Patient #012

Chief Complaints: This 89 year old white female presented for evaluation of weight loss, abdominal distention and fatigue.

History of Present Illness: She had been in her usual state of health until approximately six months prior to evaluation, when she began to notice increasing abdominal distention. She had no change in her bowel habits and no abdominal discomfort. About one month prior to evaluation, she began to note nausea upon eating, such that she was able to eat only about half of what she normally did. There was a vague, diffuse abdominal discomfort at this time and she noted a decrease in weight of approximately 20 pounds over the ensuing month. In the two weeks immediately prior to her presentation, she began to notice swelling of her distal lower extremities, bilaterally. She denied fevers and chills, night sweats, jaundice, frequent bleeding or bruising, cough, hematochezia or melena, hematemesis, breast abnormalities, vaginal bleeding, or a history of alcohol abuse or smoking. She had been seen in the Endocrinology clinic one week prior to admission and noted to have a TSH of 7.18 uU/ml and a free T4 of 1.0 ug/dl. The importance of taking her Synthroid was re-emphasized at that time.

Past Medical History: Her medical history was notable for hypothyroidism with a chronic goiter and a 5.0 cm thyroid mass which had been stable for many years. It was not known whether diagnostic workup for the mass had been undertaken. Peptic ulcer disease, status-post Billroth II surgery 15 years earlier. Anemia, with diagnostic workup, if any, unavailable at the time of admission. Lactose intolerance.

Medications: Medications included cimetidine and Synthroid, the latter at a dose of 0.075 mg qd.

Family/Social History: Family and social histories were non-contributory except as already described.

Physical Examination: A physical exam revealed a cachectic woman in no acute distress. Her temperature was 98.6^{o} F (37^{o}C), her pulse 68 and regular, her respiratory rate

14 and her blood pressure 127/81. The weight was 127 pounds. Her skin was not jaundiced. There was no palpable lymphadenopathy. HEENT examination was unremarkable. The thyroid was diffusely enlarged and non-tender; a mass was noted in the right lower aspect. There was no jugular venous distention. Lungs were clear to auscultation. The cardiac exam was unremarkable except for a I/VI systolic ejection murmur appreciated best at the left lower sternal border. The breasts were atrophic; a 2 cm firm nodule in the left lower quadrant of the left breast was noted. The abdomen was distended but was not tender. Both shifting dullness and a fluid wave were noted. Bowel sounds were normal. The marked distention made determination of hepatic or splenic enlargement difficult. Rectal exam revealed no masses and guaiac-negative stool. There was 3+ pitting edema of the lower extremities bilaterally. No focal neurologic deficits were noted.

Laboratory Data:

			Normal
CBC	Hct	45.2%	*37-47%*
	Hgb	14.9	*12.0-16.0 g/dl*
	MCV	74	*80-100 fl*
	WBC	7.1	*4-10 X $10^{9/L}$*
	platelet count	173	*200-400 X 10^{9}/L*

			Normal
Chemistries	sodium	141	*136-146 mmol/l*
	potassium	3.2	*3.5-5.0 mmol/l*
	chloride	91	*99-111 mmol/l*
	CO2	31	*24-34 mmol/l*
	creatinine	0.7	*0.6-1.0 mg/dl*
	BUN	10	*8-20 mg/dl*
	glucose	78	*73-115 mg/dl*
	calcium	9.5	*8.6-10.2 mg/dl*
	phosphorus	3.0	*2.5-4.9 mg/dl*
	protein, total	7.1	*6.0-8.3 g/dl*
	albumin	3.9	*3.5-4.9 g/dl*
	bilirubin, total	1.1	*.1-1.1 mg/dl*
	AST (SGOT)	51	*2-35 U/L*
	ALT (SGPT)	26	*0-45 U/L*
	LDH	277	*60-200 U/L*
	ALP	187	*30-130 U/L*
	Serum iron	35	*33-150 ug/dl*

Urinalysis: Unremarkable; specific gravity 1.020

Chest X-ray : Small pleural effusions bilaterally and a calcified nodule which had been seen on earlier films.

Paracentesis: Albumin 1.1 g/dl, LDH 95 U/L, RBC 33 X 10^{12}/L, WBC 32/mm^3 (mm^3=uL) (81% histiocytes), negative cytology.