



01/25/25 Morning Report with @CPSolvers



“One life, so many dreams” Case Presenter: Mount Sinai Morningside West (@msmw_medchiefs) Case Discussants: Ravi (@rav7ks), Anmol (@anugrewal19) and Oumaima (@OOutani)

CC: 60 y/of 2 week Hx of sharp shooting low back pain and intermittent spasms to the left thigh and left hip

HPI: Exacerbated by walking up stairs, and standing, has 4 year prior history of numbness in hands and feet that developed after treatment Hx follows with chronic pain clinic, and has lumbar discectomy 16 years ago. Prior to presentation underwent nerve block for lumbar pain with temporary relief and return of difficulty ambulating and now wheelchair bound and temp of 38.1. Pain exacerbated by standing, walking up stairs, and lifting objects

ROS: no bowel or bladder incontinence, hematuria, vomiting.

PMH: Triple negative Breast cancer Treated w/ paclitaxel Immunotherapy. Left breast lumpectomy Positive node. Now on carboplatin THA R hip Hypothyroid Left IJ thrombus LUE DVT LUE stent

Meds: Oxycodone, gabapentin, levothyroxine, lorazepam, wellbutrin

Fam Hx: not relevant
Soc Hx: College professor, lives w/ her 3 kids

Health-Related Behaviors: 7 pack-year smoking hx but stopped in 2019, drinks wine 6 times/wk. Occasionally smokes marijuana

Allergies: NKA

Vitals: T: 38.1 (101F) BP: 145/67 RR: 17 HR: 101 Sat: 100 RA, BMI 33.3
Exam: Gen: chronically ill
CV: normal S1 S2, RRR, no murmurs or gallops
Pulm: CTAB no wheezing or crackles
Abd: normal BS, non tender non distended,
Neuro: Alert and oriented x3, negative straight leg raise b/l, weak in lower extremities %, normal reflexes
MSK: non pitting edema to b/l LE and LUE , no point tenderness of spine
Skin: no rashes noted

Notable Labs & Imaging:

Hematology:

WBC: 19.4, monocytes 62% Hgb: 7.5 MCV 71.3 Plt: 40K Retic index: 0.2

Chemistry:

Na: 135 K: 4.1 Cr: 0.68 BUN: 8
Ca: 8.2 Ph: 1.7 Mg: 1.8 HCO3: 22.7
LDH: 360, normal haptoglobin 204, AST: 26 ALT: 20 ALP: 163 Bili: .5 total protein 5.1 alb: 1.9 lactate 1.4 ESR 120, CRP 453, INR 1.4 PTT 45.1, fibrinogen 855, D Dimer 7.59 Ferritin 217
UA: unremarkable. Cardiac markers normal. Respiratory viral screen: negative

Imaging:

EKG: sinus tachycardia
CXR: blunting of costophrenic angles
US LE doppler: LUE: no DVT
Smear: few schistocytes, few blasts, numerous immature monocytes, hypogranular neutrophils.
MRI Spine: no marrow/medullary enhancement, enhancement at L2-L3, c/f discitis/osteomyelitis, contrast enhancement extended into L psoas muscle
BMBx: 70% myeloid blasts, dysplastic erythroid precursors, no atypical plasma or lymphoid population.
Flow cytometry: CD34+, aberrant population of monoblasts 70%

Dx: Treatment related Acute Monocytic leukemia

Problem Representation: 60 y/o/f hx of breast cancer w/monocytic predominant leukocytosis and blasts on smear with MRI w/c/f for osteomyelitis and found to have 70% monocytes blasts in peripheral blood and bone marrow c/f treatment related acute monocytic leukemia

Teaching Points:

Low back pain approach:

- Less than 4 weeks — acute. First need to exclude most severe Dx. Red flags — TUNA FISH (trauma, unexplained weight loss, neuro Sx, age > 50, fever, IVDU, steroid use, Hx of cancer) + change of pain characteristics + immunosuppression.
- With risk factors, early imaging and exam are important: bowel or bladder function, weakness, positional changes, accompanying signs and Sx (numbness and tingling?).
- Recent interventions -> watch out for iatrogenic causes.

Acute weakness of lower extremities:

Localization is important. Spinal cord, nerves, NMJ, muscles?

Malignancy + non-pitting edema: lymphatic obstruction, infiltration, paraneoplastic autoimmune phenomenon, medication review.

Monocytosis:

- Need smear to confirm they are true monocytes (blasts?)
- Marker of any sort of infection (TB and subacute endocarditis are the major ones), malignancy signal (leukemia, Hodgkin’s lymphoma, CML), autoimmune.

Thrombocytopenia:

- Is it isolated? Given fever, can be due to infection. Can be chronic DIC in the setting of malignancy.
- Here we have bicytopenia + presence of immature cells on smear -> high chance of bone marrow infiltration.
- Schistocytes: think about MAHA. Where’s the RBC destruction happening — BM, macro vasculature, small vessels?

Treatment-related AML: 75% due to alkylating drugs or radiotherapy, mean latent period — 5-7 years.