Patient #063

Chief Complaint: This 38 year old black male was admitted because of weight loss.

History of Present Illness: The patient had been in good health until five months prior to his clinic visit when he started having fever and chills. He saw his local doctor at the onset of the symptoms and was told he had a Strep throat and was treated with amoxicillin. After that he developed night sweats and was seen by two other physicians. The laboratory work from those two visits was notable for negative monospot, viral hepatitis serology, and HIV tests. The patient was slightly anemic with a hemoglobin of 12.8 gm/dl. The cells were normochromic and the RDW was within normal limits.

Over several months the patient's fever, chills and night sweats improved. He was no longer changing a soaked undershirt each night. His weight loss continued, totaling 30 lb. over five months. He noted slight dyspnea with exertion but denied aches, pains, arthritis, rashes or sores. He reported a good appetite. He also admitted that he cried frequently and that he was concerned about his health.

Past Medical History: He was taking no medications and had no previous hospitalizations or operations. He did have a distant history of gonorrhea. He had no allergies.

Social History: He admitted to drinking 12 beers per week. He denied use of intravenous drugs. He works as a meat packer in a hog slaughter house. He is married and has two children. His wife works as a seamstress.

Family History: There was a positive history of tuberculosis and sickle cell trait.

Physical Examination: On physical exam he weighed 71.7 kg, the blood pressure was 110/60, pulse 84 and temperature 98.1 ^{o} F (36.7^{o} C). The skin appeared normal. He had no adenopathy. The head was normal. The pupils were equally round, reactive to light and accommodation. The fundi were normal. The TM's were normal. He had carious teeth and had missing teeth, but otherwise the oropharynx was unremarkable. There was no lymphadenopathy. There was no thyromegaly. His chest was clear to auscultation. The heart sounds were normal with no murmurs or gallops. The abdomen was soft, non-tender with no

masses and no organomegaly. The testes were descended without masses. The rectal was unremarkable and stool was guaiac negative. He had no evidence of arthritis. There was no peripheral edema.

Laboratory Data:

			Normal
CBC	Hct	29	*40-54%*
	Hgb	10.0	*13.4-17.4 g/dl.*
	MCV	77	*81-97 fl*
	RDW	15.9	*12-15 %*
	WBC	3.1	*4-12 X $10^{9/L}$*
	Neut	32	*40-70 %*
	lymph's	58	*20-50 %*
	mono	6	*2-10 %*
	platelet count	313	*150-440 X 10^{9}/l*
	sed rate	39	*0-15 mm/hr*
Chemistries	electrolytes	normal	
	renal function	normal	
	AST (SGOT)	35	*11-40 U/L*
	ALT (SGPT)	55	*10-52 U/L*
	LDH	470	*108-215 U/L*
	ALP	96	*39-117 U/L*
	GGT	135	*10-46 U/L*

Urinalysis: no protein or glucose

Skin tests: patient anergic, no reaction to PPD, candida, or mumps.

Two months later the patient showed no improvement. His Hct had dropped to 29%, still slightly microcytic. The WBC remained low at 3.1x10^{9}/L with 32% neut, 58% lymphs, and 6% monos. The sed rate had risen to 39 mm/hr. The reticulocyte count was 2%. The liver function tests remained slightly elevated. The patient underwent a bone marrow aspirate and biopsy which showed multiple small granulomas. Erythrocytic and granulocytic cell lines were

normal as were the megakaryocytes. Stains for acid fast bacilli were negative. Six weeks later bone marrow cultures for mycobacteria and fungus were also negative.