06/30/21 Morning Report with @CPSolvers

***Case Presenter**: Alec Rezigh (@ABRezMed) **Case Discussants**: Rafael Alvim (@) and Mario Suito (@mariosuitofmd)*

CC: 58 yo with increased ostomy output
HPI: Pt notes recent dx of sigmoid adenocarcinoma and 1 week ago had chemo and noted increased output. Now having to empty her ostomy bag every 4 hours. Assoc N/V, worse after eating. Subjective fevers.
Denies CP, SOB.

PMH:
Stage IIc Sigmoid Adenocarcinoma
Resection of mass 6 months prior from sigmoid (became septic after surgery requiring TPN, needed a course of micofungin)
Meds: on third cycle of chemo Capecitabine, oxaliplatin

Fam Hx:
None

Soc Hx:
Heavy ETOH and drug use but quit 2 years ago. Unemployed and lives with her mother

Health-Related Behaviors:
Allergies:

Vitals: **T**: **Afebrile HR**: **110 BP**: **104/72 RR**: **20 SpO_2**: 97% RA
Exam:
Gen: Awake and Alert NAD
HEENT: Dry MM, no lesions
CV: WNL
Pulm: WNL
Abd: Soft, td in periumbilical region. Ostomy in LLQ had watery green stool, no surrounding signs of infection
Neuro: poor attention span, no focal deficits, CN intact
Extremities/Skin: No lesions

Notable Labs & Imaging:
Hematology:
WBC: 2.8 (ANC 90% NML) Hgb: 11.3 Plt: 197
Chemistry:
Na: 123 K: 4.8 Cl: 94 CO2: 17 BUN: 23 Cr: 0.9 (0.5 baseline) glucose: 117 Ca: 8.7 Phos: NML Mag: NML
AST: 61 ALT: 16 Alk-P: 102 T. Bili: 1.3 (D.B 0.1) Albumin: 4g/dL Protein 7.7 g/dL Lactic: NML UA: normal HIV: negative Hemolysis Markers: Neg
Imaging:
EKG: Sinus Tachy CTA Chest: no PE, otherwise nml
CT Abd/Pelv: Ileal thickening into colonic anastomosis, post surgical changes, no obstruction.
Enteric GI PCR: Neg C. diff: Neg Ova/Para: Neg CEA: 5 (nml <5) prior to surgery was very elevated.
Colonoscopy: Nml anastomosis, nodular appearance and loss of vascular pattern. Biopsy showed neg viral and bacterial pathogens, parasites. Congo red negative.
MRI Brain : Diffuse leptomeningeal metastases of the right greater than left frontoparietal convexity sulci, interhemispheric fissure, cingulate sulci, right sylvian fissure and interpeduncular and prepontine cisterns.
LP: Opening Pressure NML at 1338 WBC (lymphs) Glu (30) Protein (92) cytology neg, cultures neg, VDRL neg. CSF stain positive for Grocott's methenamine silver stain (GMS): Serum Cryptococcal Ag and CSF Elevated
Final dx: disseminated cryptococcus infection

Problem Representation: A 58 y/o F w/ PMH of Stage IIc Colon cancer s/p resection 6 mon prior p/w with watery stool following chemotherapy along with some decreased attentiveness found to have hyponatremia, abnormal Brain MRI, & abnormal CSF revealing cryptococcal infection.

Teaching Points (Gabriel):

- **Increased ostomy output:**
  - True or pseudo-diarrhea?, expected or unexpected?
    - Diarrhea is a common side effect of chemotherapy.
  - Aks for tempo, quantity, previous episodes, risk factors (malignancy, immune status, antibiotics exposure, prolonged hospital stay, inadequate nutritional status)
  - Categories: watery, fatty, inflammatory.
  - Etiologies: prioritize infectious, others: medications, surgery-related.
- **Cisplatin side effects:** Nephrotoxicity, peripheral neuropathy, ototoxicity. Oxaliplatin has less side effects and no nephrotoxicity
- **Looking for clues**
  - *No fever doesn't rule out an inflammatory process, taking in consideration an immunodeficient status.*
  - **Pellagra:** diarrhea, dementia, dermatitis.
  - **Infectious-related:** fungi, C.diff, viral (CMV, adenovirus)
    - Ileal involvement: TB, Histo, paracocci
  - **Neutropenic enterocolitis:** necrotizing inflammation involving cecum usually in a context of neutropenia. Presentation: fever, abdominal pain and diarrhea.
  - **Adrenal insufficiency:** Weight loss, diarrhea, labs: hyponatremia & hyperkalemia.
  - **Diffuse leptomeningeal enhancement-ddx:** leptomeningeal carcinomatosis(eg from lung, breast, melanoma), hemorrhage, granulomatous diseases, meningitis (TB, crypto, viral)