05/17/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Mark Heslin (@Mark_Heslin) Case Discussants: Reza (@DxRxEdu) and Rabih (@rabihmgeha)

CC: 61 yr gentleman 2 weeks of polyuria polydipsia
1 week of word finding difficulty
6 day
HPI: extreme fatigue 6 days prior
5 days prior- less interactive (?emotional disturbance), tremulousness (improved)
3 days prior: Speech normal
1 day prior: nonsensical,
word finding difficulty

H/O weight loss

PMH:
HIV(1991)
CD4 335
COPD, Bells,
HTN, pulm
nodule

Meds:Albuterol, Amlo, Atorva, Benazepril, bupripion, ART(Teno, rilpi, emtri), Gabapentin

Fam Hx:
Father, paternal lung CA

Soc Hx:

Health-Related Behaviors: (-)

Allergies: NKDA

Vitals: T: HR:101 BP: 164/85 **RR:** 16 SatO2: 97%RA
Exam: Systemic: normal limits.
Neuro: Fluctuating: oriented to person, (place, year - not oriented)
Attention- word backwards
Comprehension, naming intact. Paraphasic error, naming impaired, confabulation present.
Right LMN palsy.
Right gaze preference(intermittent + associated word finding difficulty)
Sensory, Motor exam, Cerebellum normal
Gait- narrow based, negative romberg

Notable Labs & Imaging:
Hematology:
WBC:15.2(neutro) Hgb:15.5(MCV 90) Plt: 336
A1c 14 (prev 6 - 4 months ago) Glucose 550
Chemistry:
Na:129(**cNa:136**) **K:4.1** Cl:92 HCO3: 22 BUN: 22 Cr: 0.98 Ca:9.2
TP 7.4 TB 1.2,AST: 34 ALT:39 Alk-P: 353 Albumin: 3.2 INR: Normal
BOH: 3.59(High) Urine - ketone, glucose 3+. Mg/PO4: Normal
VBG: pH 7.34/45
Mental status- persistent despite Insulin.
Imaging:
Echocardiogram: Normal EF. no embolic sources
CT (head): Normal
MRI: acute vs subacute infarcts including B/L centrum semiovale, Left occipital and Temporo-occipital junction potentially **thromboembolic**. Scattered enhancing foci
EEG: Focal seizures(5/hr) → Levetiracetam→ Lacosamide
CT: Stable pulmonary nodule. **Ill defined lesion in tail of pancreas,** involvement of splenic artery. Liver, portal mets,right portal vein occlusion. Acute portal vein thrombosis
Dx: **Metastatic Pancreatic Cancer**

Problem Representation: 61yr gentleman presenting with polyuria, AMS and new onset diabetes on evaluation revealed seizures, DKA and B/L infarcts on MRI. Finally diagnosed with Metastatic Pancreatic CA

Teaching Points (Ximena):
Older person + Insulin deficiency + late onset DM = type 1 diabetes, pancreatic cancer, long standing T2DM with glucotoxicity first. Then think about zebras.
Polyuria: Defined as more than 3L urine/d
-Make sure it's polyuria & identify what presented first: polydipsia or polyuria. Usually polyuria prompts the polydipsia.
-Assess glucose through urinalysis. Observe glucose & specific gravity. SG (low) is useful to differentiate DI from DM.
-Another polyuria cause is hypercalcemia (nephrogenic diabetes)
-Mimics: urinary incontinence, confabulation
Speech problems:
-Aphasia (UMN - word finding) & dysarthria (problem pronouncing them)
-Understand time course & evaluate structural lesion vr metabolic abnormality.
HIV Diagnosis Pearls:
-Most sensitive marker for tx adherence is viral load.
-Remember about the HIV-related complications that are not related to CD4 count.
Hyperglycemia:
-Patients with hyperglycemia are hypovolemic
-DKA is usually more sudden and symptomatic. HHS progresses more slowly.
-Remember to correct Na according to glucose levels.
-Check for acid-base blood disturbances
Tx: fluids + K + insulin
-Consider toxic medications for pancreas and the check LODA.
Thrombotic events
Paradoxical embolisms, heart conditions and meningeal vasculitis can cause multiple infarcts in the brain.
Think about infections and malignancy