CASE CONFERENCE

Presenter : R2許力云
Supervisor : VS 楊毓錚

2012.06.06

CASE 1

PATIENT PROFILE

- 56 y/o F
- DAY1-18:39
- 入院方式: 步行
- T/P/R: 38.7/78/17 BP: 101/61 mmHg SpO2: 97 %
- E4V5M6
- 檢傷主訴: 病患來診為眩暈/頭暈
- Triage III

HISTORY

- Headache, cough, fever at today
- 全身無力
- 最近有感冒
- No SOB, no back pain, no chest pain
- 不知自己有發燒,只覺得噁心,上腹部不舒服
- Mild dizziness
- No tremor, no myoclonus

PAST HISTORY

- NKDA
- No HTN/CAD/DM

PHYSICAL EXAMINATION

- Conscious : E4V5M6
- Neck: supple
- Chest: clear BS
- Abdomen: Soft no knocking pain
- Extremities: warm, freely movable

IMPRESSION

- Fever with dizziness

R/O UTI

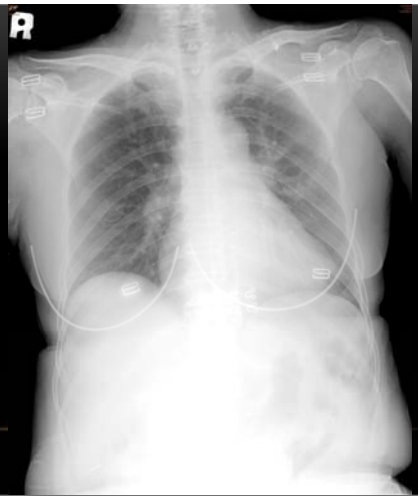
R/O virus infection

INITIAL ORDER

1850

- CBC/DC/PLT
- Panel1
- B/C *2
- U/A
- CXR
- N/S run 60 ml/hr
- Primperan 1amp IV st
- Keto 1amp IV st

CXR



LABORATORY DATA

CBC/DC/Hb/Plt		Biochemistry		Urine analysis	
Hb	12.5	Glucose	137	RBC	1-2
WBC	6.1	GOT(AST)	19	WBC	0-1
Segmented Neutro.	79.9	BUN	15	Epithelial cell	0-1
Lymphocyte	16.1	Creatinine	0.6	Cast	Not Found
Monocyte	3.8	Na	140	.cast-amount	-
Eosinophil	0.0	K	3.9	Crystal	Am.phos
Basophil	0.2	Troponin I	3.923	.Cry-amount	+
Platelet	245			Bacteria	+/-

ORDERS

1950

- 補CRP (0.138)
- Primperan 1# PO TID
- Tinten 1# PO TID
- Mucain 1# PO TID
- IV滴完後Recheck vital sign

--- 37.7/80/18 BP150/80

PROGRESS NOTE

1955

Patient still dizziness → keep obs at ER

If still S/S persist consider CT of head

SOMETHING HAPPEN…

2000

護理人員於recheck vital sign 後因見到口服藥物已開立，為察覺MBD ORDER未開立, 故讓病人回家

2240

夜班檢傷人員於檢核病歷時發現該病歷並未開立MBD ORDER，故告知夜班醫師，經聯絡患者後，表示仍不適,請病患回急診進一步評估

2ND VISIT

PATIENT PROFILE

- 56 y/o F
- DAY1- 23:349
- 入院方式：步行
- T/P/R: 36.5/75/16 BP: 103/58 mmHg SpO2: 98 %
- E4V5M6
- 檢傷主訴: 病患來診為眩暈/頭暈
- Triage III

HISTORY

- 二次回診(被叫回來)
- Epigastric cramping pain with nausea
- No cold sweating no vomiting
- Still dizziness after went home

PAST HISTORY

- NKDA
- No HTN/CAD/DM
- Gall stone hx

PHYSICAL EXAMINATION

- Conscious：E4V5M6
- Neck: supple
- Chest: clear BS
- Abdomen: Soft no knocking pain
- Extremities: warm, freely movable

IMPRESSION

- Fever R/O BTI

ORDERS

0006

- NPO
- D5S run 80 ml/hr
- VBG G6
- T-Bil
- Fucon 1amp IV st

LAB DATA

```
PH=7.401
PCO2=40.2 mmHg
PO2=46 mmHg
BE=0 mmol/L
HCO3=25.0 mmol/L
TCO2=26 mmol/L
SO2=82 %
```

T-Bilirubin	0.5

ORDERS

0225

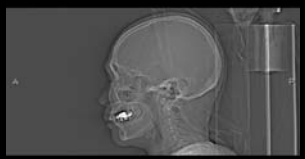
- Bedside echo

→ Negative finding

0252

- Brain CT without contrast
- Primperan 1amp IV st

BRAIN CT



ORDERS

0310

- Brain CT with contrast

BRAIN CT WITH CM

ORDERS

0340

- Consult NS

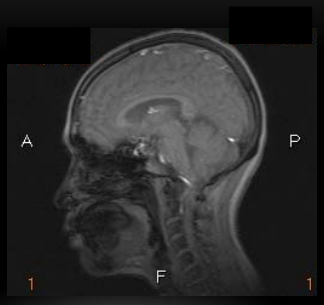
0400

- Admission to NSICU

ADMISSION COURSE

- DAY3 轉病房
- DAY3 Brain MRI performed
- DAY10 OP day 並入 NSICU
- DAY12 轉病房
- 至今住院中

BRAIN MRI



PATHOLOGY REPORT

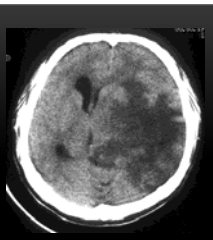
COMMENT:

Malignant lymphoma, diffuse, large B cell type, is considered. Systemic work up including bone marrow examination is recommended.

