Case History

HPI: A 34 year old African woman with a history of sickle cell disease presented to the Emergency Department with a 4 month history of progressive psychosis, diffuse limb pain, and malaise. She had been seen by her primary care physician and treated with oral opioids with little to no improvement. She had been seen in the Emergency Department 3 days prior to admission, again treated with analgesics with little improvement. The pain progressed, becoming unbearable to the patient and she re-presented to the Emergency Department.

Obtaining an accurate history and detailed physical exam was extremely challenging due to psychosis, paranoid ideations, and a language barrier. On review of systems, the patient noted severe, diffuse, sharp pain in her legs and arms. She also reported a belief that her former roommates had placed a voodoo curse on her. She admitted to auditory hallucinations and paranoid thoughts culminating in suicidal ideations and a self-injurious attempt with a knife. She was admitted to psychiatry where she continued to have severe pain, prompting transfer to the Internal Medicine service for treatment of presumed sickle cell crisis.

The patient had moved from the Ivory Coast to Seattle 10 months prior to admission and to Richmond 6 months prior to admission. While in Africa she was seeing an MD regularly and was taking antibiotics, but she is unsure which antibiotics she was taking and why she was taking them. She had no prior hospitalizations. She reported history of sickle cell with possible pain crisis in past, managed at home with oral meds.

Past Medical History:
- Sickle cell disease – reported by patient, baseline hgb unknown
- Infertility of unknown etiology (no workup to date)
- Migraines

Past Surgical History:
- None

Family History:
- Mother with sickle cell disease, Hgb S
- Father with schizophrenia
- Patient unaware of her siblings' medical histories

Social History:
- Native of Ivory Coast, Africa. Exclusively French speaking.
- Married, lives with brother and husband. No children or pets.
- Former accountant, currently unemployed.
- Denies tobacco, alcohol, or illicit drug use. Denies use of herbal or traditional medicines.

Medications:
- Ibuprofen 600 mg every 6 hours PRN
- Oxycodone 10 mg every 6 hours PRN

Allergies:
- Aspirin
- Acetaminophen

Physical Exam

Vital Signs**:** BP 131/80, HR 91/min, RR 20/min, Temp 98.4, Pox 100% on RA
General: Overweight woman who looked distressed. Ill-appearing but not toxic. Appeared stated age. No muscle wasting noted.
HEENT: PERRL, EOMI, pale conjunctiva, sclera anicteric, moist mucous membranes, oropharynx clear and without lesions
Neck: Supple, no carotid bruits, no JVD, no lymphadenopathy, mild tenderness at the base of the skull
Lymph: No cervical, supraclavicular, axillary, or inguinal lymphadenopathy
CV: Regular rhythm, constant S1/S2; no murmurs noted, PMI non-displaced, normal in size
Lungs: Full and symmetric excursion, clear breath sounds
Abdomen: Soft, nondistended, normoactive bowel sounds, tender to palpation diffusely, worst over LUQ and RUQ, no rebound/guarding, liver span 12cm, no splenomegaly, no ascites
Ext: No edema, 2+ radial, and DP pulses bilaterally
MS: 5/5 Strength with full ROM in all joints; no joint tenderness, swelling or effusions
Neuro: Alert and oriented 4/4, CN II-XII intact, diffuse hyperesthesia with pain on light touch of bilateral lower extremities, upper extremities, DTR's 2+ and symmetric throughout, no asterixis. Unable to obtain more detailed sensory exam due to paranoid ideation
Psychiatric: Endorses auditory hallucinations and paranoid thoughts throughout exam, including a fear that hospital food and medications are poisoned. Flat affect.
Skin: No rashes, erythema, ecchymoses, purpurae, or petechiae

Laboratory Data and Imaging

Sodium 142 mmol/L, Potassium 4.0 mmol/L, Chloride 112 mmol/L, Bicarbonate 22 mmol/L, BUN 8 mg/dL, Cr 0.74 mg/dL, Glucose 134 mg/dL, Calcium 8.6 mg/dL

AST 19 units/L, ALT 17 units/L, ALP 51 units/L, Total bilirubin 1.2 mg/dL, Conjugated bilirubin 0.3 mg/dL, Albumin 3.9 gm/dL

WBC 1.6 x10^9/L , Hemoglobin 10.6 g/dL, RBC 3.11 x 10^12/L, Mean Corpuscular Volume 99.6 fL, RDW 21.1%, Platelets 134 x 10^9/L, reticulocyte percent 0.7%.

Smear Review: Rare schistocytes, Teardrop cells, anisocytosis

WBC Differential: 39.3% segs, 0% bands, 0.7% eos, 0% baso, 56.3% lymphs, 3.7% monos

LDH: not done
Haptoglobin: not done

Hemoglobin electrophoresis: Hgb A 55.7%, Hgb A2 5.9%, Hgb F 1.3%, Hgb S 38.1%

TSH: 1.32

PT: 10.9, PTT: 25, INR: 1.1

Urinalysis: Yellow, pH 5.5, spec grav 1.016, protein neg, leuk esterase pos, nitrite neg, neg blood, glucose neg, ket >80, 1 rbc, 4 wbc

Urine βHCG: negative

ANA: negative

Blood cultures: no growth

HIV Ab: negative

Parvovirus B19 IgG: positive
Parvovirus B19 IgM: negative

EBV Nuc IgG: positive
EBV Capsid IgM: negative
EBV Capsid IgG: positive

CXR: no consolidation, no lymphadenopathy, no masses, no effusions

Abdominal Ultrasound:
- ❖ Normal liver morphology with mild hepatomegaly (14.4cm)
- ❖ Spleen measuring 10cm, with small focal hyperechoic lesion, likely hemangioma
- ❖ Cholelithiasis without cholecystitis
- ❖ Normal appearing kidneys, pancreas, adrenals and bowel
- ❖ No lytic or osteoblastic lesions
- ❖ No adenopathy, no evidence of vascular occlusions

Department of Internal Medicine Clinicopathologic Conference

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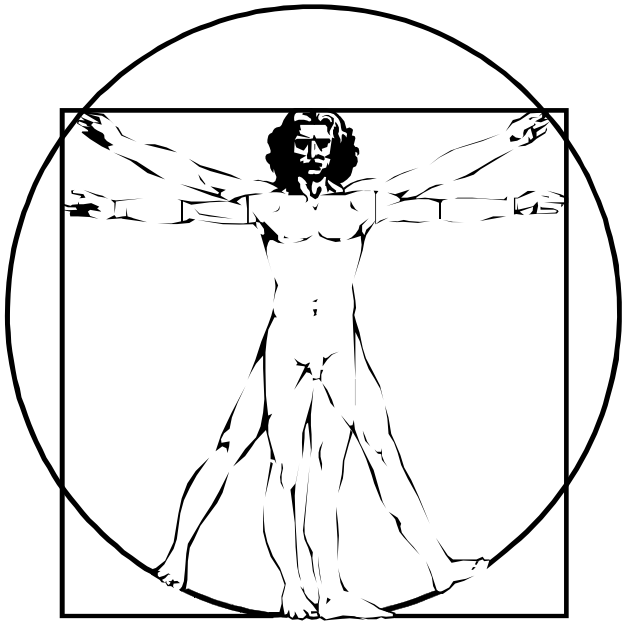

34 year old African woman who presents with limb pain, acute psychosis, and pancytopenia