6/17/23 Global VMR with @CPSolvers friends from Germany and Austria

"One life, so many dreams" Case Presenter*: Nikola Vladic (@VladicNikola)* ***Case Discussants****: CPsolvers Family <3*

CC: 79 y.o male presents with upper abdominal pain and weight loss

HPI: 4 weeks ago presented upper abdominal pain associated with fever and night sweats. Afterwards he developed slurred speech and dysphagia to solids and liquids. Weight loss was quantified at around 7kg.

PMH:
- Mycosis fungoides: Dx 2y ago, Rx with MTX , IFN-alfa. Complicated with Sezary syndrome treated with mogamulizumab -> remission
- BPH
- SCC lower lip s/p resection
- HTN w/ hypertensive CMP
- Afib w/ LAA occlusion
- S.p. bilateral open angle glaucoma

Vitals: T: intermittent fever **HR:** 130/min **BP:** MAP around 60s **SpO2** 99% on 2L NC

Exam:

HEENT: PERRL, dry mucous membranes

CV: irregular tachycardia, S1S2 normal, no murmurs or gallops

Pulm: clear lung sounds

Abd: mild distention

Neuro: GCS 15. Slurred speech. No focal deficits

Extremities/skin: no rashes, severe bilateral leg edema

Notable Labs & Imaging:

Hematology:
WBC: 1500 Hgb: 10 Plt: 28 000

Chemistry:
Na: 143 K: elevated Cl: 112 BUN: 39 Cr: 1 glucose: 50
AST: 150 ALT: 86 Alk-P: 360 T. Bili: 2.7 Albumin: 2.4

ABG:
pH 7.36, p02 88 (2L 02), pC02 27, bicarb 15.3, lactate 9.5 (with no improvement after fluid resusicitation)

LDH 29 000 CRP 110, PCT 1.3
Coags: INR 1.3, PTT 170, Fibrinogen non detectable. Haptoglobin: non detectable.
Direct Coombs (-), Blood smear: No blasts or schistocytes
Serologies: A, B, C, EBV, CMV: (-). Autoimmune hepatitis serologies: (-).
LP: nl. Ferritin 22k, Triglycerides 650, sIL-12 60k.

Imaging:
Head CT: normal
Chest CT: bilateral pleural effusion. Opacities in LL lower lobe and apex. Multiple large mediastinal lymph nodes, no pericardial effusion or PE.
CT abdomen: Retroperitoneal lymphadenopathy, Hepatosplenomegaly, Ascites
Liver biopsy: dense lymphocytic infiltrates with hemaphagocytosis. **Lymph node biopsy:** DLBCL

Final Dx: DLBCL complicated by HLH

Problem Representation: (Deutsch) Eine 79 jährige Frau mit B-Symptomatik, Hepatosplenomegalie, Panzytopenie, Hyperferritinämie und einer vorgeschichte fur T-cell lymphome.

Teaching Points (Bea):

Upper abdominal pain: life threatening events (obstruction, perforation, vascular, ectopic pregnancy)**/anatomical approach** (abdominal/extra-abdominal organs)**/image negative conditions**

Fever+night sweats+weight loss might point to a malignancy

Slurred speech: aspecific, but dysarthria/aphasia

Weight loss: increased/decreased inflammation, however the clinical picture here makes increased inflammation more likely (cancer/autoimmune/infection)

Shock (elevated HR and hypotension) => hypovolemic, cardiogenic, distributive, obstructive

Elevated lactate = greater mortality risk

Elevated LDH = infarcts, kidney/liver diseases, certain types of cancers - lymphomas&leukemias

Hypoglycemia = as it was not improving, higher chance of lymphoproliferative disease

Low WBC: infections/ bone marrow disorders, certain medications+ low platelets

Elevated K, Cl, BUN, AST, ALT, Alk-P, T.bil => Liver/kidney altered function

Prolonged PTT, INR: impaired clotting function (impaired liver/coagulation function)

Imaging of pleural effusion, opacities in LL lower lobe and apex, diffuse lymphadenopathy, hepatosplenomegaly => MO failure => malignancy/inflammatory or autoimmune disorders/infection

Hyperferritinemia: hemocromatosis, AOSD (Adult onset of Still disease), HLH,MIS-A, MIS-C

Final dx thanks to biopsy: diffuse large B-cell lymphoma, complicated by HLH