

# **AMERICAN COLLEGE OF PHYSICIANS**

**PUERTO RICO CHAPTER**



**CLINICAL VIGNETTES COMPETITION**

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## CLINICAL VIGNETTES

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## Puerto Rico Chapter American college of Physicians

### CLINICAL VIGNETTES COMPETITION Abstracts

#### Oral Presentations

**O-1 Anisakiasis Associated to Raw Fish Ingestion in Two Puertorican Patients.** Carlos Jiménez, MD; Suzette Rivera, MD; Federico Rodríguez, MD; Mamuel Marcial, MD; Esther Torres., MD, FACP - University of Puerto Rico School of Medicine, San Juan, PR

**History:** We present two female Puerto Rican patients with epigastric pain, nausea, and general malaise. Both patients had recent history of raw fish (suchi) consumption. Case 1 presented to a gastroenterologist for evaluation of these symptoms. Diagnostic upper gastrointestinal endoscopy revealed the presence of worm-like structures that were pathologically identified as Anisakid larvae. Case 2 was evaluated initially at the emergency room for her symptoms. Radiological evaluation suggested the possibility of a pancreatic inflammatory process although a definite diagnosis was not made. She was discharged from the hospital with no major sequelae. Persistence of symptoms led to an eventual outpatient evaluation that confirmed the presence of Anisakid larvae by upper gastrointestinal endoscopy. Both patients underwent endoscopy extraction of the larvae with full and uneventful recovery.

**Discussion:** Anisakiasis is an infection of larval nematodes acquired through the ingestion of infected squid and fish. Human infection is found wherever raw, poorly cooked salted, or pickled fish are consumed. Common areas include Japan (sushi and sashimi). Incidence of Anisakiasis has increased in areas where consumption of such delicatessen has increased. Clinical features depend on whether the Anisakid larvae attach or invade tissues. These vary from mild epigastric pain to signs of peritoneal irritation. No antihelminthic medications are available. Nevertheless, early removal of the larvae is curative and prevents development of complications secondary to chronic infection. Knowledge of this medical entity and its associated risk factors contributes to early endoscopic diagnosis and intervention and possibly prevents complications of late diagnosis, particularly in our Puerto Rican population.

**O-2 Tuberculous Meningoencephalities.** M. Colón MD; R. Baéz MD; M. Cabrer MD, R. Rocha, MD, E. Trinidad MD, G. González MD. (San Juan VA Medical Center)

A 58 y/o male patient with history of chronic mastoiditis, s/p left mastoidectomy, who presented to ER with mental changes and unquantified fever associated with headaches, neck pain, and gait disturbances of one week of evolution. Patient was found afebrile with nuchal rigidity and disorientation. Bacterial meningitis was considered and started on ceftriaxone, ampicillin and vancomycin. Lumbar puncture was performed, pleocytosis was found with PMN's predominance, proteins were elevated and glucose low. Head CT showed nonspecific right posterior centrum semiovale hypodensity. CXR reported no evidence of cardiopulmonary abnormalities. CSF gram stain was negative for bacteria. MRI reported focal meningeal enhancement in the left sylvian fissure with intracranial parenchyma enhancing nodules and foci of ischemia, compatible with meningo-encephalitis. Acyclovir was empirically added. But after 3 days of treatment patient persisted with dis-orientation, hypoactivity, right hemiparesis, aphasia and facial palsy. Follow up MRI was found with the same changes and interval development of bilateral acute infarcts. Lumbar puncture was repeated and pleocytosis persisted unchanged but PMN's and mononuclear cells distribution was even, hypoglycorrhagia worsened and proteins were over 500. Antibiotherapy was optimized with cefepime. Another etiologies were considered within differential diagnosis including TB and fungal CNS infection. PPD and HIV were negative, as well as India Ink, Cryptococcal and Histoplasma antigen, fungus culture and PCR for mycobacterias. Patient continue obtunded with positive right side Babinsky. He has hx of travel to the Dominican Republic. In view of facial palsy, hypoglycorrhagia and marked elevation of proteins, TB meningoencephalitis was considered and antituberculous regimen was started empirically with rifampin, INH, PZA and ethambutol with steroids. After 48 hours of therapy administration he

