**Patient**: R.K. (DOB 1957-02-21)  
**MRN**: 512678  
**Admission**: 2024-03-08 | **Discharge**: 2024-03-13  
**Physicians**: Dr. K. Sharma (Hematology/Oncology), Dr. M. Collins (Nephrology)

**DISCHARGE DIAGNOSIS**

Hypercalcemia Secondary to Relapsed Diffuse Large B-Cell Lymphoma

**ONCOLOGICAL DIAGNOSIS**

* **Primary**: Diffuse Large B-Cell Lymphoma (DLBCL), NOS, GCB subtype, relapsed disease
* **Initial Diagnosis**: March 2022
* **Relapse**: March 2024 (current admission)

**Initial Diagnosis Details**:

* Right cervical lymph node biopsy showed diffuse infiltration by large, atypical lymphoid cells
* IHC: CD20+, CD10+, BCL6+, PAX5+, MUM1-, BCL2+ (~60%), Ki-67 ~85%
* FISH: Negative for MYC, BCL2, and BCL6 rearrangements
* PET/CT (March 2022): Multiple FDG-avid lymph nodes above/below diaphragm (SUVmax 22.8), largest right cervical conglomerate measuring 6.2 x 4.8 cm; moderate diffuse FDG uptake within spleen (SUVmax 7.8)
* Bone Marrow: Negative for lymphoma
* Ann Arbor Stage: IIIB (B symptoms included weight loss)
* IPI Score: 2 (Low-Intermediate Risk) based on: Age > 60 (1 point), Stage III (1 point), normal LDH (0 points), ECOG PS 1 (0 points), Extranodal Sites = 0

**Current Relapse**:

* Presenting symptoms: 2-week history of progressive fatigue, confusion, constipation, decreased appetite, polydipsia, and bone pain; weight loss of approximately 5kg over 2 months
* CT-guided biopsy of retroperitoneal mass confirmed relapsed DLBCL, GCB subtype
* IHC: CD20+, CD10+, BCL6+, MUM1-, BCL2+ (~75%), Ki-67 ~90%
* Molecular profile pending at discharge
* PET-CT: 7.3 × 5.1 cm retroperitoneal mass with SUVmax 25.3, mediastinal lymphadenopathy, liver lesions; new hypermetabolic foci in L3 and right iliac bone consistent with osseous involvement

**CURRENT TREATMENT**

**Hypercalcemia Management**:

* IV hydration with normal saline (150 mL/hr)
* Calcitonin 4 IU/kg SC q12h for 4 doses (March 8-10)
* Zoledronic acid 4 mg IV (March 9)
* Prednisone 100 mg PO daily (5 days, started March 9)

**Planned Salvage Therapy**:

* R-DHAP regimen (rituximab, dexamethasone, high-dose cytarabine, cisplatin)
* First cycle to begin March 18, 2024
* Goal: Cytoreduction followed by evaluation for autologous stem cell transplantation

**TREATMENT HISTORY**

**First-Line Therapy**:

* R-CHOP regimen (6 cycles, March-August 2022)
* Achieved complete remission (PET/CT September 2022)
* Disease-free interval: 18 months

**COMORBIDITIES**

* Hypertension (on lisinopril)
* Prostate Cancer (Gleason 3+3=6, diagnosed 2020, active surveillance)
* Benign Prostatic Hyperplasia
* No known allergies

**HOSPITAL COURSE**

67-year-old male with history of DLBCL in remission for 18 months presented with progressive fatigue, confusion, constipation, decreased appetite, polydipsia, and bone pain for 2 weeks. On admission, patient was oriented to person only, confused about time and place, with unsteady gait requiring assistance. Labs showed severe hypercalcemia (corrected Ca 14.2 mg/dL), mild renal dysfunction (Cr 1.2 mg/dL), and elevated LDH (360 U/L).

PET-CT revealed retroperitoneal mass, mediastinal lymphadenopathy, and liver lesions. Physical examination was notable for mild abdominal distension with RUQ tenderness, palpable liver 2cm below costal margin, and tenderness over lumbar spine and bilateral iliac crests, consistent with imaging findings of osseous metastases.

Treatment focused on hypercalcemia management with aggressive hydration, calcitonin, zoledronic acid, and prednisone. Mental status improved within 24 hours as calcium decreased, with full resolution of confusion by March 10. Calcium normalized to 9.4 mg/dL by discharge with corresponding symptom improvement. Calcium levels were monitored every 6 hours initially, then every 12 hours after stable improvement.

Nephrology consultation guided fluid management and renal protection, with particular attention to maintaining urine output >100 mL/hour during initial hypercalcemia management. Pain initially managed with opioids (morphine 2mg IV q4h PRN), later transitioned to acetaminophen as hypercalcemia resolved and bone pain improved.

Multidisciplinary tumor board on March 12 recommended R-DHAP salvage followed by consideration for autologous stem cell transplantation, based on relatively long disease-free interval, good pre-relapse performance status, and absence of high-risk features.

Nutritional assessment showed mild malnutrition, which improved with dietary interventions. Physical therapy implemented a progressive mobility program. By discharge, patient was fully alert and oriented with normal calcium levels, adequate pain control, and improved mobility (ambulating with minimal assistance).

**DISCHARGE MEDICATIONS**

* Pantoprazole 20 mg PO daily
* Allopurinol 300 mg PO daily
* Acyclovir 400 mg PO BID
* TMP-SMX 960 mg PO Monday/Wednesday/Friday
* Lisinopril 10 mg PO daily
* Tamsulosin 0.4 mg PO at bedtime
* Acetaminophen 650 mg PO QID PRN pain

**FOLLOW-UP PLAN**

**Oncology**:

* Dr. K. Sharma on March 15, 2024 (pre-chemotherapy evaluation)
* First cycle of R-DHAP planned for March 18, 2024

**Procedures**:

* Central venous access device placement scheduled for March 16, 2024

**Other Follow-up**:

* Urology for prostate cancer surveillance in 3 months (unchanged)

**Patient Education**:

* Temperature monitoring twice daily; report fever >38.0°C
* Daily weight measurement
* Hydration goal: 2-3 liters daily
* Signs requiring urgent attention: fever, unusual bleeding, confusion, persistent vomiting, decreased urination

**KEY LAB VALUES**

|  |  |  |  |
| --- | --- | --- | --- |
| **Parameter** | **Admission** | **Discharge** | **Reference** |
| Ca (total) | 13.8 | 9.1 | 8.6-10.3 mg/dL |
| Ca (corrected) | 14.2 | 9.4 | 8.6-10.3 mg/dL |
| Creatinine | 1.2 | 1.0 | 0.7-1.3 mg/dL |
| BUN | 30 | 18 | 7-20 mg/dL |
| WBC | 7.8 | 8.3 | 4.0-11.0 x10^9/L |
| Hemoglobin | 11.2 | 11.5 | 13.5-17.5 g/dL |
| Platelets | 198 | 215 | 150-400 x10^9/L |
| LDH | 360 | 340 | 135-225 U/L |
| PSA | 3.6 | - | <4.0 ng/mL |
| Albumin | 3.4 | 3.5 | 3.5-5.0 g/dL |

**Electronically Signed**:  
Dr. K. Sharma (Hematology/Oncology)  
Dr. M. Collins (Nephrology)  
Date: 2024-03-13