01/05/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Fara (@farara82) Case Discussants: Rabih (@rabihmgeha) and Reza (@DxRxEdu)

CC: 65 yo female with persistent watery diarrhea or 2 weeks

HPI: 2 months ago started with productive cough with whitish sputum. After developed sweating and weight loss of 20 pounds. Then watery diarrhea (3-4 times daily).
ROS negative: hemoptysis, angina, SOB, swelling.

PMH: diabetes and HTN for 20 years
1 Year ago: ischemic event (s/p bypass)

Meds: aspirin 100 mg, bisoprolol 10 mg, atorvastatina 40 mg, pantoprazol 40 mg, metformin, insulin (actrapid 18u tds, insulatard 16u ON),

Fam Hx: non relevant (no malignancy)

Soc Hx: from Malaysia. Married. 3 Children.

Health-Related Behaviors: No smoking. No recent travelling.

Allergies: No

Vitals: T: 38ºC, **HR:** 80 bpm, **BP:** 120/80 mmHg, **RR:** 18 rpm, **SpO2** nl on RA
Exam:
Gen: alert, mildly dehydrated
CV: normal, no murmurs
Pulm: normal
Abd: soft, non tender, no hepatosplenomegaly
Extremities/skin: no swelling

Notable Labs & Imaging:
Hematology: WBC: 9.3 (N 67%), Hgb: 8.2, MCV 82, Plt: 566

Chemistry: Na: 135 K: 6 Cl: HCO3: 23, BUN: 23, Cr: 152 mcl/l (nl < 120), AST and ALT: wnl, Br nl, VBG: no acidosis.
CRP 20 mg/dl (nl < 5)

Microbiology: blood cultures positive for non typhoidal Salmonella sensitive to amox-clav
Imaging: CXR: no consolidations, no pleural effusions
ECG: non ST changes

Course: treated for Salmonella: amoxicillin 2g/4h, but still febrile after one week of ATB, but clinically stable. Repeated blood cx: no growth.
CT: microabscess of liver. ATB switched to ceftriaxone.
Still febrile after 2 weeks of ATB. CRP persistently elevated (20-30).
CT TAP: microabscesses of liver 3 cm, no lymphadenopathy, no collections.
Bronchoscopy: normal. PCR normal. AFB sputum: negative.
ETT: no vegetations.
HIV negative. Autoimmunity: negative.
Liver biopsy: DBCL

Dx: diffuse B cell lymphoma

Problem Representation: 65 yo female with PMH of diabetes and HTN presented with subacute diarrhea, cough and inflammation. Labs showed normocytic anemia, thrombocytosis and Salmonella bacteremia. Not improving with antibiotics, CT showed liver microabscesses.

Teaching Points (Ayesha):
- **Diarrhea**: May be secondary to systemic process. Duration → acute - days → prioritize infx - e.g. viral gastroenteritis, bacterial. Non-infx etiologies prioritized as duration prolongs - more than 4 weeks (chronic) → Does it wake patient at night? (remove osmotic causes, think more secretory).
- Is the cough/diarrhea referred or is it truly due to a systemic process? *Pattern recognition aids in focusing in a set differential dx*
- **Weight loss** in any patient requires a custom evaluation, tailor to each patient, but *always get an HIV test*.
- Wt loss: clues of inflammation present? (cough + sweats + diarrhea prioritizes inflammation)
- ARBs: possible cause of the diarrhea
- Evaluating symptoms: most specific marker (but not sensitive) for inflammation → main 3 buckets to consider for inflam.: infection, cancer, or AI
- If ***Infection***: Consider uncommon organisms (mycobacterial, fungal, viral (CMV, herpes, HIV). Cancer - lymphoma involving the GI tract.
- How does the imaging look? – helps determine if systemic and primary origin.
- Anemia present - help us determine if it's GI tract intrinsic or referred?
- ***Salmonella***: anyone can get it. ***nontyphoidal*** - dx of immunocompromised. Abscess formation anywhere but liver and kidney most importantly, can also form abscesses in the vasculature.
- Chest x ray - not good at evaluating parenchyma. Consider advanced imaging (ct scan abdomen - covers lower abdomen).
- ***Liver abscess***: right lobe prioritized over left due to vasculature and size.
- abx failure schema - if pt is not recovering after abx: is it an issue of source control, issue of an alternative dx (HIV?), alternative infx not being treated?