showed improvement in his clinical condition, was afebrile, following simple commands and denied headaches, aphasia, fascial palsy and right hemiparesis resolved. In view of significant improvement the benefit of therapy was given no matter that CSF TB PCR and smear were reported negative. Four weeks later laboratory reported CSF culture positive for *Mycobacterium tuberculosis* susceptible to all first line anti-TB drugs. This is a case of TB meningoencephalitis that was treated empirically since CSF gram stain and PCR were negative for mycobacterias. In patients with facial palsy, CSF hypoglycorrhagia and elevated proteins levels, *M. tuberculosis* is a organism that has to be considered. Taking in consideration that mycobacterias has a long growing period, if suspected, the benefit of therapy should be given in view of significant mortality can be presented in 40% of cases.

**O-3 A Typical Presentation of Crohn's Disease in an Elder Patient and the Importance of Wireless Capsule Endoscopy (WCE) in the Diagnosis.** Lugo Yannira, MD; Reimunde Alvaro, MD, FACP, FACG; Santiago Nilda, MD. Internal Medicine. Residency Damas Hospital, Ponce, PR

Crohn's disease has a bimodal peak incidence, in the third and the sixth decade; colon involvement is particularly common among elderly patients with Crohn's. This patient had an intermittent chronic lower GI bleeding for several years with multiple negative panendoscopic tests. The (WCE) serve as the only diagnostic procedure that was able to find lesions over the bowel segments unreachable by the common upper and lower endoscopies. This is a case of a 76 years old male patient without relevant past medical history who had been complaining of intermittent rectal bleeding for approximately 3 years associated with epigastric pain, and occasional diarrhea, but no gradual deterioration or nutritional deficiencies and no extra-intestinal manifestations characteristic of Crohn's disease. On his last admission he complained of dark stools for 1 day with non radiating constant epigastric pain for which he was admitted for further study. He has no inflammatory bowel disease family history and multiple previous upper endoscopies and colonoscopies were negative for bleeding lesions. The physical examination was basically no relevant. The patient referred only mild epigastric pain on palpation and negative extra intestinal signs or symptoms. Laboratory work up showed a CBC compatible with microcytic hypochromic anemia, with no elevation in WBC count. After successfully ruling out the most common causes of GI bleeding with anemia of a chronic

nature in an elderly patient like colon cancer, diverticulosis, angiodysplasia and ulcerative colitis it was finally decided to proceed with the wireless endoscopic capsule test. The indication for WCE in this patient was; anemia with a negative panendoscopy work up result. The result of the test showed multiple areas of small bowel strictures and ulceration with oozing and multiple aphthous ulcers, typical of Crohn's disease. The patient was started on Entocort (Budesonide) 9mg 0 daily, with a good response and currently his disease is in remission. The WCE was the only test able to accurately diagnose this atypical. presentation of gastrointestinal bleeding in a Crohn's disease patient, evidencing its extreme efficacy in particular cases where regular panendoscopies fail to reach the site of lesions and give a final diagnosis in cases of occult gastrointestinal bleeding.

**O-4 Acute Pulmonary Edema as Initial Presentantion of Thyroid Storm in a Previously Undiagnosed Asymptomatic Female After a Cesarean Section.** Rosangela L. Fernandez-Medero, MD, MPH, Associate; Belkliz Torres, MD, Associate; Juan C. Román, MD; Alfonso González, MD; Orlando Vázquez-Torres, MD; FCCPM, FACP - Hospital Episcopal San Lucas/PSM

