38-year-old man with HIV presenting with gastrointestinal bleeding

BOTSOGO

BOTSWANA ONCOLOGY
GLOBAL OUTREACH

Continuing Medical Education Announcement

Harvard Medical School

RSS 3081: Monthly BOTSOGO Tumor Board; 2018-2019 Academic Year

Today's Objectives:

- Describe the need for timely cancer case presentation and referral to treatment
- Formulate a multi-disciplinary plan for the care of common and complex oncologic cases
- Adopt successful, sustainable strategies to mitigate barriers to quality cancer care common in resource constrained environments

Target Audience:

Oncologists, internists, surgeons, radiation oncologists, infectious disease specialists, nurses, physicists, therapists, technicians, research staff, administrators, policy makers.

Financial Relationships

The following planners, speakers, and content reviewers, on behalf of themselves and their spouse or partner, have reported financial relationships with an entity producing, marketing, re-selling, or distributing health care goods or services (relevant to the content of the activity) consumed by, or used on, patients:

Name	Role	Type of Financial Relationship
Peter Vuylsteke	Faculty/Speaker	Lilly, Novartis, MSD, BMS: Advisory Boards; Speaker

All other individuals including course directors, planners, reviewers, faculty, staff, etc., who are in a position to control the content of this educational activity have reported no financial relationships related to the content of this activity

Statements

Accreditation Statement

The Harvard Medical School is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians

Credit Designation Statement

The Harvard Medical School designates this live activity for a maximum of 1 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity

This activity meets the criteria of the Massachusetts Board of Registration in Medicine for 1.0 credits of Risk Management Study

Disclosure Statement

In accord with the disclosure policy of the Medical School as well as standards set forth by the Accreditation Council for Continuing Medical Education, course planners, speakers, and content reviewers have been asked to disclose any relevant relationship they, or their spouse or partner, have to companies producing, marketing, re-selling or distributing health care goods or services consumed by, or used on, patients.

Claim your CME credits!

- To claim your CME credit for attendance at this session of the BOTSOGO Tumor Board, please fill out our survey after the Tumor Board.
- You can do this at your convenience on your personal or work computer by navigating to www.botsogo.org
  - Click “What We Do”
  - Click “Tumor Board”
  - Click the link under the section “Continuing Education Credits,” and complete and submit the survey
- Or follow the link that was emailed to our MGH BOTSOGO email list: www.tinyurl.com/tumorboard

Claim your CME credits!

- For the 2018 – 2019 academic year, the deadline to complete the online attendance survey is

Friday 21 June 2019.

- A certificate will be emailed to you in August 2019 with your CME credits for the Tumor Boards you have attended over the 2018 – 2019 academic year.

Update – February 19, 2019 Tumor Board

Session: "Ethical Issues in Oncology"

A 60 year old male patient presents to PMH with a diagnosis of high-risk prostate carcinoma.

***Update**: The patient elected to receive external radiation in his home country, rather than to seek brachytherapy in South Africa.*

Update – April 16, 2019 Tumor Board

Session: "51 year old female with abdominal distention"

Final diagnosis: "neuroendocrine carcinoma, favoring ovarian origin given distribution of disease at autopsy"

(From testing conducted at the University of Pennsylvania)

June 18, 2019

"38-year-old man with HIV presenting with gastrointestinal bleeding"

Dr. Elisabeth Zamora Batista
Dr. Mulemfu

History of Present Illness

38 years old male with previous hospitalizations for chronic abdominal pain (epigastric) and upper GI bleeding who presented at NRH in April 2019 with 1/12 Hx of

- Intermittent dry cough associated with
- SOB 4/7 prior admission
- Also reported: Night sweats, LOW, no LOA

Past Medical History

- Tested RVI: +ve since early 2012
- Started on HAART (TLD) in October 2018
- Previous CD4: 68 (10/2018)
- Most recent CD4 : 390, VL < 400 (late 2018)
- No Hx of HPT, Cardiovascular or liver disease
- No Prior TB or TB contact
- No known family Hx of malignancy

Social History

- Living with girlfriend and 2 children
- Previously worked as plant operator in Ivory Coast, now working in a mine in the Southern District
- Non smoker
- Prior Hx of Alcohol intake stopped in October 2018.

