Patient #062

Chief Complaints: This patient is a 75 year-old white male who presented for further evaluation of a one-month history of fevers, headaches, weight loss and mental status changes.

History of Present Illness: Three months prior to presentation, he noted fatigue and a decrease in his appetite. One month before presentation, he began to have fevers to 101-102^{o} F (38.5-39^{o} C) associated with chills. The fevers occurred most days. He also noted a diffuse headache, worst in the frontal and occipital areas, that was somewhat dull and sometimes sharp in character and was somewhat relieved by administration of acetaminophen. There were no visual changes or focal numbness or weakness. He did note "muffled" hearing but had no otalgia. He and his family noted intermittent confusion. His weight was noted to decrease from 220 pounds to 195.

He was admitted to the local hospital for further evaluation. His WBC was 1.6x 10^{9}/L there, and a subsequent bone marrow biopsy revealed a slight increase in cellularity with marked hyperplasia of the erythroid line and a relative decrease in the number of granulocytes precursors. No malignant cells were seen. Blood cultures were repeatedly negative. An esophagogastroduodenoscopy demonstrated an esophageal ulcer and an upper GI and barium series showed a hiatal hernia. A barium enema was consistent with diverticular disease. CT of the head, chest and abdomen showed a liver cyst and a hiatus hernia but no other abnormalities. An echocardiogram was essentially normal. An EMG was consistent with polyneuropathy and an indium scan was normal except for mild hepatosplenomegaly. The RBC sedimentation rate was 126. Other laboratory data included: negative ANA, CPK 618, aldolase 3, normal complement levels, negative anti-neutrophil cytoplasmic antibody, TSH 1.85 and negative HIV antibody titers. He was transferred to the tertiary care hospital for further evaluation.

Past Medical History was significant for coronary artery disease and COPD--requiring treatment with theophylline and inhalers.

Medications at the time of admission included theophylline, albuterol and ipratropium bromide metered-dose inhalers, and ranitidine.

Family history was unremarkable. He had visited Australia and the Philippines while in the military decades before, and had traveled to Mexico two months before admission. He had a 40 pack-year smoking history but had stopped smoking 15 years prior to admission.

Physical examination at the time of admission revealed a confused man in no acute distress. Temperature of 101.8º F (38.8º C), pulse 88, respiration's 20, and blood pressure 128/50. The head was normocephalic, atraumatic. Pupils were equal, round and reactive to light. Extraocular movements were intact. His oropharynx was clear without lesions. The neck examination was unremarkable. He had no lymphadenopathy. Lungs were clear to auscultation. Cardiac exam revealed regular rate and rhythm, normal S1 and S2, no S3 or S4, no murmur, gallop or rub. The abdomen had normoactive bowel sounds and was soft, non-tender and non-distended. The extremities were without cyanosis, clubbing or edema. His neurologic exam revealed him to be alert, oriented to person. He knew he was in a hospital, however, he did not know the city. He did not know the date. Motor strength was 5/5 in all extremities. The patient was non-reliable to sensory exam. Cerebellum: He was unable to cooperate with the exam. His gait could not be assessed and the patient required multiple people to assist him with his gait. Reflexes were 2+ throughout. He had Babinski's sign bilaterally.

Laboratory Data:

			Normal
CBC	Hct	31.6	*42-52%*
	WBC	2.3 X 10^9	*4-10 X $10^{9/L}$*
	Neut	87	*50-75 %*
	lymph's	9	*20-50 %*
	mono	2	*3-10 %*
	platelet count	162	*200-400 X 10^9/l*
Chemistries	sodium	125	*136-146 mmol/l*
	potassium	3.9	*3.5-5.0 mmol/l*
	chloride	88	*99-111 mmol/l*
	CO2	23	*24-34 mmol/l*
	creatinine	0.9	*.9-1.3 mg/dl*
	BUN	14	*8-20 mg/dl*
	glucose	121	*73-115 mg/dl*
	calcium	8.7	*8.6-10.2 mg/dl*
	phosphorus	2.3	*2.5-4.9 mg/dl*
	protein, total	6.3	*6.0-8.3 g/dl*
	albumin	3.3	*3.5-4.9 g/dl*
	bilirubin, total	1.1	*.1-1.1 mg/dl*
	AST (SGOT)	37	*2-35 U/L*
	ALT (SGPT)	44	*0-45 U/L*
	LDH	164	*60-200 U/L*
	ALP	110	*30-130 U/L*

Urinalysis: negative

Chest X-ray : hyperexpansion consistent with COPD but no other abnormalities

EKG: without signs of ischemia.