Thyroid Storm is characterized by an abrupt, severe exacerbation of thyrotoxicosis. The etiology can be related to major stress such as infection, myocardial infarct, surgery and diabetic ketoacidosis inpatients with undiagnosed hyperthyroidism or due to inadequate therapy in a hyperthyroid patient. We report a case of a 22 years old female patient with no history of systemic diseases admitted with an IUP of 36 weeks on active labor who developed a Pulmonary Edema and a Thyroid Storm few hours post a cesarean section. The procedure was performed due to cephalo-pelvic disproportion without complications, but six hours later the patient suddenly began with shortness of breath, palpitations, and chest tightness. On physical exam patient looked anxious, presenting tachycardia and tachypnea with moderate respiratory distress and bilateral basal lung crackles. The Chest X-ray reported massive vascular congestion suggesting pulmonary edema. Patient was started on oxygen supplement. In order to rule out pulmonary embolism as the etiology of pulmonary edema a V/Q Scan was obtained, which reported low probability. A 2-D Echocardiogram showed: LVEF 60 % and severe mitral valve insufficiency. Because patient continued with respiratory distress, hypoxemia and tachycardia, non responsive to a diltiazem drip, a thyroid function test was

requested considering a post-partum thyroiditis. TSH levels was  $< 0.01$  IU/ml, Free T4  $> 12$  ng/dl, and T uptake: 46%. The patient was diagnosed with Thyroid Storm and started in propylthiouracil, beta blockers and, IV steroids. The patient had an undiagnosed hyperthyroid presenting as thyrotoxicosis complicated with a Thyroid Storm, congestive heart failure and pulmonary edema secondary to the stress of a Cesarean section hyperthyroidism is the second most common endocrine problem in pregnant women. Clinical hyperthyroidism is diagnosed only in 0.1% to 0.2% of all pregnant women. Most complications occur in patients who are undiagnosed or uncontrolled. These patients have greatest risk for pregnancy-induced hypertension, premature delivery, congestive heart failure, thyroid storm and infectious complications. Normal pregnancy mimics and amplifies some of the hyperdynamic cardiovascular changes that are caused by thyrotoxicosis. Approximately 53% of pregnant women with untreated hyperthyroidism develop thyroid storm.

**O-5 Tetanus: Still a Menace?** Yolanda Figueroa, MD; Michelle Rivera, MD; Carlos González, MD, FACP -University of Puerto Rico School of Medicine, San Juan, Puerto Rico

**Case report:** Tetanus, although a known preventable cause of death, many adults are inadequately accinated against this pathogen. In the US the annual incidence between 1998 to 2000, was 0.16 cases per million population, with a predominance in the over 60 y/o population. An 80 year old male with High Blood Pressure and Prostate cancer treated with radiation and resection 7 years ago, presented progressive dysphagia and lock jaw four days prior to admission. After an evaluation by a primary care physician, he was treated as an URT infection with antibiotics. After three days, in view of no improvement and worsening of symptoms, patient visited the center of diagnosis and treatment of Isabela where he was sent to ASEM for further evaluation by ENT service. Upon arrival signs and symptoms pointed to generalized tetanus, and suspicion confirmed after a thorough history revealing that 15 days prior to the beginning of symptoms, he suffered a nail puncture in his right hand. He did not sought medical attention at that time, and he had no history of recent vaccines. Immediately he was transferred to the ICU, where he received tetanus toxoid and 6000 U Tetanus IgG, distributed trough out his body intramuscularly. Patient was nasotracheally intubated and placed in mechanical ventilatory support for adequate neuromuscular blockade and sedation. For management of autonomic dysfunction, patient received beta adrenergic blockers to maintain a heart

rate between 60 to 65 bpm. As adjunctive antimicrobial therapy Flagyl was elected. He continues under supportive treatment.

