Patient #021

Chief Complaint: This 62 year old white male presented with diarrhea for 3 months.

History of Present Illness: He was well until 3 months prior to admission, when he developed watery diarrhea. The diarrhea was not associated with meals. There was no hematochezia or melena. Two months prior to admission, his stools became light tan in color. In addition, his urine became dark. He experienced episodes of facial and neck flushing, and developed a pruritic rash over his arms and chest. He denied shortness of breath and wheezing. He also denied fevers, chills, sweats, abdominal pain, nausea, or vomiting. He had lost 20 lbs in weight, which he claimed was intentional. He had not traveled or taken antibiotics, and no one else at home was ill with diarrhea.

Past Medical History: He had hyperlipidemia, with elevated cholesterol and triglycerides. No hospitalizations or surgery.

Medications: none

Allergies: none known.

Family History: noncontributory.

Social History: He is a former truck driver. He smoked 2 packs of cigarettes per day for 20 years, but quit 20 years ago. He drinks alcohol occasionally.

Physical Examination: Well developed, well nourished white male in no acute distress. BP 110/60; pulses 70; respirations 18; temperature 97.8^{o}F (36.5^{o}C).

The skin was mildly icteric; there were areas of erythema with scaling on the chest, back, and arms. The head was normocephalic and atraumatic. The conjunctivae were pink. The sclerae were mildly icteric. The pupils were equal, round, and reactive to light and accommodation. The fundi were benign. The oropharynx was clear. The neck was supple. There was no lymphadenopathy or thyromegaly. The lungs were clear. The heart had normal sounds, without gallops or murmurs. The abdomen was soft, with normoactive bowel sounds. There was no tenderness. The liver was 12 cm to percussion in the midclavicular line; the lower border was 3 cm below the right costal margin. The spleen was not enlarged, and no masses

were palpated. Rectal examination revealed a normal sized prostate; the stool was guaiac negative. The extremities showed no cyanosis, clubbing, or edema; peripheral pulses were 2+ and symmetric. The neurologic examination was normal.

Laboratory Data:

			Normal
Chemistries	sodium	140	*135-149 mmol/l*
	potassium	4.4	*3.5-5.3 mmol/l*
	chloride	103	*98-108 mmol/l*
	CO2	22	*24-32 mmol/l*
	BUN	15	*6-20 mg/dl*
	creatinine	0.9	*0.5-1.5 mg/dl*
	glucose	138	*70-110 mg/dl*
	calcium	9.2	*8.6-10.4 mg/dl*
	phosphorus	2.8	*3.0-4.5 mg/dl*
	uric acid	5.1	*4.0-8.0 mg/dl*
	protein, total	6.3	*6.0-8.0 g/dl*
	albumin	3.2	*3.6-5.0 g/dl*
	bilirubin, total	9.0	*0-1.2 mg/dl*
	AST (SGOT)	63	*0-50 U/L*
	ALT (SGPT)	60	*0-70 U/L*
	LDH	177	*0-250 U/L*
	ALP	177	*40-125 U/L*
	amylase	100	*23-85 U/L*

			Normal
CBC	Hgb	14.2	*14.0-18.0 g/dl*
	Hct	40.9	*42-52%*
	MCV	91	*84-99 fl*
	WBC	8.5	*4.8-10.8 X* $10^{9/L}$
	Neut	85	*40-70 %*
	lymph's	8	*25-45 %*
	mono	4	*2-12 %*
	bands	2	*0-10 %*
	eosinophils	1	*0-6%*
	platelet count	360	*150-400 X* $10^{9}/l$

Urinalysis: trace protein and 2+ bilirubin; microscopic examination was unremarkable.

Chest X-ray : normal heart and lungs

EKG: unremarkable.