10/7/21 Morning Report with @CPSolvers

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CC: 31yM with progressive asthenia and exertional intolerance

HPI:

- Sporadic hematochezia for 1y. Bleeding episodes became regular last 3mo with daily episodes.
- Intense presence of mucus in stool. Anal discomfort and tenesmus
- Denies weight loss, increase in defecation frequency, purulent discharge

PMH:
HIV+ diagnosed 3yo ago

Meds:
ART

Fam Hx:
One brother with chronic diarrhea

Soc Hx:

Health-Related Behaviors:
syphilis treated 3x. Multiple male partners

Allergies:

Vitals: **T**:96.8F **HR**: **92** **BP**: 120/70 **RR**: **18** **SpO_2**: 99%

Exam:
Gen: ill, pale, alert, oriented
Abd: bowel sounds present, flaccid plain slightly tender to palpation in left iliac fossa. No signs of peritonitis.
GU: no rectal bleeding, only abundant mucus. Anuscopy elicited hyperemic mucosa and adhered mucus. No hemorrhoids or masses.
Extremities/Skin: no skin or nail changes.

Notable Labs & Imaging:
Hematology:
WBC: 8500 Hgb: 5.3 microcytic hypochromic Plt: 545,000

Chemistry:
Na: 135 K: 4.5 Cl: CO2: BUN: 12.6 Cr: 0.74 AST: 21 ALT: 10 Alk-P: 54. INR: 1.08. aPTT: 11.2
LDH normal, ESR elevated
Low serum iron 10. TIBC normal 367. Ferritin low 6. Transferrin 287. TSAT 3% low.
ABG pH 7.4, pCO2 41, bicarb 25.3
Infection: O&P stool -ve, c diff -ve, E. histolytica -ve, VDRL -ve
Imaging:
Ab CT: no lymph node enlargements or free fluid. Unspecific thickening of rectal wall
Colonoscopy: mild rectal mucosa oedema with small erosions.
Rectal biopsy: moderate chronic proctitis, small lymphoid aggregates. No granulomas.

Rectal swab: chlamydia -ve, N. gonorrhoeae +ve

Final Dx: gonococcal proctitis

Problem Representation: 31yo male with history of +HIV and syphilis presented with progressive asthenia, exertional intolerance, sporadic hematochezia, and intense mucus presence in stool. Rectal biopsy revealed chronic proctitis with small lymphoid aggregates. N. gonorrhoeae +ve with rectal swab.

Teaching Points (Vale)
Proctitis Ddx = colitis Ddx + STIs & foreign bodies.

- **Who is the patient?**
  - Age -> IBD, Infections, foreign body > malignancy.
  - **HIV related infections:** common infxs w/ worse presentations, STIs, HIV-related infxs.
  - HIV also increases the incidence of malignancy and autoimmune dz.
  - Don't anchor on HIV too fast.

💎 The most common cause of thrombocytosis is reactive -> not only infections! Could be explained by acute severe anemia.
💎 **Syphilitic proctitis:** Usually presents w/ syphilitic hepatitis -> elevated AlkP.
  - VDRL neg: early dz or Prozone phenomenon.

Pathognomonic biopsy findings in IBD:
  - UC -> neutrophilic infiltration w/ abscesses
  - Crohn's -> granulomas