**O-6 Ileal Perforation Secondary to Disseminated Fungal Infection.** Hurnberto M. Guiot, MD, Associate; Jorge Bertrán-Pasarell, MD; Carlos Sánchez-Sargentón, MD-UPR School of Medicine

Fungal infections can evolve into disseminated and serious clinical pictures, especially in patients with compromised immune status. We report the case of a 43 year-old male pharmacy assistant from Camuy, Puerto Rico, who presented to our institution with pancytopenia and an acute abdomen. Abdomino-pelvic CT scan suggested mesenteric ischemia. During emergent exploratory laparotomy he was found with perforated ileum and liver granuloma. Seven days after surgery he persisted with recurrent fever and pancytopenia (WBC 3,200 per :1L, which later worsened to 1,800 per :1L; hemoglobin 9.2 g/dL; Plateletes 65,000 per I: 1L) despite intravenous antibiotic therapy with piperacillin/tazobactam and metronidazole. Pathology report showed granulomatous enteritis, perforated, with suppurative peritonitis secondary to histoplasmosis, confirmed by PAS stain. Bone marrow aspiration showed histiocytosis with encapsulated organisms in some of the histiocytes. Bone marrow culture showed a yeast-like organism that is growing in vitro as mold. Histoplasma PCR is pending. Our patient was started in intravenous antifungal therapy with amphotericin B lipid complex (3 mg/kg/day) for 14 days, after which he was changed to oral itraconazole 200 mg twice daily. Resolution of fever occurred in the first 48 hours. He was found to be HIV positive (confirmed by Western Blot) with 66 CD4 T-cell count and 615,000 viral copies. He denied intravenous drug use, but admitted several unprotected heterosexual contacts. This case illustrates an ileal perforation secondary to disseminated histoplasmosis as first manifestation of HIV seroconversion and successful treatment, with amphotericin B lipid complex. Histoplasmosis is the most prevalent endemic mycosis in the United States and it is also endemic in Puerto Rico. In most persons, infections are subclinical or asymptomatic, but in some immunocompromised persons effective cellular immunity never develops and disseminated histoplasmosis can occur. Disseminated histoplasmosis complicating HIV infection is an AIDS-defining illness that occurs in 1% of AIDS patients nation-wide, but it can be much more common in endemic areas. Although gastrointestinal ulcerations (particularly in ileum) have been well described (occurring in up to 35-40% of patients), we found only a

few reports of ileal perforations secondary to disseminated histoplasmosis in literature. Efficacy of treatment with lipid formulations of amphotericin B in solid organ recipients is well established, but successful therapy with amphotericin B lipid complex in patients with HIV (as in this case), although theorized, has not been widely reported.

**O-7** **An Unusual Case of Abdominal Pain.** Ofelia Rodríguez, MD; Eduardo Quesada, MD; Eduardo Aquino, MD; Associate, Miguel Pérez Arzola, MD, FACP; Felix Cortés, MD MACP, FACC, Jesús Monasterio, MD, FACS Internal Medicine Residency Damas Hospital

This case is a 63 years old female that was admitted with abdominal pain mainly localized in the left lower quadrant, with diffuse radiation to the rest of the abdomen. It persisted for two days and worsened on the day of admission. It was associated with two episodes of vomits and fever. She has no urinary symptoms or lumbar zone tenderness. No familial history of dextrocardia. Physical exam: discrete abdominal, distention; bowel movements diminished at the left lower quadrant with guarding and rebound tenderness at this site. The remainder physical examination was normal. ECG findings: Lead I: P, QRS and T waves inverted or upside down. Lead II: represents the usual lead III and vice versa. AVR and AVL: reversed and prominent negative deflections are seen in AVL rather than in AVR. AVF: Unaffected. V1-V6: complexes of decreasing amplitude. V1 is the equivalent of the usual V2 and vice versa. Differential diagnosis was made with dextroposition of the heart, dextroversion of the heart and misplaced electrodes. Chest X-Ray: Findings described are consistent with situs inversus totalis. Abdominal and pelvic CT: situs inversus, inflammatory process at cecum and proximal ascendant colon which were located on the left side of the abdomen, most likely the Manifestation of a perforated appendicitis. No abscess was seen or free intraperitoneal air. The patient was started on empiric antibiotic coverage with cleocin and cipro. Surgical intervention was performed with the finding of perforated and gangrenous appendix and severe inflammation at the left side. Post-op garamycin was added to the therapy. The surgical wound was closed by second intention 3 days later without complications. The patient recovered and was discharged home to continue with oral antibiotic therapy. The incidence of dextrocardia in situs inversus is 1:5,000 to 1:10,000. A review of the American medical literature from 1965 to present revealed only 13 acute presentation of situs inversus, with the following distribution: appendix (4 cases), trauma (4 cases), cardiovascular (3 cases), gastrointestinal (3 cases),

gallbladder (3 cases), spleen (1 case). The case presented is a typical “after-the-facts-findings” were the initial evaluation overlooked a typical presentation, just side-reversed.

