01/04/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Willis Knighton (Instagram @wkinternalmedicineresidency) Case Discussants: Ravi (@rav7ks) and Johann (@johannedjimbimd)

CC: 74Y/M presents to the office concerning of weight loss over the past 6 months

HPI: white male regularly followed by hematology. Unexplained unintentional weight loss of 25 pounds. Significant increase in fatigue. Describes feeling tired. Progressive fatigue affecting his ability to carry out normal activities.

ROS (-): fever, chills , night sweats, SOB, edema, orthopnea, hemoptysis, N/V
ROS (+): 25 pounds w/l unintentional, fatigue

PMH:
NHL diagnosed 22 years ago (remission)
Prostate cancer (remission)
Dementia
HIV (well-controlled)
HTN
Ischemic Cardiomyopathy
Tubular adenoma

Meds:
Dabigatran,
levothyroxine
Lopinavir, emtricitabine
DIgoxin
Atorvastatin
Carvedilol, Entresto

Fam Hx: None

Soc Hx: Chronic active smoker, 50 pack year, no recent travel.

Allergies: None

Vitals: T: 98.7 F**BP:** 122/73 mmHg **RR:** 16 **HR**: 84 bpm **Sat: 9**8% RA
Exam: Gen: appeared fatigued.
CV: normal S1 S2 RRR no rales no gallops
Pulm: clear, B/L airentry+, no added sounds
Abd: soft, non tender
Neuro: intact, normal.
MSK: no cyanosis, no joint tenderness, no lymphadenopathy

Notable Labs & Imaging:
Hematology: WBC:9.7, Hgb: 9.7 Plt: 185 Hct: 28.8 MCV:109.8
Chemistry
Na: 141K: 4 Cr: 1.27,BUN:16 Ca: 9, Mg:2 Glu: Cl: 104 HCO3: 29
LDH: 158 AST:nl ALT:nl ALP: Bili: nl Albumin: 3.7, total protein: 6.5
Iron: 68, TIBC: 196, iron saturation-35, Ferritin 116 B12 & Folate:normal,
TSH: 1.66, T4: 4.6. PSA: <0.06
HIV viral load :undetectable, CD4 count: **374**
Imaging:
CT chest: **20-30 predominantly non calcified nodule in the upper lobe appears** new, <6 mm in size, **scattered granulomas in lung bases**.
F/u 3-6 months CT recommended.
CT abdomen & pelvis: unremarkable.
TB test: Culture, PCR, quantiferon gold: Negative.
Repeat CT chest: nodules increase in size with cavitary lesions, emphysema.
Bronchoscopy with BAL: no growth of fungal, bacteria, TB, aspergillus, histoplasma, cryptococcal. No malignant cells.
RF, ANA, Anticentromere, anti dsDNA, myomarker 3 panel: negative
VATS Biopsy: **conspicuous nodules with stellate configuration in a bronchiolocentric distribution, mixed infiltration of eosinophils and histiocyte like cells suggesting Langerhans cell Histiocytosis**

Dx : Pulmonary Langerhans Cell Histiocytosis.

Problem Representation: 74Y/M with PMH of NHL, HIV, Prostate cancer came in with 25 lbs unintentional weight loss over 6 months,. Chest CT showed non calcified nodules with cavitary lesions Dx as Pulmonary Langerhans Cell Histiocytosis.

Teaching Points (Sohil):

I) Chronic weight loss: why patient presents now? Intentional? Ddx: Malnutrition vs malabsorption vs hypercatabolic (eg malignancy, endocrine, infections).

II) NHL (peak at 50). HIV: immunosuppression → malignancies like NHL (T or B cell, nodal or extranodal, in remission?). Diffuse large B-cell lymphoma most aggressive.

III) Physical exam: -lymphadenopathy does not exclude "hidden" lymphomas like MALT. No CNS symptoms to indicate advanced HIV disease

IV) CD4 count = 374. High enough to r/o most conditions except TB. Other malignancy is MM, esp with age and sex of patient. CRAB (hypercalcemia, renal disease, anemia, bone pain)

V) military pattern on CT scan: TB vs fungal infection vs malignancy. Smoking needs follow up scan. Eg: Sarcoidosis, coccidiomycosis, among many others!

VI) Follow-up: Cavitational nodules and tree-in-bud on CT. Septic emboli vs autoimmune vs malignancy vs infection

VII) Consider validity of tests. Sensitivity/specificity? Eg: Tumor markers are not sensitive nor specific.