Patient #112

Chief Complaints: A 36 year-old white man with a history of mild mental retardation presented to his local hospital for evaluation of diarrhea and weight loss.

History of Present Illness: The patient was reportedly feeling well, living semi-independently with his father and working as a gardener in his developmental center. However, his sister noted that he had lost weight over the previous 6 months with a decrease in his waist size, from 34 to 30 inches. He denied anorexia, nausea or vomiting, abdominal pain, diarrhea, constipation or blood in the stool at that time. He was subsequently seen by a physician who noted him to be 129 lb. but well-developed with otherwise unremarkable exam. Details of his workup at that time are unavailable but he was placed on iron therapy for a microcytic, hypochromic anemia. He went on a trip to Southern California 3 months later but six days into the trip developed foul-smelling, greasy, non-bloody diarrhea with fecal incontinence. He also developed nausea and vomiting without hematemesis and was brought to a hospital in California for further evaluation. There was no history of fever, chills, or sweats. No other travel companions were ill.

On presentation he was noted to have clinical evidence of volume depletion and was admitted for IVFs and further diagnostic evaluation.

Previous medical History: Mild mental retardation; microcytic, hypochromic anemia.

Previous Surgical History: Status post cholecystectomy and appendectomy.

Medications: iron supplements.

Social History: works as a gardener in a developmental center. Lives with his father. Never married but has a girlfriend who also lives in his home. Has smoked 1 ppd for the last 13 years. No history of alcoholism or IVDA.

Family History: Mother with diabetes, HTN, CAD and CVA. Father with severe COPD. No history of colon cancer or GI disorders.

Review of Systems: As per HPI; no history of rashes or change in skin pigmentation, cough, chest pain, arthralgias, headache, or change in baseline mental status.

Physical Examination: Patient is a pale, cachetic man in no apparent distress but appears weak and fatigued. Vital signs were: temperature: 97.5^{o}F (36.5^{o} C), blood pressure 86/52, pulse was 82, respirations were 18, and weight was 115. Skin exam showed no rashes or hyperpigmentation. Nodes: No axial or inguinal adenopathy appreciated. HEENT: PERRLA. Discs were sharp without papilledema. Dry oral mucous membranes. Neck supple. No lymphadenopathy or thyromegaly. Lungs were clear to auscultation without rales or wheezes. Cardiac exam showed regular rate and rhythm without murmurs or gallops. The abdomen was soft., non-tender and non-distended, with no abnormal bowel sounds. No hepatosplenomegaly or masses. Extremities: Bilateral 1+ pedal edema. No clubbing. No joint tenderness, swelling or decreased range of motion. Rectal: Normal tone. Greenish-black strongly heme-positive stool. Neuro: Notable only for slow mentation (reported as baseline), otherwise non-focal.

Laboratory Data:

			Normal
CBC	Hct	27.9	*42-52%*
	Hgb	9.0	*14.0-18.0g/dl*
	MCV	67	*80-100 fl*
	WBC	15.5 X 10^{9}	*4-10 X $10^{9/L}$*
	Neut	91	*50-75 %*
	lymph's	7	*20-50 %*
	mono	2	*3-10 %*
	retic count	<2.0%	*0.5-2.5%*
	Serum iron	22	*33-150 ug/dl*
	TIBC	241	*210-400 ug/dl*
	Ferritin	104	*30-284 ng/ml*
			Normal
Chemistries	sodium	134	*136-146 mmol/l*
	potassium	4.3	*3.5-5.0 mmol/l*
	chloride	103	*99-111 mmol/l*

CO2	20	*24-34 mmol/l*
creatinine	1.0	*.9-1.3 mg/dl*
BUN	20	*8-20 mg/dl*
glucose	84	*73-115 mg/dl*
calcium	8.7	*8.6-10.2 mg/dl*
phosphorus	2.8	*2.5-4.9 mg/dl*
magnesium	2.0	*1.5-2.3 mg/dl*
protein, total	6.5	*6.0-8.3 g/dl*
albumin	2.3	*3.5-4.9 g/dl*
bilirubin, total	0.5	*.1-1.1 mg/dl*
AST (SGOT)	24	*2-35 U/L*
ALT (SGPT)	33	*0-45 U/L*
LDH	100	*60-200 U/L*
ALP	144	*30-130 U/L*
cholesterol	94	*<200 mg/dl*
amylase	37	*23-100 IU/L*
lipase	40	*40-240 IU/L*

Urinalysis: no cells or casts.

Chest X-Ray: No acute cardiopulmonary changes.

Abdominal X-Ray: Multiple air-fluid levels within large and small bowel.

The patient received intravenous fluids with some symptomatic improvement.

Stool for fecal WBCs: occasional.

Stool for O & P: x3 negative.

Culture (Salmonella, Yersinia, Shigella, Vibrio, Campylobacter, and C. difficile negative

Thyroid studies: TSH of 7.0 (nl .45-6.0)

The patient was placed on Synthroid. HIV was negative. An abdominal ultrasound showed mild hepatic and splenic enlargement, without other abnormalities. An abdominal and pelvic CT scan was remarkable for small bilateral pleural effusions, periaortic and pelvic

adenopathy, and irregularity of the rectosigmoid colon. An EGD was notable for mild gastritis but no duodenitis. Colonoscopy to the terminal ileum showed no evidence of colitis.