**O-8** **An Unusual Cause of Massive GI Bleeding: Small Bowel Gastrointestinal Stomal tumor (GIST).** Ana De Jesús, MD, Associate; J. Román, MD; Associate, J. Gutiérrez-Núñez, MD, FACP, E González, MD, Associate; Rafael Pérez, MD. - Veterans Affairs Medical Center, Medical Service, San Juan, Puerto Rico.

58 year old male with history of osteoarthritis presented to San Juan VA Medical Center complaining of two days history of melena after he was started on Naproxen five days previously, in addition to two years history of sulindac use. Upon admission he was found with port wine bleeding on rectal exam and negative nasogastric lavage. Significant decrease in Hgb/Hct levels 9.2/26.9 (baseline three months earlier 15.8/45.3) was reported. Initial impression of NSAIDS induced peptic ulcer disease, versus bleeding secondary to diverticulosis were suggested as etiologies. Upper endoscopy with superficial gastric ulcers and duodenitis and lower colonoscopy with few diverticuli on sigmoid and cecum but no bleeding site identified. He developed episodes of hematochezia with hemoglobin drop to 6.9 and became hemodynamically unstable. In view of negative findings on endoscopy and colonoscopy that could explain massive amount of blood loss, bleeding scan was performed. It revealed active gastrointestinal bleeding in the left side of abdomen originating from small bowel. Angiography revealed bleeding at jejunal branches and required embolization but it was partially successful. The patient required 17 units of pack red blood cells transfusions. Emergent exploratory laparotomy found with jejunal mass that was resected. Pathology with evidence of Gastrointestinal stromal tumor (GIST) of low malignant potential and negative margins of resection. Bleeding resolved and hemoglobin continued, stable. GIST are uncommon and account for <1% of GI malignancies. Usually located in the stomach, where it can be addressed by upper endoscopy. We report that acute life-threatening bleeding with hemodynamic instability can occur with this type of malignancy. Even in patients with NSAIDS use, further etiologies should be considered in the workup of massive GI bleeding with benign upper and lower endoscopy. Angiography can facilitate location and diagnosis of source of bleeding. In our patient the accurate diagnosis of GIST in small bowel resulted in

complete resection and cure. Complete resection can be accomplished in 70% of primary non-metastatic tumors with the clinical suspicion at the appropriate timing.

**O-9 Crescentic Membranous Glomerulonephritis in an Elderly Man with Positive Serology for Hepatitis C and Systemic Lupus Erythematosus.** Nelson Matos, MD, Guibel Perera, MD, William Hurtado, MD, Laura Lespier, MD, FACP, Héctor Córdova, MD, FACP. Medical Service, Veterans Affairs Medical Center, San Juan, PR

A 66 y/o man with hypertension, osteoarthritis and lumbar disk herniation was admitted with anasarca of three weeks of evolution. He was taking Rofecoxib, Valdecocixib and Lisinopril. Anasarca was accompanied by general malaise, fever, arthralgias and myalgia.

Laboratory results showed a BUN of 46.4 mg/dL and a creatinine of 1.8 mg/dl with a total protein on a 24 hr urine collection of 4.26 g/24 hrs. Initial chest-X-ray showed bilateral pleural effusions.

