Patient #072

Chief Complaint: This patient is a 65-year-old white female who was admitted for evaluation of severe anemia.

History of Present Illness: She was first noted to have anemia one month prior to admission, when her hematocrit was noted to be about 30%. Workup at that time revealed thrombocytopenia (platelet count approximately $100x10^9$/L), but her WBC was normal. Her B-12 level was normal, the serum iron was 42 and a haptoglobin level was less than 5. She was eventually discharged for further outpatient workup but was readmitted one month later because of worsening dyspnea and fatigue and a decline in her hematocrit to 19.9%. She denied any melena, hematochezia, hematemesis, hematuria or hemoptysis. There was no nausea, vomiting or recent change in her bowel habits. Her weight was stable but she had noted an increase in her chronic lower extremity edema. There was no fever. She had been taking her thyroid replacement medication every day.

Past Medical History: Pulmonary fibrosis--diagnosed three years prior to admission by open lung biopsy. It was felt to be idiopathic after a workup. Her symptoms and lung function had worsened despite therapy with prednisone and cyclophosphamide, and the cyclophosphamide had been discontinued more than a year before admission. Hypothyroidism. Membranous glomerulonephritis--diagnosed four months prior to admission by renal biopsy after she was noted to have significant and sustained proteinuria; no clear underlying cause was identified at that time.

Medications included Synthroid, prednisone (60 mg qd), furosemide, ranitidine, and verapamil. Family and social histories were non-contributory.

Physical Examination revealed a woman in moderate respiratory distress. Her temperature was 98.5º F (37º C), with a pulse of 80, respirations of 24 and a blood pressure of 168/96. HEENT exam was unremarkable. The neck examination revealed 8 cm of jugular venous pulse elevation. The lungs had crackles halfway up the posterior fields bilaterally. Cardiac exam showed a regular rhythm, with a II/VI systolic murmur heard best at the left

upper sternal border. No extra heart sounds were present, though the P2 was prominent. Bowel sounds were present and normal. There was no abdominal tenderness, masses or organomegaly. The stool was negative for occult blood. Examination of the extremities revealed 2+ lower extremity edema bilaterally to the knees but no clubbing.

Laboratory Data:

			Normal
CBC	Hct	19.9	*37-47%*
	Hgb	6.8	*12.0-16.0 g/dL*
	WBC	13.8	*4-10 X $10^{9/L}$*
	platelet count	69 X10^{9}	*200-400 X 10^{9}/l*

Peripheral blood smear: moderate anisocytosis and numerous schistocytes. Few platelets were seen.

Chemistries	sodium	137	*136-146 mmol/l*
	potassium	4.8	*3.5-5.0 mmol/l*
	chloride	104	*99-111 mmol/l*
	CO2	23	*24-34 mmol/l*
	creatinine	2.9	*.0.6-1.0 mg/dl*
	BUN	89	*8-20 mg/dl*
	glucose	173	*73-115 mg/dl*
	calcium	8.5	*8.6-10.2 mg/dl*
	albumin	3.4	*3.5-4.9 g/dl*
	bilirubin, total	1.6 (almost all unconjugated)	*.1-1.1 mg/dl*
	AST	54	*2-35 U/L*
	ALT	41	*0-45 U/L*
	LDH	813	*60-200 U/L*
	ALP	74	*30-130 U/L*
	PT, PTT	normal	

Urinalysis: 3+ protein and a few RBC's, but no casts seen.