Previous Hospitalizations I

Feb 2012:

- Abdominal pain, headache, fever.

- Hematemesis following an episode of epistaxis on a background of MALARIA and THROMBOCYTOPENIA
- LABS: HB 13.9, WBC 7.2, PTL 59,MCV 83.3
- PT 12.0000, INR 1.09
- U/E : Normal, - ABD USS : Normal
- Tested RVI : +ve

Previous Hospitalizations II

October 2018:

- Epigastric pain, Hematemesis:1/52, melena.

O/ Epigastric tenderness, Polylymphadenopathy.

- Labs: WBC 6.29 Hb 7.3 Hct 23.2, MCV 85.9, PTL 463 (N: 68.8%, L: 17.6 %, Eos: 2.4%), U/E: Normal
- Imaging: CT scan A/P showed multiple nodules in bilateral lungs; LAD in L side of stomach, abdominal cavity and pelvis. Enlarged cyst in liver without obvious enhancement.
- Booked FNAC
- Request for Leave of absence.

Previous Hospitalization III

October 2018: Abdominal pain, Bloody diarrhea, melena

- Symptomatic anemia
- O/ Epigastric tenderness, Lymphadenopathy.
- LABS: HB 4.7, WBC 8.9, PTL 569, MCV 84.3
- AlPh: 93, ALT: 63, AST: 70, TotProt: 79, Alb: 29, INR:1
- DRE: no fissures, no ulceration, no rectal masses, no prostate enlargement, old blood on glove finger
- Left inguinal Lymph Node FNAC: taken
- 11/2018: Endoscopy: Active chronic gastritis 2**H-Pylori*, No malignancy. Started triple therapy.
- Received Blood transfusion and discharged.

Current Hospitalization

April 2019:

- Intermittent dry cough for 1/12
- SOB 4/7
- Night sweats
- LOW.

