Patient #113

Chief Complaints: This 50 year old man was referred for evaluation of splenomegaly and thrombocytopenia.

History of Present Illness: Two years prior to referral this 50 year old man underwent a medical evaluation for a change in his insurance status, and was found to have splenomegaly and thrombocytopenia. He had an evaluation that included normal B-12 and folate levels. A bone marrow aspirate showed erythroid hyperplasia and a few ring sideroblasts. The abdominal CAT scan showed cholelithiasis and splenomegaly. A hemoglobin electrophoresis showed elevated levels of fetal hemoglobin. Further laboratory testing revealed an elevated reticulocyte count and abnormal liver function tests.

In the year leading up to his referral, the patient noted fatigue and decreasing exercise tolerance. He complained of dyspnea on exertion. He denied blood loss and past hematologic problems but did admit to easy bruising. He denied alcohol abuse.

Past Medical History: The patient had had adult onset diabetes for several years and was taking glyburide 2.5 mg/day. He had a hiatal hernia and was on ranitidine 150 mg twice per day. He was also taking folic acid. He was on Lasix 40 mg/day for unspecified reasons.

The past history was also notable for distant kidney stone removal, tonsillectomy, and left inguinal herniorrhaphy.

Social History: He worked as a heavy equipment operator. He denied alcohol use, smoking and intravenous drug use.

Family History: His sister died of pancreatic cancer. His mother had congestive heart failure and a "honeycomb lung".

Review of Systems: He noted a non-productive cough. He also mentioned arthritis and an enlarged heart. He had had some suprapubic pain as well as epigastric pain and occasionally a sour taste in his mouth.

Physical Examination: His temperature was 98.5^{o} F (35.9^{o} C), pulse 95, and blood pressure 147/81. He weighed 95.6 kg. He had multiple spider angiomata on his chest. There were

ecchymoses on the distal extremities. The pupils were equal, there was no icterus. The fundi were normal. The oral pharynx was normal. Tympanic membranes were normal. There was no adenopathy. There was no thyromegaly. The lungs were clear. The heart sounds were normal with no murmurs or gallops. The abdomen was soft and non-tender. The liver had a span of 15 cm. The spleen tip was easily palpable two finger breadths below the costal margin. There was no evidence of ascites. He had external hemorrhoids. The genitalia were normal. There was 1+ peripheral edema. The neurologic exam was normal.

Laboratory:

			Normal
CBC	Hct	27	*40-54 %*
	Hgb	12.6	*13.4-17.4g/dl.*
	MCV	113	*81-97 fl*
	RDW	16.3	*12-15 %*
	WBC	3.5	*4-12 X $10^{9/L}$*
	Neut	43%	*40-70 %*
	lymph's	43%	*20-50 %*
	mono	9%	*2-10 %*
	platelet count	73	*150-440 X 10^{9}/L*
Chemistries	bilirubin, total	2.7	*0-1.2 mg/dl*
	bilirubin, direct	.5	*0-0.2 mg/dl*
	AST (SGOT)	92	*11-40 U/L*
	ALT (SGPT)	103	*10-52 U/L*
	ALP	115	*39-117 U/L*
	GGT	255	*10-46 U/L*
	PT	normal	*10-13 sec.*
	APTT	normal	*21.5-31.9 sec.*

		Normal
Serum iron	227	*35-165 ug/dl*
TIBC	338	*320-550 ug/dl*
percent saturation	67	*20-45%*
ferritin	>1000	*30-284 ug/L*
Vitamin B-12	538	*>200 pg/ml*
folate	9.2	*>2.5 ng/ml*
alpha fetoprotein	normal	
HBsAb	positive	
HBsAg	negative	