**Patient**: Terence Fletcher (DOB 1950-04-22)  
**MRN**: 891275  
**Admission**: 2025-04-01 | **Discharge**: 2025-04-08  
**Physicians**: Dr. M. Johnson (Hematology/Oncology), Dr. A. Williams (Hematology), Dr. T. Garcia (Nephrology)

**Discharge diagnosis: AIHA secondary to CLL**

**1. Oncological Diagnosis**

* **Primary**: CLL (Diagnosed November 2023)
* **Immunophenotype**: CD5+, CD19+, CD20+(dim), CD23+, CD200+, sIgM/IgD+(dim), kappa restricted
* **Molecular**: IGHV unmutated (favourable), del(13q14) in 60% of cells, no del(17p)/TP53 mutation
* **Risk**: CLL-IPI High Risk (6 points), Binet Stage B
* **Prior Treatment**: Acalabrutinib 100 mg PO BID (started January 2024)
  + Good partial response: WBC decreased from 68.5 × 10^9/L to 22.6 × 10^9/L
  + No prior significant toxicities until current AIHA

**2. Current Presentation (AIHA)**

* **Presenting Features**: Profound fatigue, dizziness, jaundice for 5 days
* **Diagnostic Labs**:
  + Hgb 6.2 g/dL
  + Elevated indirect bilirubin (4.8 mg/dL)
  + Elevated LDH (845 U/L)
  + Decreased haptoglobin (<10 mg/dL)
  + Positive DAT (IgG)
  + Reticulocytes 12.5%

**3. Treatment for AIHA**

* Prednisone 1 mg/kg/day (80 mg daily) started 4/1/2025
* Rituximab 375 mg/m² IV (700 mg) administered 4/3/2025
* 2 units extended phenotype-matched pRBCs on 4/1/2025
* Folic acid 1 mg PO daily
* Acalabrutinib continued to prevent CLL flare-up

**Response to Treatment**

* Hemolysis stabilized by hospital day 4
* Hemoglobin increased from 6.2 to 8.5 g/dL
* Decreased bilirubin from 4.8 to 2.6 mg/dL
* Decreased reticulocyte count from 12.5% to 8.2%
* Improved symptoms: resolution of dizziness, decreased fatigue

**4. Relevant Comorbidities**

* Malignant Melanoma (2016, no recurrence)
* CABG (2-vessel, 2017) for CAD
* CKD stage G2 (eGFR 72 mL/min/1.73m²)
* Hypothyroidism (post-RAI for Graves' disease, 2008)
* Allergies: Penicillin (anaphylaxis), Sulfa drugs (rash), Latex (contact dermatitis)

**5. Discharge Medications**

**New**:

* Prednisone 80 mg PO daily × 7 days, then taper by 10 mg every 7 days
* Folic acid 1 mg PO daily
* Valacyclovir 500mg PO BID (due to rituximab)
* Atovaquone 1500 mg PO daily (while on steroids)
* Calcium carbonate 600 mg + Vitamin D 400 IU PO BID
* Famotidine 20 mg PO (10h before or 2h after Acalabrutinib)

**Continued**:

* Acalabrutinib 100 mg PO BID
* Levothyroxine 88 mcg PO daily
* Metoprolol succinate 50 mg PO daily
* Atorvastatin 40 mg PO daily
* Aspirin 81 mg PO daily
* Acetaminophen 650 mg PO Q6H PRN

**Stopped**:

* Pantoprazole (due to interaction with Acalabrutinib)

**6. Follow-up**

* Dr. M. Johnson in 1 week (4/15/2025)
* Weekly CBC, reticulocyte count, LDH, and bilirubin until AIHA resolves
* Flow cytometry to assess CLL disease burden in 2 weeks
* Continue weekly rituximab (375 mg/m²) for a total of 4 doses (next: 4/10/2025)
* Monitor blood glucose 3× daily while on high-dose steroids

**Patient Education Provided**

* Bleeding risk (Acalabrutinib + Aspirin + Prednisone): Report unusual bruising, black/bloody stool
* Infection risk (CLL/treatments): Report fever >100.4°F, chills, new cough
* Worsening anemia: Report increased fatigue, dizziness, shortness of breath

**7. Lab Values (Admission → Discharge)**

* Hemoglobin: 6.2 → 8.5 g/dL
* Hematocrit: 18.5 → 25.3%
* WBC: 22.6 → 25.8 × 10^9/L
* ALC: 19.2 → 21.2 × 10^9/L
* Platelets: 110 → 125 × 10^9/L
* Reticulocytes: 12.5 → 8.2%
* LDH: 845 → 480 U/L
* Total Bilirubin: 4.8 → 2.6 mg/dL
* Haptoglobin: <10 → 22 mg/dL
* DAT: Positive (IgG) → Positive (IgG)

**Electronically Signed By**:  
Dr. M. Johnson (Hematology/Oncology) - 2025-04-08 15:30  
Dr. A. Williams (Hematology) - 2025-04-08 14:20  
Dr. T. Garcia (Nephrology) - 2025-04-08 13:45