



9/4/24 Morning Report with @CPSolvers



“One life, so many dreams” Case Presenter: Sawsan Sweilmeeen Case Discussants: Stephanie Sherman and Zaven Sargsyan

CC: 38 yo male admitted for severe anemia

HPI: 1 month ago, easy fatigability and generalized weakness, looks pale. Few days later, got a CBC showing low Hb and XR showing widened mediastinum w/o consolidation.
ROS: no constitutional symptoms, rest is normal.

PMH:

Med:

Fam Hx:

Soc Hx:

Health-Related Behaviors:

Non smoker

Allergies:

Vitals: T: afebrile HR: 110 BP: 128/78RR:

Exam:

Gen: looks ill, conjunctival pallor, no jaundice

HEENT: bilateral palpable cervical LN

CV |Pulm: Abd: Neuro: nml

Extremities/skin:

Notable Labs & Imaging:

Hematology:

WBC: 24.16 neutro predominance Hgb: 5.5 retics 9 MCV 103 Plt:nml LDH 400

Chemistry:

Tbili 31 (nl 22)Dbili 15 Hapto <20

Blood film: normochromic normocytic anemia, no abnormal cells

HIV, Hep sero -

Coombs direct and indirect + showed warm and cold antibodies

Further Management: high dose methylprednisolone for 3 days, with no improvement and Hb dropped to 4, pt became more symptomatic.

CT: mediastinal and hilar lymphadenopathy

Trucut biopsy L supra clav: atypical lymphoproliferative cells

BM biopsy and aspiration: erythroid hyperplasia and no abnormal cells

– He was then given IVIG for 2 days, 6 days later his HB improved to 7.5,

– He was discharged due to insurance purposes , he was given methyl prednisone, folic acid and neurobion .

– 10 days after discharge he was seen and his Hb was 9.6

Excisional biopsy L supra clav: Hodgkin Lymphoma nodular sclerosing type

Evolution: He was started on chemotherapy ABVD and after 1 cycle his HB was 11.6

Dx: AIHA 2/2 Hodgkin lymphoma

Problem Representation: 38 Y/O M with 1 month of fatigue, pallor, and 1 week of dry cough. Exam: conjunctival pallor, cervical lymphadenopathy. Labs: severe normochromic normocytic anemia, WBC 24.16, elevated LDH, hyperbilirubinemia, Coombs (+3). No response to high-dose steroids; Hb dropped to 4. CT: mediastinal and hilar lymphadenopathy. Biopsy: atypical lymphoproliferative cells; BM: erythroid hyperplasia, no abnormal cells.

Teaching Points: (Anmolpreet):

I] Severe anemia in a man: we think about→

- Where he could be losing his blood? → *GI tract* or *genital tract* (in females through menstruation)
- Important to know if it is *acute/chronic*?
- *MCV* will be important to understand the etiology.
- To evaluate if the *other cell lines* (WBC, platelets) have also been affected.

II] Widened mediastinum: mass/ lymphadenopathy? Aortic issues(aneurysm?), NEOPLASIA

III] Lymphadenopathy: Cervical LAD makes us want to look out for other areas of body to see if it is systemic LAD.

Anemia seems to be secondary to a disease process.

IV] ?Query Hemolytic anemia: suspicion of an infection precipitating hemolysis. LDH, PBF, DAT test would be helpful.

V] Autoimmune hemolytic anemia: primary or secondary (to a viral illness, autoimmune disease, blood cancer)

VI] Hodgkin Lymphoma: 2 types: Classical (has following 4 subtypes) and Nodular Lymphocyte Predominant.

1. Nodular sclerosing (most common)
2. Lymphocyte rich
3. Mixed cellularity
4. Lymphocyte depleted

VII] Hodgkin Lymphoma: Excisional biopsy > Core needle biopsy!!!