Physical Exam

T: 37.8 C, BP: 118/74, P: 108 , RR: 24

O2 sat 97% on room air

Pt bed @45 degrees, obvious respiratory distress, no pallor, no jaundice

Pulm: crackles bilaterally

Abdomen: normal

Neuro: normal

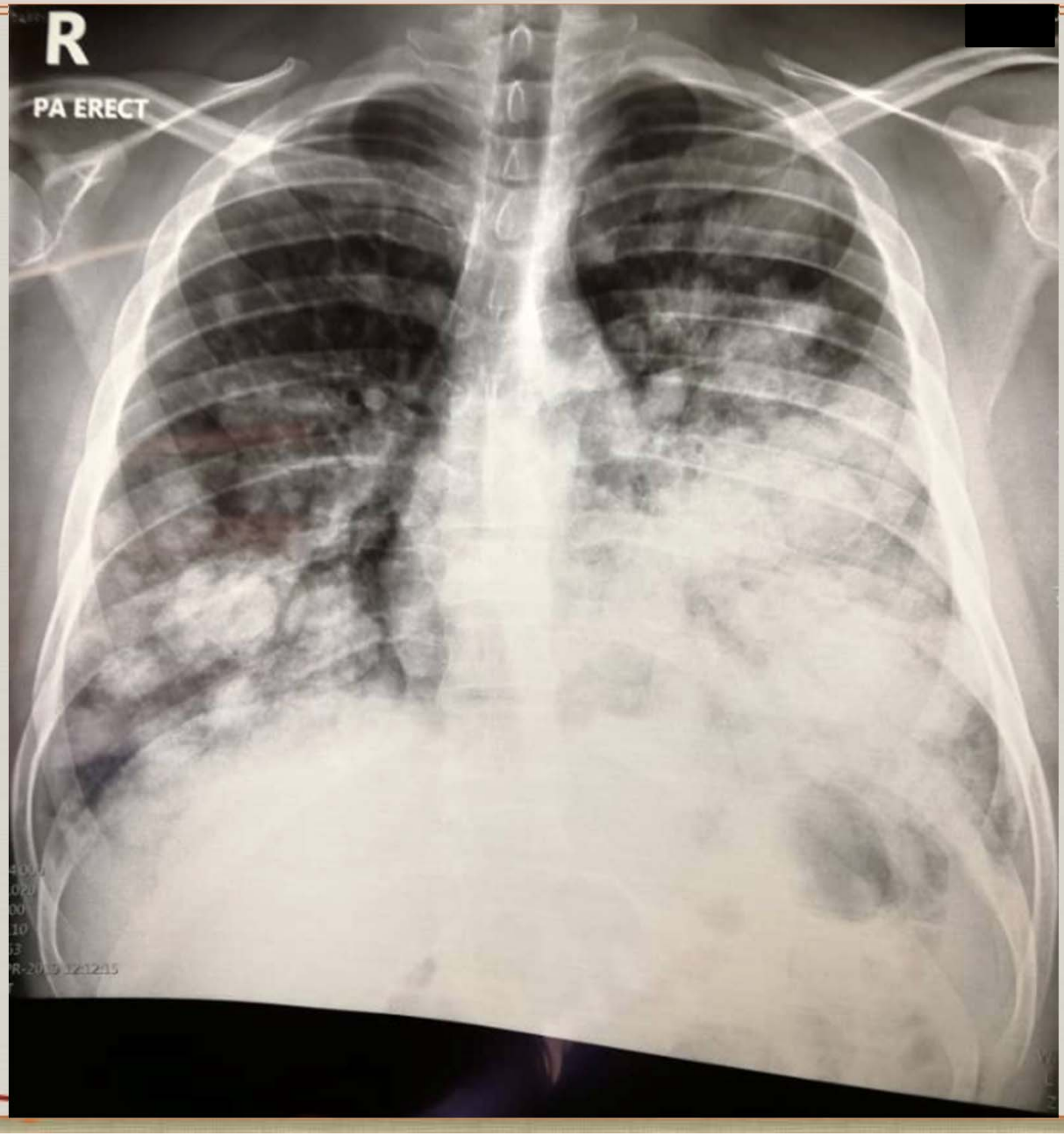
Lymph: Left cervical and inguinal LAD

Basic labs and Imaging

WBC: 11.25 MCV: 73 Hb: 11.9 Plat: 454
Na: 137.2 K: 5 Cl: 110.4 Cr: 89 Urea: 6.7
AST: 60.6 Al Ph: 115.4

- C X-RAY: canon balls in both lungs
- ABD USS: liver 16.88cm, Spleen 11.5 cm smooth contours and normal parenchyma.

Chest XRAY



Differential diagnosis

Lung metastasis

HIV associated → ?NHL, rule out primary site (GI/GU/Heme)