Platelet count was low and Thrombotic Thrombocytopenic Purpura was initially considered. Several transfusions of fresh frozen plasma were given without improvement. A percutaneous kidney biopsy was performed. The preliminary result was compatible with lupus nephritis. Serologic studies revealed: low C3 (57 u), low C4 (<6 u), ANA >1:2560 (diffuse), anti-DS-DNA > 200 units, anti-RNP 1.97 u, anti-Smith <1.0, positive Hepatitis C antibody, positive RA factor, cryocrit <1%, positive anti-SS-A. The patient was started on cyclophosphamide and high dose prednisone. A week later, he developed an episode of non-sustained ventricular tachycardia. He was transferred to CCU for close monitoring and cyclophosphamide was discontinued. Azathioprine was started. Cardiac catheterism performed w/o evidence of coronary artery disease with a LVEF of 55%. A gallium scan was negative for myocarditis but shows a perihilar process. A chest CT scan was performed that only showed a large left pleural effusion. The final kidney biopsy report showed with immune-complex glomerulonephritis with membranous pattern and crescents. Renal function slowly improved with resolution of protein range proteinuria and normalization of serum complements and ANA titer. Crescentic glomerulonephritis is an unusual presentation of SLE in the elderly (less than 1%). Even though 20-40% of HCV-infected patients have ANA seropositivity, only a few cases of SLE coinciding with HCV infection have been reported. The presence of nephropathy in HCV-infected patients with ANA seropositivity should prompt the physician to obtain a kidney biopsy to diagnose lupus nephritis. Membranous lupus nephritis is favored over

HCV-associated membranous GN due to the presence of subendothelial mesangial extensions and irregular glomerular proliferative changes in addition to the subepithelial immune deposits. The diagnosis of lupus nephritis had important therapeutic implications in our patient resulting in marked improvement in renal function.

**O-10 Pheochromocytoma, an Elusive Diagnosis of Secondary Hypertension Depending on Clinical Presentation.** Yolanda Figueroa, MD; Eduardo González, MD; Marielsa Rabelo, MD; Vilma Rabell, MD, FACP University of Puerto Rico School of Medicine, San Juan Puerto Rico

A 26 year old female with history of allergic rhinitis and no systemic illness who 8 months prior to admission started to present intermittent period of diaphoresis, headaches, and palpitations lasting minutes to hours which were not associated to a particular circadian pattern. Other associated symptoms were constipation and pallor. Due to these symptoms she sought evaluation by a cardiologist and neurologist 6 months prior to admission. Physical examine revealed no elevated blood pressure. 24 hour cardiac monitor was negative for pathology. During that time period she noticed that medication Allegra D exacerbated these episodes. Three months prior to admission the intermittent episodes were becoming more frequent and prolonged. She sought medical evaluation by primary physician 2 months prior to admission. For the first time elevated blood pressure was documented. Altace was prescribed with no response. Worsening symptomatology made her seek evaluation at hospital where she was admitted. Suspected pheochromocytoma was entertained due to history of pheochromocytoma and neurofibromatosis in 2nd degree relative. Work up revealed both elevated VMA and catecholamine in 24 hour urine collection. CT scan of abdomen revealed 4.1 cm left adrenal mass. After alpha blocker therapy laparoscopic resection of pressures. Laboratory workup characteristic associated with MEN syndrome or neurofibromatosis. Pheochromocytomas are responsible for hypertension in 0.2 % of patient making it an elusive diagnosis in the absence of elevated blood pressure at time of evaluation. Timely diagnosis is extremely important due to high morbidity in untreated patients and since surgical intervention could be curative. Current data suggest that genetic testing should be done in cases of sporadic pheochromocytoma due to possibility of inheritance. This patient is being considered for genetic testing.

**O-11 Acetylcholine Receptors Antibody Negative Myasthenia Gravis Presenting During Last Trimester of Pregnancy.** Alfredo Terrero, MD, (Associate); José Ramírez-Rivera, MD,FACP.- Department of Medicine, Universidad Central Del Caribe, School of Medicine, Bayamón, Puerto Rico.

