**Patient**: Raymond Mitchell (DOB 1955-11-13)  
**MRN**: 629384  
**Admission**: 2025-03-15 | **Discharge**: 2025-03-22  
**Physicians**: Dr. A. Sharma (Hematology/Oncology), Dr. L. Washington (Gastroenterology), Dr. C. Rodriguez (Neurology)

**Discharge diagnosis: PMF with Wernicke encephalopathy under Fedratinib**

**1. Hematological Diagnosis**

* **Primary**: PMF (Diagnosed 2023-08-15)
* **Current Status**: DIPSS-Plus high risk
* **Bone Marrow** (2023-08-12): Hypercellular (80%), marked megakaryocytic proliferation and atypia, grade 3 reticulin fibrosis, collagen fibrosis, increased osteosclerosis
* **Molecular**: JAK2 V617F+ (VAF 42%), CALR-, MPL-, additional mutations: ASXL1, EZH2
* **Cytogenetics**: 46,XY,del(13)(q12q22)[15]/46,XY[5]
* **Risk Stratification**:
  + DIPSS: 5 points (High risk)
  + DIPSS-Plus: 5 points (High risk)
* **Clinical Manifestations**: Anemia requiring transfusions, thrombocytopenia, leukocytosis, marked splenomegaly (22 cm), night sweats, weight loss, fatigue

**2. Current Admission**

* **Presentation**: Nausea, vomiting, diarrhea for 5 days; progressive confusion
* **Diagnosis**: Thiamine deficiency (level 45 nmol/L) with Wernicke-like encephalopathy
* **Cause**: Fedratinib-induced; missed follow-up of low thiamine level 3 weeks prior (system error)
* **Treatment**:
  + IV thiamine (500 mg TID × 3 days, then 250 mg daily × 5 days)
  + Fedratinib discontinued, start of Momelotinib
  + IV fluid resuscitation
  + Symptom management: ondansetron, famotidine, loperamide
* **Response**: Mental status returned to baseline by day 5

**3. Prior Treatment**

* **Ruxolitinib** (2023-09-15 to 2024-10-20):
  + Multiple dose reductions due to thrombocytopenia
  + Minimal response (~10% spleen reduction)
  + Discontinued due to progressive disease
* **Fedratinib** (2024-11-10 to 2025-03-14):
  + 800 mg PO daily
  + Good response: 30% spleen reduction, improved symptoms, hematologic improvement
  + Discontinued due to current complication

**4. Comorbidities**

* Hypertension
* Type 2 diabetes (HbA1c 6.8%)
* CAD (NSTEMI 2018)
* Dyslipidemia
* CKD
* Gout
* BPH

**5. Discharge Medications**

* Momelotinib 200 mg PO daily (started on discharge)
* Thiamine 100 mg PO TID
* Ondansetron 8 mg PO q8h PRN
* Loperamide 2 mg PO after each loose stool (max 16 mg/day)
* Famotidine 20 mg PO BID
* Amlodipine 5 mg PO daily
* Lisinopril 10 mg PO daily
* Atorvastatin 40 mg PO daily
* Aspirin 81 mg PO daily
* Allopurinol 100 mg PO daily
* Tamsulosin 0.4 mg PO daily at bedtime
* Acetaminophen 650 mg PO q6h PRN

**6. Follow-up Plan**

* **Hematology/Oncology**: Dr. A. Sharma in 1 week (3/29/25)
  + Weekly visits for first month, then biweekly × 2 months, then monthly
  + CBC weekly × 4 weeks, then biweekly × 8 weeks, then monthly
  + CMP, LDH, uric acid weekly × 4 weeks, then monthly
  + Thiamine level weekly × 4 weeks, then monthly
* **Spleen Monitoring**: Abdominal ultrasound in 3 months
* **Neurology**: Dr. C. Rodriguez in 2 weeks (4/5/25)
* **Gastroenterology**: Dr. L. Washington in 1 month (4/22/25)
* **Transplant Evaluation**: Appointment scheduled for 4/10/25

**Patient Education**

* Momelotinib administration and side effects
* Importance of thiamine supplementation
* Reporting neurological symptoms immediately
* Signs of disease progression

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

* WBC: 12.6 → 11.8 ×10^9/L
* Hemoglobin: 10.0 → 9.8 g/dL
* Platelets: 98 → 105 ×10^9/L
* Creatinine: 1.8 → 1.3 mg/dL
* eGFR: 38 → 56 mL/min/1.73m²
* LDH: 386 → 370 U/L
* Thiamine: 45 → 120 nmol/L
* CRP: 2.2 → 0.8 mg/dL

**Electronically Signed By**:  
Dr. A. Sharma (Hematology/Oncology) - 2025-03-22 14:45  
Dr. L. Washington (Gastroenterology) - 2025-03-22 13:30  
Dr. C. Rodriguez (Neurology) - 2025-03-22 12:15