silverstein (@jordynsilvs)* ***Case Discussants***: *Sarah Onorato (@sonorato11) and Ashwini Joshi (@ashwini3845)*

CC: anemia & constipation/fevers

HPI: 45M sent by PCP for expedited w/up of chronic IDA
3y ago: dx with IDA, tx long rounds of PO Fe, and IV Fe infusions.
2 wks ago: reports constipation, daily fevers up to 101 @home; lost 15-20lb, recently started Metformin. + night sweats, intermittent RUQ epigastric pain, sharp, pulsating, non associated with food/triggers

ROS: denies runny nose, sore throat, CP, SOB, dysuria, fatigue/dizziness, no recent travel, no exp to animals, no pets, no recent insect/tick bite

PMH:
HIV- 15y ago, well controlled
Latent TB, tx 10 yr ago, full tx
preDm
Syphilis
IDA
EGD/Colo- 3 sessile polyps + gastropathy

Meds: Metformin, HIV meds

Fam Hx:
Mother with breast CA in 60s

Soc Hx:lives alone, works @ airport w/ baggage

Health-Related Behaviors:
No tob, EtOH occasionally
Allergies:

Vitals: **T**: **101.7** **HR**: **117** **BP**: 139/91 **RR**: 18 **SpO_2**: 98
Exam:
Gen: well appearing, obese man, NAD
HEENT: no cervical, axillary, mandibular LAD
CV: tachycardic, regular, no m/r/g
Pulm: CABL
Abd: ND, soft, diffusely TTP worse in RUQ/epigastric area, no rebound/ guarding
Neuro: AOx3, no focal deficit
Extremities/Skin: wnl

Notable Labs & Imaging:
Hematology:
WBC: 12.8 (N predom) Hgb: 10 Plt: 456 MCV: 76
B12: 540 Folic Acid: 15 Fe: 17(L) Ferritin: 135 Trans sat: 5 (L) Transferrin: 230 Retic Abs count: 68 Smear: Hypochromia, microcytosis
Chemistry:
Na: K: Cl: CO2: BUN: Cr: glucose: Ca: Phos: Mag:
AST: 17 ALT: 38 Alk-P: 95 T. Bili: 0.5 Albumin: 3.7 TP: 8.8
Lactate: 1 Lipase: 14
Imaging:
EKG: sinus tach; CXR: Clear lungs
Abd U/S: nl gallbladder, liver with fatty infiltration and SM
CT Scan: irregular enhancing and nodular mural thickening, exophytic mass @mid distal ileum, adjacent enlarged mesenteric LN with dominant mass 4.5 cm, and poor enhancement of a branch of sup. mesenteric v c/f thrombus
Bx of Lesion: **poorly differentiated neoplasm, malignant GI neuroectodermal tumor, MGNET**

Problem Representation: 45M pmh HIV, intestinal polyps, and chronic IDA p/w subacute inflammatory syndrome and RUQ pain, fth SM and mid ileal exophytic mass with Bx confirming malignant GI neuroendocrine tumor.

Teaching Points (Sukriti):
Investigate the Sx: Chronic IDA + acute inflammatory syndrome + RUQ epigastric pain
When faced w/ multiple symptoms the first step is to Identify the main components of the current syndrome to track.
Next, analyse the foreground in the context of the background: Lower the threshold; Natural course of the disease/additional pathology altering the course; Unrelated.
Making sense of IDA, layering time course, localisation:
Acute: Blood loss, hemolysis vs Chronic: Production problem (raw materials, toxic (alcohol, medication), Slow bleed
- Localises to duodenum

Collecting Clues:
HIV expanded the spotlight of infections and malignancies to consider, such as lymphoma, kaposi's sarcoma (<well controlled)
- Tx for latent TB only 60% effective; GI tract 3rd most common site for extrapulmonary TB

Ferritin 1st sign of IDA, <15 likelihood ratio high; in an inflamed patient, ferritin may be spuriously elevated
Splenomegaly: Water (Portal HTN), Cells (WBC- AI, cancer, granuloma, infection; RBC), Molecules (amyloid)
- Solid tumors are allergic to the spleen; exception: melanoma

Protein gap: Polyclonal vs Monoclonal
Framing a hypothesis: Ileal mass + SMV thrombus > Malignancy, Infection
Metastatic > Primary: Peritoneal carcinomatosis, hematogenous > Duodenal: adenoca; Ileum: NET; Anywhere: Sarcoma, lymphoma