12/16/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Krithika (@krithikakripashankar5)* ***Case Discussants****: Ravi (@rav7ks) & Maddy (@MadellenaC)*

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

Scribing (Manaswini)

CC: 48 Y/O F presents with easy fatigability x 3 months, weight loss x 2 months

HPI: Pt % of decreased working capacity for 3 months, lost about 5 kgs in 2 months, experiences early satiety, experiences intermittent headaches resolving after a few hours, B/L intermittent burning of feet

ROS: No SOB, cough, chest pain, N&V, loose stools, weakness of limbs, loss of sensation in limbs, or visual disturbances

PMH: DM type 2 x 2 years
Hysterectomy x 4 years (AUB?)
Treated for Malaria x 6 months back

Meds: Metformin, Glimepiride

Fam Hx: -

Social Hx: -

Health-Related Behaviors: -

Allergies: -

Vitals: T: 97.2 **HR**: 90 **BP**: 130/70 **RR**: 16 **Sat**: 97% **BMI**:
Exam: Gen: AAOx 3
HEENT: JVD raised, no pallor, icterus, lymphadenopathy
CV: No murmurs, S1 S2 heard
Pulm: B/L NVBS, no added sounds
Abd:Distention of abdomen, non-uniform, hepatomegaly(liver span- 20cm), splenomegaly(spleen 7 cm below the left costal margin)
Neuro: No focal neurological deficits, no loss of sensation/motor weakness
Extremities/skin: B/L LL ankle edema, varicose veins

Notable Labs & Imaging:

Imaging: **CT Abdomen (Plain and contrast):** Massive splenomegaly with dilated splenic vein, portal vein and few collaterals at splenic hilum
Focal splenic infarct in the inferior pole region. Mild hepatomegaly with no signs of cirrhosis.No evidence of granulomatous/lymphomatous deposits in the splenic parenchyma.Negative for abdominal lymphadenopathy
ECHO: Normal
PS for MP-Negative
IgM, IgG antibodies-negative
HIV, HBSAG, HCV- non reactive
Hematology
Hb-15.6, RBC- 7.3 mill/cumm, WBC-16060(N72, L23, M03, E02, B00), Plt-5.34(raised), PCV- 53, MCH-18.9, MCHC- 29.3, MCV- 64.3, ESR-20 mm, LDH-222
Ferritin - Normal
Smear- RBC-increased in number, microcytic, hypochromic and normocytic, normochromic in appearance, elliptocytes, tear drop cells and occasional polychromatophils, relatively raised WBC and platelets
CMP, LFT(AST-25 ALT-14, ALP-135, Total bilirubin-1.5) , RFT- Normal, Glucose-113,Urinalysis - Urine Albumin 1+, Normal, PT-19.9, Aptt-32.6, INR-1.6

BM aspiration- dry tap,
Erythroid increased in number with normo to megaloblastic maturation with dyserythropoietic(10%)marrow, increased myeloid series with predominant myelocytes, metamyelocytes, with sequential differentiating forms, mild increase in basophilic and eosinophilic series, increased Megakaryocytes

FISH- BCR-ABL negative
Molecular genetics-JAK2 exon 14+
Serum Erythropoietin-2mU/mL

Dx: Polycythemia Vera (Positive JAK 2 mutation)

Started on hydroxyurea, phlebotomy and antiplatelets and pt is doing better now.

Problem Representation: Middle aged woman with 3 months of constitutional symptoms, intermittent headaches and B/L burning of feet, presented with JVD, massive splenomegaly, with erythro, leuko, thrombocytosis, dry tap bone of marrow with increased proliferation of erythroid, myeloid and megakaryocytic cell lines, low EPO and a positive JAK2 mutation

Teaching Points (Shriya)

-Time course and pattern crucial in chronic symptomatology;constant vs intermittent
-**Fatigability:**at rest vs exertion(heart,lung,kidney,blood)
-**Weightloss with Fatigue**=Inflammation vs malignancy
-**Early satiety** could be indicative of either GI patho or CNS signal defect(leptin);obstructive lesion and malabsorption l/t wt loss.Also could be gastroparesis sec to DM(emptying study)
-**Intermittent burning feet** could be d/t vitamin B12 deficiency/malabs,DM ,alcohol,toxins.
-**Abdominal distension**:blood in peritoneum,mass, fluid
-**HSM**=hematological disorders vs portal hypertension vs infectious process
-**JVD** :high filling pressure>PE,tamponade,
-**Volume overload with JVD** :high Right heart pressure
-Splenomegaly being massive can cause infarct due to loss of perfusion and collaterals point the process to be chronic.
-Splenic infarcts are rare.Think of malignancy,endocarditis,(emboli vs thrombus)
-**Polycythemia**=PCV vs secondary(high altitude,COPD,sleep apnea).
-Myeloproliferative disorders >thrombocythemia,polycythemia,massive splenomegaly(extramedullary hematopoiesis),teardrop cells