9/13/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Alec Rezigh(@) Case Discussants: Reza(@DxRxedu) and Rabih(@rabihmgeha)

CC: 47 presenting with SOB, fatigue

HPI: Progressive dizziness**, SOB** x 3 weeks
Pain in ankle, hands
No swellings or redness
Over 6 months noticed
Weight gain x20 pounds, amenorrhea
Hair loss, constipation

No fever, chills, chest pain
No headache
NO GI symptoms
No rashes/leg swelling but chronic pain in B/L knee

PMH:
Atrophic gastritis
IDA, B12
OA B/L Knee

Meds:
Acetaminophen sos
No Iron or B12 supplements.

"ArtiKing" - Diclofenac, dexamethasone.

Fam Hx:
Unknown, adopted as a child.

Soc Hx:
1 pack q 2 weeks
Works as cook
From El Salvador originally
Lived in Texas all her life
No children.
Social EtOh use.

Health-Related Behaviors:

Allergies:

Vitals: T: afebrile **HR:** 63/min **BP:** 111/62 **RR:**18/min **SpO2:**97% RA BMI 42
Exam: Awake alert; **Gen:** Face appear full, rounded
HEENT: conjunctival pallor. No LAD. Enlarged dorsal fat pad
Cardio-pulm: Normal.
Abd: soft, no rebound tenderness
Neuro: No visual field anomaly. Rest normal
Extremities/skin: no erythema, warmth, synovitis.
Stretch marks on B/L abdomen, faint reddish-purple discoloration
B/L pulses 2+

Notable Labs & Imaging:
Hematology:
WBC: 7.4(N71E0)Hgb: 5(No baseline) MCV 68, Plt: 523
Chemistry:
Na:140 K:4.5 Cl: 107 CO2 22 BUN: 16Cr: 0.7 glucose:101 Ca:9 LFT: Normal, A1c 5.1
UA: No proteinuria, hematuria
Pregnancy test (N)
Ferritin 12, TSAT 2%,B12 <100, Folate: normal, LDH, Haptoglobin: Normal
RI <2, PS: microcytic anemia. no blasts/schistocyte, PT,apTT,INR: normal.
IF-Ab: negative, Anti-parietal Ab: positive.
ANA: 1:80(speckled), complement: normal, RA, CCP, ENA: negative
Cortisol: 2.6(3) **ACTH** 1.5**(low)**(7) **Stim:** 3→9→11.4(failured stim test) **PRL:** 32(26)
FSH,LH,IGF-1: Normal TSH 5.93(5.3), fT4(0.4(0.6) , **anti-TPO**:115(34)
HIV negative EGD: atrophic mucosa(HPE: chronic atrophic gastritis. H.pylori negative)
Parvovirus B19 IgM: positive.
Imaging:
EKG: NSR
Xray : B/L OA, rest chest, wrist normal
MRI Brain, pituitary: Normal
Dx: Exogenous Cushings, Supplement induced AI, Hashimoto Hypothyroidism

Problem Representation: 47yr female presenting w/ weight gain, SOB normotensive, w/ cushingoid appearance with labs suggestive of severe IDA, adrenal insufficiency secondary to "AtriKing" supplements.

Teaching Points:
Framing The Patient: making sense of what we have
Alopecia : rare enough to think about as answering our case
Characterizing the hair loss -> diffuse vs focal(think alopecia areata, scarring in lupus)
Most cases due to androgen excess, DHT sensitive hair cells that fall out in a horse shoe pattern because hairs in the back are resistant to DHT.
Constipation: When to worry about it? Sudden onset, refractory to treatment, associated with red flags(neuro symptoms, weakness, etc.) Secondary causes of constipation: obstruction, pseudoobstruction, electrolyte abnormalities, opiates, iron pills, autonomic issues (amyloid issues, spinal cord issues)
Amenorrhea: secondary amenorrhea (deficiency in estrogen vs progesterone) vs primary(obstructive structural life long cause, fixed disturbance in the hormonal axis)
deficiency in estrogen: (hypothalamic and pituitary dysfunction vs ovarian)
deficiency in progesterone: much more common, excessive androgens (cushings, PCOS, exogenous, etc.)
SOB: Fever and SOB -> pneumonia until proven otherwise , Puffy and SOB -> rush towards HF
Puffy -> is it water weight or something else? SOB and weight gain without HF -> most commonly deconditioning -> gaining weight(cushing?) for something else then getting SOB, *feeling better about the SOB not being from HF is confirmed by*
Patient's origin story -> infections, cultural norms, behavior patterns, malignancy risk profile, etc.
Cushing Syndrome? *(where did it come from where did it go)*
Moon facies,purple striae, weight gain , enlarged fat pad , The 3 big anti-anabolic symptoms associated with Cushing's syndrome are: 1. Ecchymosis 2. Osteopenia
3. Thin skin (LR 116)
Framing of cushing: exogenous steroids(more common than you think, seen even sometimes with weight gain herbal medication) vs endogenous (hypothalamic pituitary adrenal axis vs ectopic cushing)
Value of Visual field anomaly -> anatomy of pituitary and hypothalamic stalk relative to optic chiasm
Ectopic cushing(WBC elevation, bicarb elevation consequent to aldosterone activation)
Tunnel vision -> consider the pertinent negatives -> glucose and BP not where we expect them to be!!!! -> is there adrenal insufficiency?
Exogenous glucocorticoids -> patient experiences highs and lows
Dexamethasone is not picked up by the cortisol assay -> this can be an exogenous glucocorticoid!!!!
Addressing the possibility of Adrenal insufficiency
pernicious anemia -> suggested initially by atrophic gastritis and confirmed in further testing , autoimmune adrenalitis, vitiligo, flavor of autoimmunity -> Autoimmune polyglandular syndrome -> send ACTH test
Adrenal insufficiency is at the level of pituitary or hypothalamus with negative imaging pointing more to hypothalamus