10/26/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Frances & Sarabesh **Case Discussants**: Austin & Alec

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

Scribing (Nguyen):

CC: 70yo M presents with dry cough

HPI:

AAA repair 1 month ago, post-op CT scan shows stent occlusion and incidental R lung mass 6 cm in size, worsening dry cough since then. Increased fatigue and decreased appetite over the last 3 to 4 weeks, with 40 lbs loss over 2 years. Yes chills, no fevers, abdominal pain, nausea, vomiting, diarrhea, rash, lower extremity swelling.

PMH:

adult-onset asthma, nasal polyposis, AAA s/p EVAR, eosinophilia, prediabetes, seizure, mild cognitive impairment

Meds:

Triple therapy
Cetirizine
ASA 81
Montelukast
Clopidogrel
Donepezil
Memantine
Escitalopram
Lacosamide

Fam Hx:

Colorectal cancer in father, bladder cancer in mother
Colonoscopy 10/2021 normal

Social Hx:

Live in rural NY
no history of substance use

Health-Related Behaviors:

No sick contacts, recent illness, recent travel.

ROS:

Allergies: NKDA

Vitals: T: 36.1 **HR**: 71 **BP**: 128/73 **RR**: 16 **Sat**: 94

Exam: Gen: awake and alert, appears **cachectic** **HEENT**: normal **CV**: normal **Abd**: normal **Neuro**: normal **MSK/skin**: normal **Pulm**: **diminished breath sounds at lung bases b/l.** otherwise normal

Notable Labs & Imaging:

Hematology: WBC: 26.5 (40.3 later) Hgb: 12 Plt: 268 MCV: 93
absolute eos 17k, eos% 67.2%

Chemistry: Na: 138 K: 4.1 Cl: 105 Ca: 8.7 Mg: 2.0 BUN: 20 Cr: 0.7 Glu: 115
AST: 27 ALT: 23 ALP: 208 T. Bili: 0.5 T. protein: 6.1 Alb: 3.1 ESR: 49 CRP: 3.6

EKG: NSR, occasional PVCs, poor R wave progression

CXR: b/l costophrenic angle blunting, well-circumscribed mass R middle lobe 8.2x5.5 cm

Infectious labs: Sputum culture: rare yeast, likely contaminant
Quantiferon gold indeterminate Mycobacterial culture (-)
Legionella urine Ag (-) strep urine Ag (-) blood culture (-) aspergillus Ag (-) aspergillus IgE (-) histoplasma Ag (-) blastomycosis Ag(-) serum fungitell (-) serum strongyloides (-), strongyloides serology (-), schistosomiasis (-), HIV (-), Karius (-)

Autoimmune labs: serum complement normal. p-ANCA (+), other autoimmune serologies (-)

CT: b/l pleural effusion (R>L), increased from prior. Unusual loculated effusion in the minor fissure not significantly changed from previous CT
=> CT-guided drainage. Fluid predominantly RBCs, (-) malignant cells, culture, gram stain, ova/parasites

Hematology labs
Absolute CD4 1,520. B and T cell quantitation otherwise normal with no deficiencies.

BCR/ABL (-) **HES panel** (-) **MPN panel** (-) for JAK2V617F, CALR exon 9, MPL exon 10

NGS panel SF3B1 mutation and DNT3A variant of uncertain significant

Bone marrow biopsy: hypercellular marrow with multilineage dysplasia, increased and dysplastic eosinophils, mature non-Hodgkin B-cell lymphoma (20%), no increase in blast

Peripheral blood flow cytometry: Kappa-restricted monoclonal B-cell population

PET/CT: no FGD-avid disease

Dx: Mature non-Hodgkin B-cell lymphoma

Problem Representation: Older man with acute worsening of chronic eosinophilia resulting in hypereosinophilia in the setting of acute to subacute lung mass and chronic atopy with atypical features.

Teaching Points (Noah)

Incidental stent occlusion: Asymptomatic? Exam? Triage acute-on-chronic ischemia.

PAD with stent occlusion: Proxy for metabolic syndrome and classic ASCVD risk factors, if absent, query hypercoagulable.

Lung mass: Risk factors (age, behaviors), tempo (truly 1 month vs longer and unrecognized), imaging characteristics (big size).

Asthma diagnosis red-flags: Late-onset in life, therapy is ineffective, significant eosinophilia. Maybe not classic asthma?

Eosinophilia: Base-rate atopy, but atypical features (steroid-resistant) and associated findings force us to consider: infections; drug-related; reactive (malignancy, autoimmune).

Absent PAD risk factors: Similar thought-process to asthma diagnosis in relabelling. Maybe not classic PAD, but peripheral arterial ischemia due to: hypercoagulability vs vasculopathy (itis given the inflammatory background).

Eosinophilia in the hospital: > 500 is probably clinically relevant. The higher the count, the more narrow the differential diagnosis. First pivot point is clonal versus not?

HES is a complication: Skin, heart, GI tract, with infiltration - here only subtle clue is mildly elevated alk phos

Hickam's dictum vs Occam's razor: Time course and temporality of findings against each other.

Atypical features of rapidly enlarging mass: Well-circumscribed mass along the fissure trajectories.

Overlap in clinical features gives us pause and prompt us to seek a more "objective" measure for the diagnosis. In this case, BMBx.