11/6/25 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: (Pavandeep Kaur) **Case Discussants**: (Rabih@rabihmgeha) & (Sam@samkeenanbarry)

https://clinicalproblemsolving.com/present-a-case/

Scribing (Seeme)

CC: 70 y old M came to ED with SOB

HPI:

Initially was on exertion but now also on rest associated with palpitations, frequent visits to ED. Patient has been bed bound while was previously able to do activities independently.

This visit seen in GI for colonoscopy

Macrocytosis may be indicative of congenital cause

ROS: Vomiting, diarrhea and weight loss, no chest pain, cough or abdominal pain, no bleeding, not eating much

PMH:

Persistent macrocytosis (from 2019)

Osteoarthritis

Migraines

Depression

A fib

Occipital stroke-residual visual disturbance

Meds:

Vit D

Atorvastatin

triptans

Fam Hx:

-

Social Hx:

retired

Health-Related Behaviors:

Smoking history in past

Prev gone to prison

Allergies:

NKDA

Vitals: T: **HR**: 96 **BP**: 156/72 **RR**: 18 **Sat**: 98 **BMI**:

Exam: Gen: Pale , alert and oriented, conjunctival pallor

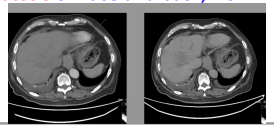
HEENT: Scattered seborrheic keratosis on face and back, No LN

CV: No murmur

Pulm: B/L equal air entry

Abd: Soft, no organomegaly

Neuro: nl **Extremities/skin**: nl



Notable Labs & Imaging:

Hematology:

WBC: 6.6, 7, 4 ,4, 3.2,2.9 Ntrs: 4.3, 4.7,1.6,1.2

Hgb: 131, 138, 113, 106 (133-173) , 71 Plt: 167, 168,115,98 MCV:107,108,108,123

When PLT 98, Hb 106

U+E and LFTS: nl

Hb: 48 (133-173) MCV: 105 (80-96). PLT: 10, Monocytes high 1.8 (0.2-0.8), immature platelet fraction: high 15.2 (1-6) lymphocytes low 1 (1.5-4),

PT and PTT nl, Retic: 23 (50-100)

Chemistry:

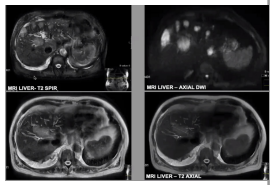
Ca: 2.14 (low) AST: ALT: 19 Alk-P: 212 Bili: 26 (1-21)

CRP: 64 (H)

A fever spike, right arm swelling

AFP:1197, Ca 19-9: 75 (H)

Fe- 20, Sat-61%, Ferritin-1000, Normal B9 and B12



Imaging:

MRI liver: Supra and infra diaphragmatic LN, multiple masses

CXR: Enlarged heart with perihilar haziness associated with effusions

Doppler: No evidence of DVT, mild subcutaneous edema , evidence of non-vascular mass anterior to subclavian vessels

CTAP: enlarged mediastinal lymph nodes, paraesophageal and paraaortic lymph nodes, subcarinal lymph node of 25mm, splenomegaly

Lymph node biopsy: 99% necrotic cells with few floating cells

Bone marrow biopsy: Morphological balsts more than 20%, 15% Cd34+CD117 +myeloid progenitors, lymph node biopsy: Metastatic CA with Hep Par 1

Dx: AML with origin in primary liver tumour (HCC)

Problem Representation: 70 yo M presents to the ED with SOB and palpitations, vomiting, diarrhea and weight loss. He had persistent macrocytosis and was found to have pancytopenia with monocytosis. Imaging revealed multiple liver masses compatible with HCC and bone marrow biopsy revealed a co-existing diagnosis of AML.

Teaching Points (Gerardo)

SOB + palpitations in elderly: cardiac insult vs high adrenergic tone

Neuroendocrine tumors can cause carcinoid syndrome if they bypass the liver (diarrhea, vasomotor symptoms)

Macrocytosis: metabolic derangement vs nutritional (copper, iron, b12) vs bone marrow problems vs alcohol vs liver disease vs reticulocytosis

Immature platelets in the periphery: platelets forced out vs consumption

Pathologic monocytosis (eg CMML): tendency to infiltrate, could clue towards chronic granulomatous infection or cancer infiltrating the bone marrow

Chronic macrocytosis: MDS vs MDS-AL vs

Hematologic malignancies promt TLS labs: uric acid, potassium, creatinine, BUN

Myelophthisis: bone marrow infiltration by cancer, can cause hepatosplenomegaly due to extramedulary hematopoiesis (DDx with leukemia and lymphoma)

Longstanding hematologic disorder can trigger acute leukemia