05/28/21 Morning Report with @CPSolvers

***Case Presenter**: Api Chew (@api_chew) **Case Discussants**: Rabih Geha (@rabihmgeha) and Prof Rez (@DxRxEdu)*

CC: Chronic cough

HPI: 67F chronic cough for 3 mo.
3 mo: Dry cough, w/o chest pain, SOB, weight loss.
1 mo: Progressive worsening, cannot lie on the bed. Needs to sit on the chair. Fatigue, decrease appetite, unintentional weight loss. X2 negative Covid. Polydipsia, polyurea.
Denies: Hoarseness, chest pain

PMH: no h/o TB, HTN, OAD

Meds: Tylenol as needed

Fam Hx: Unremarkable

Soc Hx:Originally from South-East Asia. No recent travels or risk exposures.

Health-Related Behaviors:No alcohol, tobacco or illicit drugs.

Allergies: Not known

Vitals: **T**: 37C **HR**: 90 **BP**: 136/72 **RR**: 16 **SpO_2**: 94% ra
Exam:
Gen: Not in acute distress
HEENT: Multiple dental caries, no thyroid gland enlargement or palpable lymphadenopathy.
CV: Nl, no DVT
Pulm: Localized wheezing in RUL w/ crackles.
Abd:
Neuro: Unremarkable reactive pupils
Extremities/Skin: No swelling

Notable Labs & Imaging:
Hematology:
WBC: 13 Hgb:16 Plt: 377

Chemistry:
Na: 127 (Corrected 135) K: 4.7 Cl: 101 CO2: 14 BUN: 21 Cr: .8 glucose: 500 Ca:9.6 Phos: Mag: 1.6
AST: Nl ALT: Nl Alk-P: T. Bili: Nl DB Nl TP: 8 Alb: 3
UA: No RBC, WBC, Glucose 4+, Ketones -ve
ABG: ph 7.37 HCO3 14 PCO2 27 Lactate .9
Imaging:
EKG:
CXR: RUL mass
CT: 8-7 cm cavitary lesion in RUL w/ 2cm wall thickness. No pleural effusion or lymphadenopathy.
Bronchoscopy + bx: A branching acute angle hyphae consistent w/ Aspergillus.
IgG for Aspergillus +

Final Dx: Chronic cavitary pulmonary Aspergillosis.

Problem Representation: 67F w/ PMH of HTN and OAD p/w chronic cough for 3 months, polydipsia and polyuria. Physical exam showed wheezing in RUL w/ crackles and images showed a cavitary lesion. Labs were notable for hyperglycemia.

Teaching Points (Travis)

- Chronic cough:What you choose to form a schema around is important. Dont get led astray
- When you hear chronic cough, pause….Study the accompanying symptoms (landscape). If other things are going on, then direct your attention that way.
- Orthopnea or Orthopnemia, more fluid in the left side of the, heart, more fluid in the kidneys, more urination at night. When lying supine, leading to low hgb.
- Things that get worse when lying flat: UACS (post nasal drip): , GERD, and CHF (but he has no PND). Timing from symptoms developing and lying supine is important.
- Weight Loss : inflammatory (Infection, autoimmune, and malignancy) vs non inflammatory.
- Pivot point??? Polyuria...could this be leading to his polydipsia. You are drinking too much or you have DM (mellitus vs insipidus).
- Central vs Nephrogenic: Central more common, nephrogenic is more rare and more localized (hypercalcemia or amyloidosis)
- The exam: Focal wheezing represents obstruction in a focal area usually implying mucous plugging, what is blocking? Intraluminal mucous or an extraluminal mass.
- Dental caries: Could there be something esoteric like scurvy or something that has been marinating like endocarditis.
- Those with hyperglycemia will lose weight as they lose water.
- The mass explains the cough, now the PR.. Keep it simple
- Pancythemia! Hemoconcentration. Protein Gap of 5: Is this monoclonal or polyclonal (plasma cell dyscrasias). If its polyclonal activate the IMADE pneumonic.
- Why do they have new onset DM (new or not). We assume its new. The base rate tells us it is type 2. Strong genetic predisposition, obesity contribution. What points to this being a problem of the pancreas and not resistance? Lack of acanthosis nigricans, and weight loss. Is this IgG4 disease or is this some paraneoplastic disease like cushing.
- Cavitary lung lesion: Infection (staph, kleb) subacute (nocardia, melioidosis, fungal), Malignancy (SCC or mets, lymphoma), Autoimmune diseases like GPA.