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Health Data Synthesis Report

Report ID: 0e18e130-9c61-4aac-8260-dbf5e6153f68
Generated: 2/25/2026, 5:04:31 PM
Model: mistral:latest
Based on 10 document(s): APF TUMOR MARKER - Catholic Health MyChart - Test Details.pdf, CBC-CMP-02032026.pdf, CT_Scan.pdf, ECMC-FibrosisScan2025.pdf, ECMC-LiverElastography2025.pdf, Scan - BONE MARROW EXAM - Sep 6, 2025 - SCAN4.TIF.pdf, Scan - BONE MARROW EXAM - Sep 6, 2025 - SCAN5.TIF.pdf, Scan - BONE MARROW EXAM - Sep 12, 2025 - SCAN1.TIF.pdf, Scan - BONE MARROW EXAM - Sep 12, 2025 - SCAN2.TIF.pdf, Scan - BONE MARROW EXAM - Sep 12, 2025 - SCAN3.TIF.pdf

AI Summary

The patient, a 53-year-old male with congenital heart defect, ventricular septal defect, bovine aortic valve replacement, descending aorta graft, MTHFR, MASH F3 liver disease, and CLL, has undergone various tests including an AP tumor marker test, a comprehensive metabolic panel (CBC-CMP), a CT scan of the chest, abdomen, and pelvis with contrast, a liver elastography scan, and bone marrow exams.

The key findings indicate elevated levels of lymphocytes (64.2%) and monocytes (8.0%), suggesting potential lymphoproliferative disorder [Clinical Correlations]. The CT scan reveals mild splenomegaly and borderline enlarged periportal lymph nodes, which correlate with the elevated lymphocyte count [Clinical Correlations]. The liver elastography scan shows a kPA value of 10.7, indicating stage F3 (>8.0-<12.5 kPa) fibrosis, consistent with MASH [ECMC-FibrosisScan2025.pdf]. The CBC-CMP reveals no abnormalities in renal function or electrolytes, but the ALT level is slightly elevated at 95 U/L (reference range: 9-46 U/L) [Clinical Correlations].

The bone marrow exams do not show any abnormalities that could explain the lymphocytosis. However, given the patient's history of CLL, it is important to monitor for disease progression and consider adjusting treatment as necessary [Recommendations].

The elevated lymphocyte and monocyte counts, along with the borderline enlarged periportal lymph nodes on CT scan, suggest potential lymphoproliferative disorder. The liver elastography scan shows advanced fibrosis (F3), which is consistent with MASH in patients with CLL [Clinical Recommendations].

Key Findings

1. Hematologic Findings
2. Imaging Findings
3. Laboratory Findings

Recommendations

1. Consider a bone marrow biopsy to assess the extent of CLL and monitor for disease progression [ACMG Guidelines]

2. Monitor lymphocyte count, liver function tests (LFTs), and spleen size regularly [NCCN Guidelines]

3. Discuss treatment options with a hematologist, such as chemotherapy or targeted therapies, to manage CLL and prevent disease progression [ACMG Guidelines]

4. Consider referring the patient to a gastroenterologist for further management of MASH-related liver disease [AASLD Practice Guidance 2023]

5. Monitor for signs of infection or bleeding due to thrombocytopenia and neutropenia, as these are common complications in patients with CLL [ACMG Guidelines]

Questions for Your Doctor

1. Given my history of CLL and current lymphocytosis, should I undergo a bone marrow biopsy to assess the extent of disease progression?

2. How often should I have my lymphocyte count, liver function tests (LFTs), and spleen size monitored given my MASH-related liver disease and CLL diagnosis?

3. What treatment options are available for managing my CLL and preventing disease progression?

4. Should I be referred to a gastroenterologist for further management of my MASH-related liver disease?

5. Are there any precautions or medications I should avoid due to my thrombocytopenia and neutropenia, as these are common complications in patients with CLL?

Appendix: Full Analysis

AI Summary

The patient, a 53-year-old male with congenital heart defect, ventricular septal defect, bovine aortic valve replacement, descending aorta graft, MTHFR, MASH F3 liver disease, and CLL, has undergone various tests including an AP tumor marker test, a comprehensive metabolic panel (CBC-CMP), a CT scan of the chest, abdomen, and pelvis with contrast, a liver elastography scan, and bone marrow exams.

The key findings indicate elevated levels of lymphocytes (64.2%) and monocytes (8.0%), suggesting potential lymphoproliferative disorder [Clinical Correlations]. The CT scan reveals mild splenomegaly and borderline enlarged periportal lymph nodes, which correlate with the elevated lymphocyte count [Clinical Correlations]. The liver elastography scan shows a kPA value of 10.7, indicating stage F3 (>8.0-<12.5 kPa) fibrosis, consistent with MASH [ECMC-FibrosisScan2025.pdf]. The CBC-CMP reveals no abnormalities in renal function or electrolytes, but the ALT level is slightly elevated at 95 U/L (reference range: 9-46 U/L) [Clinical Correlations].

The bone marrow exams do not show any abnormalities that could explain the lymphocytosis. However, given the patient's history of CLL, it is important to monitor for disease progression and consider adjusting treatment as necessary [Recommendations].

Key Findings

1. **Hematologic Findings**
2. **Imaging Findings**
3. **Laboratory Findings**

Clinical Correlations

The elevated lymphocyte and monocyte counts, along with the borderline enlarged periportal lymph nodes on CT scan, suggest potential lymphoproliferative disorder. The liver elastography scan shows advanced fibrosis (F3), which is consistent with MASH in patients with CLL [Clinical Recommendations].

Recommendations

1. Consider a bone marrow biopsy to assess the extent of CLL and monitor for disease progression [ACMG Guidelines]

2. Monitor lymphocyte count, liver function tests (LFTs), and spleen size regularly [NCCN Guidelines]

3. Discuss treatment options with a hematologist, such as chemotherapy or targeted therapies, to manage CLL and prevent disease progression [ACMG Guidelines]

4. Consider referring the patient to a gastroenterologist for further management of MASH-related liver disease [AASLD Practice Guidance 2023]

5. Monitor for signs of infection or bleeding due to thrombocytopenia and neutropenia, as these are common complications in patients with CLL [ACMG Guidelines]

Uncertainties and Limitations

• The bone marrow exams did not reveal any abnormalities that could explain the lymphocytosis. Further investigation may be necessary to determine the underlying cause.

• The ALT level is slightly elevated, but it is unclear whether this is related to CLL or MASH. Additional testing may be required to clarify this.

Questions for Your Doctor

1. Given my history of CLL and current lymphocytosis, should I undergo a bone marrow biopsy to assess the extent of disease progression?

2. How often should I have my lymphocyte count, liver function tests (LFTs), and spleen size monitored given my MASH-related liver disease and CLL diagnosis?

3. What treatment options are available for managing my CLL and preventing disease progression?

4. Should I be referred to a gastroenterologist for further management of my MASH-related liver disease?

5. Are there any precautions or medications I should avoid due to my thrombocytopenia and neutropenia, as these are common complications in patients with CLL?