03/17/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Kuchal *Case Discussants*: Dr.Gupta and Dr.Decloux

CC: 83 yo gentleman, a Traditional Chinese Medicine practitioner, presented with AMS and generalized weakness.

HPI: last normal previous night. Presented to ED via EMS with complaints of AMS and generalized weakness. According to his neighbor, his oral intake has been decreased since 2 months prior to admission. 1 day prior to admission, pt was found on the floor and was unable to move. Pt declined to visit doctor. Pt was brought back to his bed and had sips of water. On the day of admission, he remained confused and his neighbor called EMS. Upon arrival, complained of pain in his urinary area. His relative reported slurred speech, his neighbor denied it.

PMH:
Parkinson's disease, multiple strokes

Meds:
Chinese herbs

Fam Hx:

Soc Hx:

Health-Related Behaviors:
smoking/alcohol all denied

Allergies: NKA

Vitals: T: 36.4 BP: 121/58 RR: HR: 114 **Sat: 95% on 2L NC BMI:20**
Exam: Gen:
HEENT:Soft mobile 2cm mass in the left neck, dry tongue, dry skin
CV: Irregular heart rhythm, mild systolic murmurs at LLSB
Pulm: Mild crackles in the right lower lung
Abd: Palpable bladder
Neuro:CN II- XII intact, movement preserved in 4 extremities. Alerted to time and place.
DRE: prostate enlarged

Notable Labs & Imaging:
Hematology:
WBC: 11.1 (neutrophil predominant) Hgb:17.3 Plt: 156 Hct: MCV:
Chemistry
Na: 149 K: 4.3 Cr: 1.26 BUN: 56 Ca: 9.4 AST: 47 ALT: 19 Ca: 9.4 albumin: 3.7
T-bili: 2.5 glucose: 61 AG: 24 ammonia: 34 beta-hydroxybutyrate: 5.1
CO2: 19 lactate: 2.4
U/A: ketone (+), large blood, protein 30 mg, WBC 40-50, RBC 5-10, bacteria (+), nitrite (-), leuk esterase (-)
Covid (-)
Imaging:
EKG: irregular rhythm, no acute change in ST-T. Rhythm favors Afib.
CXR: calcification in aorta, increased bronchovascular infiltration (R>L)
TTE: severe LV hypertrophy, LVEF 80%, hyperdynamic LV function, grade 1 diastolic dysfunction, mild AR & TR, trivial MR
CT head: diffuse atrophic brain, moderate chronic microvascular ischemic disease, chronic lacunar infarcts in bilateral gangliocapsular regions, right pons and left cerebellum. Multiple small lucencies within bones.
CT c/a/p with contrast: tree in bud configuration in the LLL, moderate atherosclerosis in aorta, mild hyperplasia of the bilateral adrenal glands
Started abx and IVF, patient opted hospice care
Dx: Sepsis and ketoacidosis (DKA/starvation); suspect myeloma or osteolytic metastasis of cancer of unknown origin (?)

Problem Representation: A 83 year male presenting w/ acute AMS, urinary retention with left neck mass & irregular rhythm on exam. Investigations confirmed AF w/ imaging s/o lytic bone lesions, TIB nodules. Patient diagnosed with possible Osteolytic mets of unknown primary

Teaching Points (Vijay):
AMS → Primary CNS(SOL, Structural - Stroke, Seizure)
Metabolic(hormonal,Glucose,Na,O2,CO2,BUN) **U**(Uremia), **D**(drugs) **I**nfections **E**ndocrinopathies
Weakness → Objective vs Subjective weakness
- Slurring: Seizure/Stroke
- **Time course:** Acute vs acute on chronic

Exposure: Indoor(bugs/ticks/mites/ Toxins - CO)
Toxidrome: Anticholinergic(Dhatura/Herbs), Aspiration
HAGMA: Ketoacidosis(Starvation/drug induced), Lactate
Hyperdynamic EF: Hypovolemia, High output
Tree-In bud: Non-specific. Viral, atypical, fungal, granulomatous
Lytic Bone lesion + Neck mass: Myeloma, mets, LCH, Granulomatous(Endemic mycosis)
Ammonia could be elevated in paraproteinemia
Infections(e.g, Nocardia etc) can masquerade as Malignancy.