



# 08/30/21 Endocrine Morning Report with @CPSolvers



Case Presenter: Amanda Barreto (amandabarretof2) Case Discussants: CPSolvers chat <3

<p><b>CC:</b> acute AMS</p> <p><b>HPI:</b> 28YF w/ metastatic breast cancer who develops AMS overnight</p> <p>Admitted with dyspnea for 3 days Made NPO overnight due to concern in respiratory status Noted to be lethargic and slow to respond to questions the following morning. On admission, the patient was mentating appropriately</p> <p>7 liters of urine output overnight</p>	<p><b>Vitals:</b> all normal</p> <p><b>Exam:</b></p> <p><b>CV:</b> regular rate and rhythm without murmurs, rubs, or gallops</p> <p><b>Pulm:</b> lung clear to auscultation</p> <p><b>Neuro:</b> Patient A&amp;Ox3 but answering questions more slowly; able to follow commands, no focal neurologic deficits</p>	<p><b>Problem Representation:</b> <b>28F w/ PMHx of BC and metastasis to the CNS and bones presents with acute AMS and polyuria.</b></p>		
<table border="1"> <tr> <td data-bbox="23 578 187 1081"> <p><b>PMH:</b> Bony and CNS metastasis</p> <p><b>Meds:</b> -</p> </td> <td data-bbox="187 578 513 1081"> <p><b>Fam Hx:</b> -</p> <p><b>Soc Hx:</b> -</p> <p><b>Health-Related Behaviors:</b> -</p> <p><b>Allergies:</b></p> <p>-</p> </td> </tr> </table>	<p><b>PMH:</b> Bony and CNS metastasis</p> <p><b>Meds:</b> -</p>	<p><b>Fam Hx:</b> -</p> <p><b>Soc Hx:</b> -</p> <p><b>Health-Related Behaviors:</b> -</p> <p><b>Allergies:</b></p> <p>-</p>	<p><b>Notable Labs &amp; Imaging:</b></p> <p><b>Chemistry:</b> <u>Admission:</u> Na: 136 K: 4.2 Cl: 102 Bicarb 24 BUN: 17 Cr 0.7</p> <p><u>NPO overnight:</u> Na: 144 K 4.1 Cl 105 Bicarb 25 BUN 20 Cr 0.9</p> <p>Serum osmo 288 Urine Osm 78 Urine Na 20 Specific gravity 1.006</p> <p>Given DDAVP and her urine osmolarity rose appropriately</p> <p><b>Final dx: central DI</b></p>	<p><b>Teaching Points (Gabriel):</b></p> <ul style="list-style-type: none"> <li>● <b>AMS + BC background:</b> <ul style="list-style-type: none"> <li>○ Malignancy related:           <ul style="list-style-type: none"> <li>■ Hypercalcemia → ectopic PTH secretion and bone metastasis</li> <li>■ Hypoglycemia</li> <li>■ Adrenal insufficiency-hyponatremia</li> <li>■ Thrombosis, metastasis</li> </ul> </li> <li>○ Malignancy non related (MIST: Metabolic, Infectious, Structural, Toxins)</li> <li>○ + polyuria (&gt;3L/day) → hypercalcemia should be considered. Mechanism is through nephrogenic DI: downregulation of AQ2 channels, inhibition of NKCC &amp; ROMK, Ca deposition in the renal medulla → impaired generation of interstitial osmotic gradient.</li> </ul> </li> <li>● Hypertatremia is not a common presentation of DI.</li> <li>● Sodium jump suggests DI in a water deprivation context. <u>A low urinary gradient would support this hypothesis.</u></li> <li>● <b>Approaching Diabetes insipidus:</b> <ul style="list-style-type: none"> <li>○ Central: Trauma, Surgery, SAH, pregnancy, increased ICP, familial, hypothalamus compromise.</li> <li>○ Nephrogenic: electro (hyper Ca, hypo K), meds (loop diuretics, Li), Sickle cell dz, infections (HIV)</li> </ul> </li> </ul>
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