Patient #291

Chief Complaint: This 61 year old white male presented with weight loss and fatigue.

History of Present Illness: The patient was in his usual state of health until 3 months prior to admission, when he experienced weakness and fatigue. He complained of being continually tired, spent most of his days at home, and required daily naps. His appetite decreased, and he lost 25 pounds. He experienced diffuse abdominal fullness, without relation to meals. He also experienced frequent arthralgias, and pain in his lower back. He denied fevers, sweats, or chills.

Past Medical History: He had a history of hypertension. He also had a history of atrial fibrillation. He had bilateral herniorrhaphies 20 years prior to admission.

Medications: Hydrochlorothiazide, Digoxin, Motrin.

Allergies: none known.

Family History: No known familial diseases.

Social History: The patient is Jewish, of Eastern European extraction. He has smoked 1 1/2 packs of cigarettes per day for 40 years. He rarely drinks alcohol.

Physical Examination: Thin white male in no acute distress. BP 130/70; pulse 88, irregularly irregular; respirations 16; temperature 98.6^{o}F (37^{o}C).

The head was normocephalic and atraumatic. The conjunctivae were slightly pale. The sclerae were mildly icteric. The pupils were equal, round, and reactive to light and accommodation. The fundi showed mild arteriolar narrowing, without hemorrhages or exudates. The neck was supple, without jugular venous distention or thyromegaly. There was no lymphadenopathy. The lungs were clear. Cardiac examination revealed a normal apical impulse, and normal heart sounds, without gallops or murmurs. The abdomen was soft, with normoactive bowel sounds. There was mild right upper quadrant tenderness. The liver was 16 cm in the midclavicular line. The spleen tip was palpable. Rectal and genitourinary examinations were normal. The stool was guaiac negative. The extremities showed no cyanosis, clubbing, or edema. Neurologic examination was within normal limits.

Laboratory Data:

Normal

CBC	Hgb	11.8	*14.0-18.0g/dl.*
	Hct	32.7	*42-52%*
	MCV	93	*84-99 fl*
	reticulocyte ct	5.5	*0.5-1.5 %*
	WBC	3.8	*4.8-10.8 X $10^{9/L}$*
	Neut	58	*40-70 %*
	lymph's	35	*25-45 %*
	mono	4	*2-12 %*
	bands	3	*0-10 %*
	platelet count	70	*150-400 X 10^{9}/l*
Chemistries	sodium	138	*135-149 mmol/l*
	potassium	4.0	*3.5-5.3 mmol/l*
	chloride	108	*98-108 mmol/l*
	CO2	26	*24-32 mmol/l*
	BUN	16	*6-20 mg/dl*
	creatinine	1.2	*0.5-1.5 mg/dl*
	glucose	120	*70-110 mg/dl*
	calcium	9.9	*8.6-10.4 mg/dl*
	phosphorus	3.4	*3.0-4.5 mg/dl*
	protein, total	7.7	*6.0-8.0 g/dl*
	albumin	4.3	*3.6-5.0 g/dl*
	bilirubin, total	1.8	*0-1.2 mg/dl*
	bilirubin, direct	0.4	*0-0.4 mg/dl*
	AST (SGOT)	53	*0-50 U/L*
	ALT (SGPT)	21	*0-70 U/L*
	ALP	379	*40-125 U/L*
	Serum iron	63	*50-150 ug/dl*
	TIBC	228	*255-419 ug/dl*

Urinalysis: normal

Chest X-ray : normal heart and lungs.

Serum and urine protein electrophoreses: no monoclonal spikes.

Haptoglobin: 70.3 (nl= 13-163 mg/dl).

Coomb's test : negative.

Radiographs of the lumbar spine, hips, and distal femurs: normal

Liver-spleen scan: markedly enlarged spleen, and heterogeneous uptake in the liver.