10/10/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Kirtan (@KirtanPatolia)* ***Case Discussants****: Jeffrey (@jeffreyshen)*

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

Scribing (Valentina):

CC: 89-year-old gentleman with **generalized weakness** and **slurred speech** for 1 week

HPI: Outside hospital work up with:

- CT head normal
- CBC normal
- Ca: **14** mg/dL
- Cr: **3** mg/dL
- eGFR: **20** mL/min/1.73m2

He received **fluids with improvements in his symptoms** and was transferred to our hospital for further care.

PMH:
Non-metastatic prostate cancer, treated with radiation 5 years ago, currently in remission

HFpEF

Meds: Carvedilol

Fam Hx: —

Social Hx: —

Health-Related Behaviors: no smoking, no alcohol

Allergies: —

Vitals: normal
Exam: CV: nl **Pulm**: nl **Abd**: nl
Neuro: Alert and oriented to person, place and time, no slurring noted. Motor exam normal, sensory exam normal, gait normal
MSK: B/l leg swelling to the mid shins, skin normal, joint normal

Notable Labs & Imaging:

Hematology: CBC: initially nl -> WBC: nl Hgb: 10g/dL Plt: nl MCV: 90 fL
Chemistry: Ca: previously 14 ; now 11
BUN: 90 Cr: previously 3; now 3 GFR: 20 **UA**: normal
AST: 108 ALT: 46 ALP: 214 T. Bili: normal T. protein: 6.3 Alb: 3.6 ;
CK: normal LDH: 400; Peripheral smear: normal; haptoglobin: normal;
Coombs: negative
Iron studies: Ferritin: 700 ng/mL Transferrin saturation: 26%
B12: normal Folate: normal
PTH, PTHrp, 1-25 Vit.D: normal
HIV, Hepatitis, Syphilis, TSH: normal

IgG 1100 (normal); IgA 500; IgM 900 (upper limit of normal: 230)
Serum protein electrophoresis M spike
Immunofixation electrophoresis IgM k spike 0.3 g/dL
k/l kappa 60/lambda 12; ratio=5
Flow cytometry: CD5 negative and CD10 negative monoclonal B cells.
Marginal-zone or Lymphoplasmacytic lymphoma

Imaging:
US: of the liver with doppler normal
CT head (initial) normal
CT chest clear, cyrrhotic morphology with multiple low attenuation foci, mild splenomegaly
MRI abdomen: multiple enhancing lesions in liver and spleen. Skeletal lesions
MRI and CT spine: numerous skull and lytic spinal lesions
PET: Diffuse Lymphadenopathy, skeletal lesions, hepatic and splenic lesions

Final Dx: DLBCL

Problem Representation: 89 male, with 1 week of weakness and slurred speech responsive to fluids, hypercalcemia, acute kidney injury and normocytic anemia, found with M-spike, lytic bone lesions, hepatosplenomegaly

Teaching Points (Krithika)

***AMS→ Neurological vs External (metabolic,toxic,etc)**
***Hypercalcemia→PTH vs non PTH mediated, PTHrp**
***DDx-Weakness secondary to hypercalcemia(resolved with reduction of calcium levels), Muscle etiology(? CPK), RBC-hemolysis (raised liver enzymes, calcium), exogenous calcium intake, paraneoplastic- PTHrp, Vit D overproduction from granulomatous disease, Multiple myeloma(?SPEP,Serum and urine Immunofixation, Mets from prostate CA, other malignancy**
***Waldenstrom macroglobulinemia, MGUS, Marginal cell lymphoma(plasmacytic variant), IgM MM**
***Waldenstrom Macroglobulinemia-lymphoplasmacytic lymphoma, presents often with hyperviscosity symptoms,has high M spike normally, rare to cause extensive lytic lesions**
***Myeloma- M spike>3g, almost never causes hepato, splenomegaly, unless complicated by amyloidosis- deposits called Amyloidoma- in lymph nodes, spleen, liver, soft tissues**
***Marginal zone lymphoma- very common to cause diffuse nodular lytic bony mets,can involve liver and spleen, classic CD5, CD10 negative cell population, but normally a low grade lymphoma-less aggressive**
***Myc + ⟶ high grade lymphomas- DLBCL or Burkitts**