Patient #022

Chief Complaints: This 37 year-old white male was admitted for evaluation of severe anemia and recurrent fevers.

History of Present Illness: This patient has known HIV infection and a prior history of candidal pharyngitis, herpes zoster and herpes simplex proctitis. Several months prior to admission, he noted the development of malaise, intermittent fevers to as high as 104^{o} F (40^{o} C) and a continuous, mild nausea. His hematocrit, which had been 42% seven months earlier, was noted to be 26%. It did not improve significantly with a decrease in his dosage of AZT. A CD4 count was 40. An EGD and colonoscopy were unremarkable. Duodenal biopsy was negative. Blood cultures, including special cultures for MAI, were negative. An abdominal CT scan at that time revealed splenomegaly and aortocaval and portahepatic lymphadenopathy. Lymph node biopsy was interpreted as "inconclusive," but it was felt that the specimen probably was not malignant.

Over the few weeks immediately prior to admission, he began to feel lightheaded. The intermittent fevers continued. About a week before admission, his hematocrit was found to be 19.8%. He was transfused with two units of packed red blood cells and his AZT was discontinued. One week prior to admission, he had one episode of hematochezia after straining at stool for several hours. No melena or hematemesis were noted. Two days prior to admission, a repeat hematocrit was 13.9% and he was admitted to the hospital for further evaluation.

Past Medical History: Medical history is significant for HIV positivity for six years, non-PCP pneumonia, syphilis, candidal pharyngitis, herpes zoster and herpes simplex proctitis.

Medications: Medications included monthly aerosolized pentamidine and trazodone.

Family/Social History: He is homosexual without any history of alcohol or tobacco abuse. Family and social histories are otherwise unremarkable.

Physical Examination: Physical exam revealed a pale, cachectic man. His vital signs included a temperature of 103^{o}F (39.5^{o}C) , pulse of 78 (regular), respiratory rate of 12, and blood pressure of 86/60. The skin had no bruises or petechiae. There was shotty bilateral

inguinal lymphadenopathy but no other palpable lymphadenopathy. The HEENT exam was unremarkable other than pale conjunctivae and some oral thrush. Cardiac and pulmonary examinations were within normal limits. Abdominal examination revealed right upper and left upper quadrant tenderness without rebound or involuntary guarding. Splenomegaly was noted. No other masses were appreciated. Stool was guaiac-negative. The extremities were unremarkable and no neurologic deficits were noted.

Laboratory Data:

			Normal
CBC	Hct	12%	*42-52%*
	Hgb	4.2	*14.0-18.0g/dl.*
	WBC	2.4	*4-10 X* $10^{9/L}$
	Neut	81	*50-75 %*
	lymph's	9	*20-50 %*
	bands	9	*0-15%*
	platelet count	38	*200-400 X* 10^{9}*/l*
Chemistries	electrolytes	WNL	
	creatinine	0.4	*.9-1.3 mg/dl*
	BUN	14	*8-20 mg/dl*
	calcium	7.1	*8.6-10.2 mg/dl*
	phosphorus	3.7	*2.5-4.9 mg/dl*
	protein, total	6.5	*6.0-8.3 g/dl*
	albumin	2.2	*3.5-4.9 g/dl*
	LDH	266	*60-200 U/L*

Transaminases were within normal limits as were alkaline phosphatase and bilirubin. Coagulation times were normal

Serum iron	<20	*33-150 ug/dl*
TIBC	167	*210-400 mcg/dl*
ferritin	1015	*7.3-199 ng/ml*

Reticulocyte count 1.3% when corrected for anemia. Haptoglobin was normal.

Urinalysis: Unremarkable

Chest X-ray : Unremarkable