09/13/21 Morning Report with @CPSolvers

***Case Presenter**: Mason Jeffries (@) **Case Discussants**: Aaron Fried (@) and Case Birschbach(@)*

CC: Nausea, vomiting, and a fall for 2 days

HPI: 54F w/ SLE presenting with diarrhea for 2 days. On the day of admission, she referred constipation, cough, and lightheadedness.
Regarding the fall, patient was unable to recount details.

ROS:
No fever, no chest or belly pain, no skin changes or urinary symptoms.
Reports feeling weak.
More difficulty ambulating with some dizziness over the past 2 days.

PMH:
SLE diagnosed in 2019 with an episode of unprovoked DVT. APLS. Neuropathy; Ulcerative cutaneous leukocytoclastic vasculitis, ; Pulmonary restrictive disease; serositis. Lupus Cerebritis; Refractory ITP.

Meds:
Plaquenil, prednisone, Rituximab (held recently due to hospitalization that led to bacteremia); Azathioprine, Xarelto

Fam Hx: -

Soc Hx: -

Health-Related Behaviors:
No recent travel

Allergies: -

Vitals: **T**: 37.2 **HR**: 98 **BP**: 113/74 **RR**: 19 **SpO_2**: 99%
Exam:
Gen: Alert and oriented, to person and time, but not to place. Not in acute distress. Confused and tired.
CV: Normal **Pulm**: Normal
Abd: Normal active bowel sounds, nontender and nondistended.
Neuro: Slow speech, unable to answer many questions. Some difficulty following instructions. No focal deficits. Intact CNs. Hyperreflexive upper and lower extremities on right side. Right sided dysmetria.

Notable Labs & Imaging:
Hematology:
WBC: 5.4 Hgb: 6.8 (basal Hb 9) Plt: 251
ANC normal ALC: low CD4: <35
Chemistry:
Cr: 1.3 (basal Cr 0.9) Albumin 2.6 AST/ALT nl Bb nl ESR: 26
Bland UA HIV: Unremarkable Hepatitis panel: Unremarkable
Covid Test: Negative
LP: Clear colorless fluid; Glu: 46; Protein: 34, 1 Nucleated Cell
Meningitis Panel: Negative Cultures with no growth
Imaging:
EKG: Normal CT abd: Normal
MRI: Severe chronic microvascular ischemic disease
Plasma CMV (2000) and EBV (7000) both elevated
LDH normal IgG: Elevated IgM: Normal IgA: Normal
EGD: patchy white plaques throughout the esophagus (candidiasis)
Single 5cm deeply excavated clean ulcer at the hepatic flexure
Ulcer pathology: EBV positive B-cell lymphoproliferative disorder suggestive of EBV large B-cell lymphoma
PET-scan: Hypermetabolic focus within colon near hepatic flexure associated with subtle wall thickening and pericolic fat stranding.
Final dx: Diffuse Large B Cell Lymphoma

Problem Representation: 54F w/ SLE presenting with diarrhea, constipation and lightheadedness w/ associated neurologic symptoms

Teaching Points (Laura <3**)**:

- Nausea and vomiting: non specific. **GI or neuro?**
- **Immunosuppressed:** think about infection
- Is this related to the SLE? Or complications of: disease progression, immunosuppression, treating medicines, side effects?
- **SLE**: can affect any organ/system. Skin, musculoskeletal system, and pulmonary system are primarily affected. Patients with CNS manifestations may experience headaches, depression, anxiety, seizures, stroke, or cognitive impairment.
- History of Idiopathic Thrombocytopenic Purpura: recurrent? primary stroke? Clotting disorder?
- Neuro + GI -> neuromuscular disease
- Upper neuron syndrome: weakness, decreased muscle control, easy fatigability, altered muscle tone and exaggerated deep tendon reflexes.
- **GI symptoms**: could be the cause of loss of water and blood. Possibly related to immunosuppression - abdominal pathology (underlying steroids use, other risk factors).
- Luminal (enteritis), ischemic disease (mesenteric vasculitis), infectious enteritis (not opportunistic).
- Causes of GI ulceration: NSAIDs, H. Pylori, EtOH
- Lymphopenia: steroids, SLE (**is it active?**), lymphoma (GI tract), other causes.
- No inflammation doesn't mean no infection!