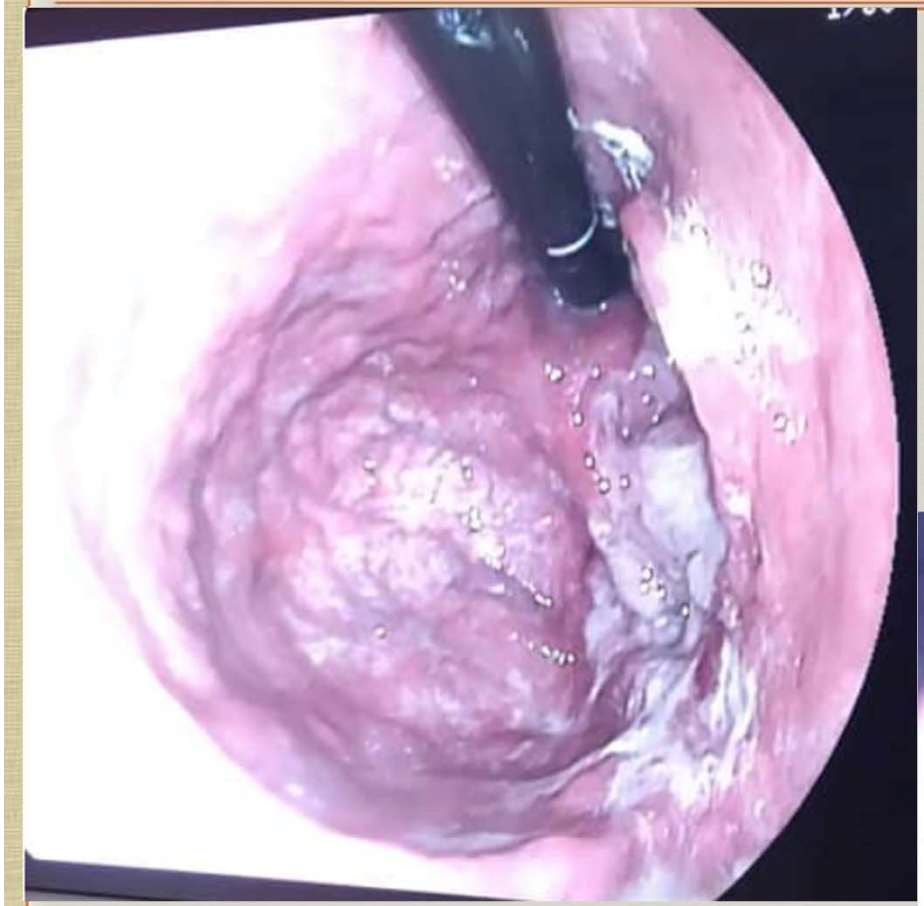
LRTI

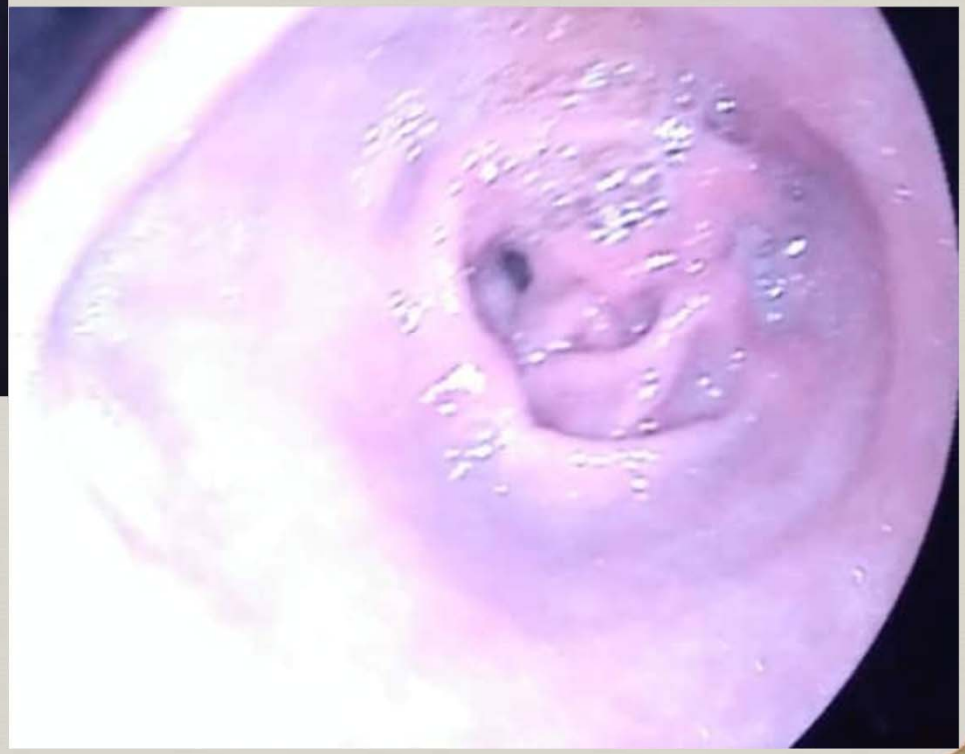
Symptomatic anemia

Additional Imaging and work up

- Endoscopy + Biopsy: ulcerated lesion with malignance aspect.

Endoscopy





Hospital Course

- Patient stabilized and discharged home awaiting gastric biopsy result
- Pathology reports:
  - Inguinal lymph node FNA: High grade NHL
  - Gastric Biopsy: Extranodal marginal zone B cells lymphoma (Maltoma)

Histopathology

Dr. Alina

Patient Follow Up

- May 2019
- Presented with fever, restlessness, SOB and weakness
- Obtunded with severe hypoxemia and polypnea over 45 breath/min
- Initial ABG PO2 57 mmHg
- Pt placed on mechanical ventilation support and admitted to ICU with acute respiratory failure, metabolic acidosis.
- Certified dead, May 2019. *(Date of death not listed to protect patient privacy)*