



11/25/24 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Rahul (@RahulPottabath1) Case Discussants: Alec (@ABRezMed), Austin (@@RezidentMD)

CC: 38 y/o M presents with SOB for 20 days, insidious in onset and gradually progressed so he was not able to perform minimal work such as wearing clothes. He also complaint of easy fatigability for 30 days, swelling of both feet for 20 days

HPI: no nocturnal awakening, no dyspnea with laying down. The edema is up to the knees for past 20 days. Swelling of feet not subside with rest and subsided with oral furosemide. H/o yellowish discoloration of eyes 1.5 months ago not associated with itching and pale colored stools and subsided with medication ursodeoxycholic acid, jaundice lasted for 1 week. Patient noticed blackish discoloration of stools 2-3 episodes per day for 3 days stools were sticky and malodorous at that time. H/o bleeding gums present for 2 days and then **susided**.

PMH:
Hypothyroidism,
DM2

Meds: thyroxine 50 mg (poor compliance), metformin 500 mg

Fam Hx: none
Soc Hx: none
Health-Related Behaviors: smokes 2 -3 cig per day. Alcohol use disorder for 8 years, he used to take 90-180 ml of brandy per day. Chews tobacco

Allergies: none

Vitals: T: afebrile **BP:** 130/80 **RR:** 14 **Sat:** 98% **HR:** 106 **BMI:** 21.6
Exam: **Gen:** conscious, coherent, cooperative.
HEENT: wnl
CV: wnl
Pulm: wnl
Abd: wnl
Neuro: wnl
MSK: wnl
Legs: pedal edema, pitting in nature and extended up to kees.
Other signs: Alopecia
Thyroid exam: uniform swelling of 6.4 cm noted in neck region without any nodularity swelling. Moves with deglutition.

Notable Labs & Imaging:
Hematology:
WBC: 3300 Hgb: 5 Plt: 12 K Hct: MCV: 90.2, MCH 29.5, MCHC 32.2, reticulocyte 0.5%, reticulocyte index 0.05
PBS: anisopoikilocytosis, normocytic normochromic RBCs, macrocytes + ovalocytes +, WBC count is decreased with lymphocytosis.
Iron: iron 9,6m TIBC 476, %transferrin 2%, transferrin 30, B12 160 pg/ml, direct and indirect coombs -, LDH 4210
Infectious work-up: typhoid -, HIV -, HbSAg -, HCV -, dengue -, HSV -EBV - CMV - and parvovirus B19 -
Bone marrow aspiration: erythroid hyperplasia with megaloblastic maturation.
Chemistry
BUN 27, Creatine: 0.59, Na 129, K 4.9, Cl 99
TBili 2.2, ALT 40, AST 48, ALP 69
TP 6.5, albumin 3.5 gm/dl, globulin 3 gm/dl
CRP neg, ESR 22 mm in 1st hour
Thyroid profile: T3 99.65, T4 8.7, **TSH 7.8**
HbA1c 7.5%
DM work-up: FBS 140, PPBS 215
8 AM cortisol 42 (133-537), anti parietal cell IgG + 36 (NV < 20), anti TPO + 932 (NV < 60)
Imaging:
Upper GI endoscopy: grade 1 hiatus hernia, non-erosive gastritis
USG abdomen and pelvis: borderline splenomegaly

Dx Autoimmune polyendocrine syndrome type 2

Problem Representation: 38 M p/w SOB; swelling; episodes of black stools/bleeding gums with PMH of DM and hypothyroidism, found to have anemia and thrombocytopenia; very high LDH with positive TPO enzyme and parietal cell IgG.

Teaching Points(Parisa):
Edema + subacute dyspnea → Heart; liver; kidney → BP; age
Subacute dyspnea → in the hospital settings heart failure unable to do their ADLs associated w swelling; on exertion; PMH; FH
Causes → Cardiopulmonary(base rate); diaphragm issue; endocrinopathies; systemic anemia; inflammatory compartment
No orthopnea nocturnal dyspnea → it is not heart causes
GI bleeding → dark stools mucosal bleeding → peptic ulcers, malignancies, vascular malformation, coagulation disorders (plt dysfunction/ coagulopathies) → endoscopy
Linking edema w/ GI bleeding → stigmata of cirrhosis → spider angioma; jaundice telangiectasia; asterixis; JVP; signs of malnutrition (rash)
#Conjunctival pallor for anemia by focusing on the paleness of anterior conjunctival rim is reliable indicator.
DM + Hypothyroidism → autoimmune polyglandular syn → co-occurrence of multiple glands involvement pancreas adrenal
Anemia + thrombocytopenia → no miss TMA; TTP; liver dx portal hypertension → pancytopenia → 4S systemic; substance; space occupying; stem cell → the more cell lines are involved the more we think toward BM.
BUN/Cr → Urea reabsorption increased → blood in the GI lumen; intravascular volume depletion; catabolic state (ICU settings); steroid use
#Patients p/w mucosal bleeding thrombocytopenia → hematological and nutritional causes → Vit c deficiency could compromise vascular integrity
Lymphocytosis → reactive vs atypia
Low B12+ low Iron → multiple vit deficiency → malabsorption
Elevated LDH → abnormal cell turnover → acute liver injury; hemolysis; fragile cells coming out of marrow d/t vit deficiency; leukemia; lymphoma; sepsis
Observing multiple abnormal cell types varying in size (anisocytosis) poikilocytosis → nutritional deficiencies and liver disease
#Given the severe B12 deficiency and low retic count → TMA needs reevaluation
Immunosuppressed + high LDH SOB → disseminated histoplasmosis (despite no respiratory sx); AI (lupus)
#TPO antibodies support diagnosis of Hashimoto's thyroiditis
#Adrenal insufficiency can cause pancytopenia