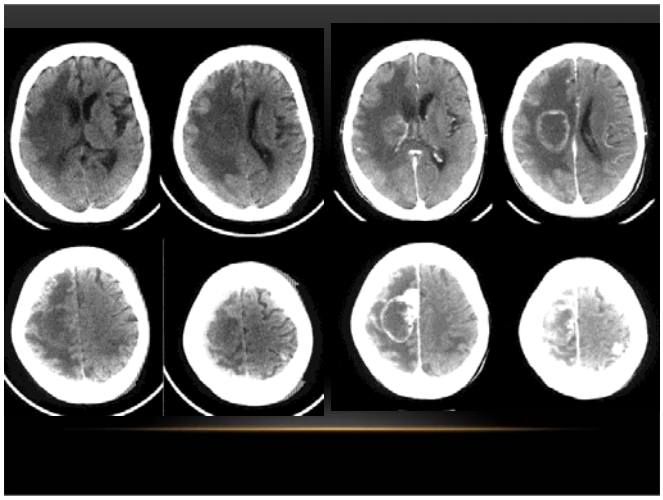
FINAL DIAGNOSIS

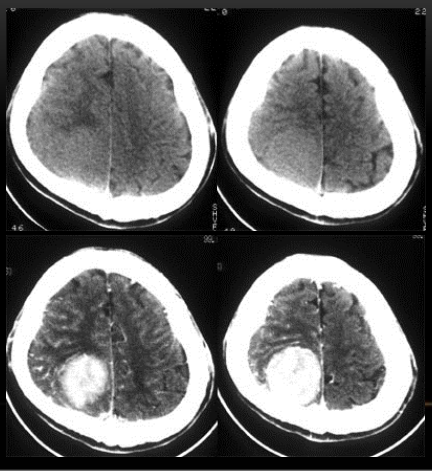
- Brain Tumor (left medial temporal area) , malignant lymphoma, diffuse, large B cell type

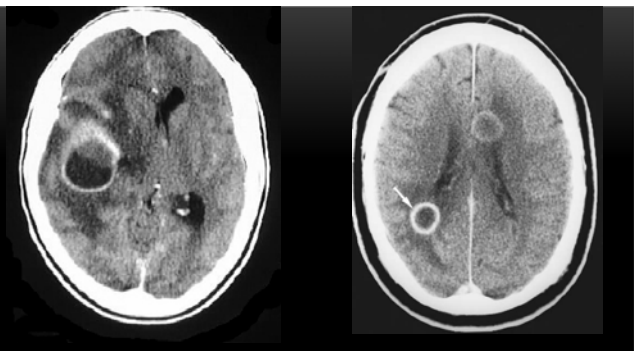
DISCUSSION



- Brain tumors usually appear as hypodense, poorly-defined lesions on noncontrasted CT scans
- 70-80% of brain tumors will be apparent without the use of contrast.
- Calcification and hemorrhage associated with a tumor can cause it to have a hyperdense appearance.
- Tumors should be suspected on a non-contrasted CT scan when significant edema is associated with an ill-defined mass.
- Intravenous contrast material can be used to help define brain tumors. Contrast media will leak through the incompetent blood-brain barrier into the extracellular space surrounding the mass lesion, resulting in a contrastenhancing ring







Abscess: Brain abscess will appear as an ill-defined hypodensity on non-contrast CT scan. A variable amount of edema is usually associated with such lesions and, like tumors, they frequently ring-enhance with the addition of intravenous contrast.

CNS LYPHOMA---SITES

PCL can manifest in the brain, its coverings, the eye, or spinal cord. Five distinct clinicopathological entities have been described:

- Intracranial lesion (solitary or multiple)
- Diffuse leptomeningeal or periventricular lesions
- Vitreous/uveal deposits
- Intradural spinal cord lesion
- Nerve seeking lymphoma (Neurolymphomatosis)

CNS LYMPHOMA---SYMPTOMS

Primary cerebral lymphoma — a retrospective series of 248 immunocompetent patients with primary intracerebral lymphoma reported the following symptoms at presentation :

- Focal neurological deficits — 70 percent
- Neuropsychiatric symptoms — 43 percent
- Signs of raised intracranial pressure — 33 percent
- Seizures — 14 percent
- Ocular symptoms — 4 percent , such as Systemic B symptoms (fever/chills, night sweats, weight loss, malaise)

CNS LYMPHOMA---RADIOGRAPHY

- solitary non-hemorrhagic mass, situated in the deep white matter adjacent to the ventricular surface.
- The borders are sharply circumscribed in the majority of lesions (87 percent), but may be ill-defined (15 percent).
- Although mild surrounding edema is present in the majority of cases.
- Mass effect may be seen in over half of the cases

CNS LYMPHOMAS---TREATMENT

- Patients with primary central nervous system lymphoma are typically not offered surgical debulking, since the extent of surgical resection does not influence patient survival. Stereotactic biopsy is usually recommended, providing a high rate of positive tissue diagnosis with a low rate (<2 percent) of morbidity and mortality. Definitive treatment is usually chemotherapy, radiation, or a combination of these modalities.

THANKS