



07/05/24 Morning Report with @CPSolvers



“One life, so many dreams” Case Presenter: Yuji Yoshikawa (@) Case Discussants: Reza (@DxRxEdU) and Rabih (@rabihmgeha)

CC: weight loss

HPI: 86 -year-old man with PMH of Interstitial pneumonia referred for weight loss and new suspected HF.

1 week prior visited local doctor for suspected LVH

Appetite decreased for 1-2 months eating less than one meal per day, over 10 % weight loss

Referred for suspected chronic HF. Interstitial pneumonia well controlled; steroids tapered off and discontinued 3 months ago.

PMH: Interstitial Pneumonia

Meds:
Pirfenidone for IPF
Azilsartan
Rivastigmine for AD

Fam Hx: none

Soc Hx: none

Health-Related Behaviors:
20 Cig/day for 30 years

Allergies: no known allergies

Vitals: T: 99.1 HR: 79 BP: 125/75 Spo2: 96%

Exam:

Gen: emaciated, fatigue, sluggish

HEENT: conjunctival pallor, no JVD, no lymphadenopathy, no goiter

CV: no murmur, no peripheral edema

Pulm: mild crackles in the lung bases

Abd: soft non-tender

Notable Labs & Imaging:

Hematology:

WBC: 4720 Hgb: 8.4 MCV 79 Plt: 166k

Eos 3.7%

Chemistry:

Na: 140 K: 4.4 Cl: 111 HCO3: BUN: 16 Cr: 1.08

AST: 21 ALT: 12 Albumin: 2.7 BNP 72.4 (high in Japanese unit) CRP 4.65 (high)

Imaging:

EKG: sinus rhythm, moderate ST depression V4-V6,

Echo: EF 67%, ventricular hypertrophy not evident, LA dilation,

E/e' 12.16 not indicated LVH (>14) Diastolic dysfunction ruled out

CXR: CTR 60% (<50) GGO, dull CP angle

Chest CT: pericardial effusion and thickening

EGD: no abnormality

Abdominal CT: no mass lesions, Pancreas enlarged and increased capsule like structure.

Cortisol 8.8 (nl) ACTH 105 Thyroid function wnl, Low complement

Autoimmune and vasculitis panel negative

AIP- IgG 3118 IgG4 703

Dx: IgG4 related disease

Problem Representation: An 86-year-old man with PMH of interstitial pneumonia and suspected LVH presented with >10% weight loss. Abd CT showed an enlarged pancreas, and elevated IgG and IgG4. The final diagnosis was IgG4-RD.

Teaching Points (Seyma):

Weight loss: Inflammatory (Infx, Cancer, Autoimmune) vs non-inflammatory

→ Patients w/ HF usually retain fluid and gain weight.

HF + weight loss: Cardiac cachexia; Inflammatory etiologies (Infx, Autoimmune, Malignancy); **Hypermetabolism** (Thyrotoxicosis, Pheo, Diabetes, malignancy); **Low intake** (access to food, dementia/depression, loss of appetite, anorexia, dysphagia, weakness); **Malabsorption**

HFpEF > older people w/ metabolic syndrome (HTN, Diabetes)

Low nutritional intake does not cause low Albumin in isolation

New low MCV: Iron deficiency anemia, ACD >>

ST-depressions in anterior leads: obtain a posterior ECG to not miss a posterior STEMI!

ST depressions → think of cardiac ischemia: demand ischemia vs underlying coronary dz

Pericardial thickening is a clue for pericarditis, esp. Tb leading worldwide

Constrictive pericarditis: usually p/w normal BNP (prevents ventricle from dilation)

Pericardial effusion: Volume overload (e.g. ESRD, HF, cirrhosis), Infx, Autoimmune, Malignancy

Low complements: IgG4, Cholesterol emboli, Post-Strep GN, SLE, Cryoglobulinemic vasculitis, MPGN

Pancreas subject of systemic dz: Infx (Tb!!!), Autoimmune (IgG4 → Clue:

Eosinophilia), Histiocytic dz (Rosai Dorfman), Malignancy (Pancreatic lymphoma)

High IgG4: low specificity; 20% chance for something else (rule out mimickers like Tb)

Gold Standard for IgG4 dx is Histopathology + usually Steroid- responsive