Patient #161

Chief Complaint: This 43 year old black male presented with abdominal pain and dark urine for 7 months.

History of Present Illness: He was in his usual state of health until 7 months prior to admission, when he developed abdominal pain. The pain was mostly dull and aching, but was occasionally sharp and stabbing. It was located in the midepigastrium, and radiated to the back and right upper quadrant. Episodes of the pain would last 2-3 days. Food intake would not change the pain. The patient was made worse by lying down, and was sometimes relieved by sitting up. During episodes of the pain, the patient often noticed that his urine was reddish-brown in color. Three months before admission, he developed a non-tender, non-pruritic rash on his hands. He also noted darkening of his face. He denied fever, chills, nausea, vomiting, constipation, or diarrhea. He had difficulty concentrating at times, but denied any behavioral changes.

Past Medical History: Syphilis 1 year prior to admission, treated with penicillin.

Medications/Allergies: none.

Social History: He is a heavy cigarette smoker and alcohol drinker. He has used intravenous drugs for the past 5 years.

Physical Examination: Well developed, thin black male in no acute distress. BP 130/70; pulse 80; respirations 16; temperature 98.4^{o}F (36.9^{o}C).

The skin showed increased facial pigmentation, and hyperpigmented, non-tender, macular and vesicular lesions over the dorsum of both hands. The head was normocephalic and atraumatic. The conjunctivae were pink. The sclerae were anicteric. The pupils were equal, round, and reactive to light and accommodation. The oropharynx was benign. The neck was supple. There was no lymphadenopathy. The lungs were clear. The heart showed normal sounds, without gallops or murmurs. The abdomen was soft, with normoactive bowel sounds. There was no tenderness, hepatosplenomegaly, or masses. Rectal examination showed no masses; the stool was guaiac negative. The extremities showed no cyanosis, clubbing, or edema. Neurologic examination was unremarkable.

Laboratory Data:

			Normal
CBC	Hgb	15.1	*14.0-18.0g/dl.*
	Hct	46.6	*42-52%*
	WBC	4.6	*4.8-10.8 X $10^{9/L}$*
	differential	normal	
	platelet count	280	*150-400 X 10^{9}/l*
Chemistries	sodium	138	*135-149 mmol/l*
	potassium	4.2	*3.5-5.3 mmol/l*
	chloride	97	*98-108 mmol/l*
	CO2	24	*24-32 mmol/l*
	BUN	8	*6-20 mg/dl*
	creatinine	0.8	*0.5-1.5 mg/dl*
	glucose	94	*70-110 mg/dl*
	bilirubin, total	0.8	*0-1.2 mg/dl*
	AST (SGOT)	58	*0-50 U/L*
	ALT (SGPT)	59	*0-70 U/L*
	ALP	106	*40-125 U/L*
	amylase	110	*23-85 U/L*
	Serum iron	190	*50-150 ug/dl*
	TIBC	291	*225-419 ug/dl*
	ferritin	762	*36-255 ng/ml*

Urinalysis: trace protein; microscopic examination was normal.

Chest and Abdominal X-rays: unremarkable