Myasthenia gravis is an autoimmune disease characterized by weakness and fatigue of the skeletal muscles of the face and extremities. Twice as many women are affected as men, usually in their second or third decade of life. Pregnancy is associated with 19-41% of exacerbations. We present a 19 year old, mother of two, who came to the outpatient clinics of neurology 10 days after her last Cesarean section with involuntary inward movement of the eyes, diplopia, palpebral ptosis, difficulty in maintaining erect her shoulders and trouble swallowing liquids and solids for the preceding 3 months. The day of consultation she began with shortness of breath. On examination decreasing of intensity of her voice, slurred speech, bilateral palpebral ptosis, and mild dropping of shoulders were found. The temperature was 36.6 degree Celsius, pulse: 90 per minute, respiratory rate: 18 per minute and blood pressure: 135/85. Arterial blood samples showed PH of 7.38, PCO<sub>2</sub> of 50mm Hg, PO<sub>2</sub> of 70mm Hg, and oxygen saturation of 94%. The tensilon test was positive and diagnosis of myasthenia gravis was confirmed. Treatment with solumedrol 60mg intravenously, immunoglobulins 0.4g/kg/d intravenously and oral mestinon 60 mg every 6hrs plus oral mestinon 180mg SR at bed time were initiated and rapid improvement occurred. She was discharged 2 weeks after the admission. Five attempts to demonstrate acetylcholine or anti-stratial antibodies in her serum have yielded negative results. Electromyography showed early neuromuscular junction dysfunction. The underlying pathophysiology of myasthenia gravis is the production of auto antibodies against human acetylcholine receptors, usually an immunoglobulin G. These antibodies interfere with the conduction of impulses across myoneural junctions by decreasing the number of available acetylcholine receptors. Those with more severe disease usually have higher titers. However, in 10-20 % of patients these antibodies are not detected. Forty percent of this group have an antibody to muscle-specific tyrosine kinase. They are "MUSK positive"; a finding associated with localized disease, more severe bulbar involvement and lesser response to immunomodulation treatment.

**O-12 Disseminated Fungal Infection with Severe Cutaneous Involvement in a Kidney Transplant Recipient.** Humberto M. Guiot MD (Associate), Rosana Amador MD (Associate), Jorge Bertran-Pasarell MD, José Gutiérrez Núñez, MD, FACP UPR School of Medicine, San Juan, PR

Infections in immunocompromised patients can have atypical presentations or can disseminate more often. We report the case of a 24 year-old male patient with kidney transplant and arterial hypertension, using amlodipine, prednisone, and tacrolimus (unknown dose). Patient had poor medical compliance, with no follow-up for more than 6 months. Approximately since that time, the patient developed a nodular painless lesion in his left foot, which became larger with time. Gradually, similar lesions of different sizes appeared over entire body. Some of them drained spontaneously a purulent greenish/yellowish material. Three days before admission, he started with generalized, severe, throbbing headache without visual symptoms but reported neck rigidity. His mother manifested change of behavior and irritability. Neighbors, worried about patient's absence and about pestilence coming from his house, notified police authorities and brought him to our institution. Upon examination, the patient was morbidly obese, afebrile, alert and oriented, but irritable, with occasional crying spells during interview and exam. Strong, pestilent odor was present. He had tachycardia (121 beats/min). Skin examination was impressive, as patient showed multiple nodular lesions, erythematous, over face, back, upper and lower extremities. Some larger tumoral lesions (flesh-colored) on hands and feet were evident. Some of them, especially the biggest ones of up to 5 cm in diameter, had cauliflower appearance. There was malodorous drainage from, some of the lesions. Pictures from this case are available for illustration. Laboratories showed leukocytosis (15,200 per iL), bandemia (18 bands), anemia (hemoglobin 6.2g/dL). He had elevated renal parameters (BUN 170mg/dL, Creat 17.1mg/dL). Smear from draining lesions revealed hyaline, branching hyphae. The patient was started in conventional amphotericin B to cover fungal infection. Vancomycin and piperacillin/tazobactam were added to cover for possible over-imposed bacterial skin infection. He required hemodialysis. Over the days, patient showed clinical improvement, with significant diminution in size of lesions. Final culture identification revealed *Aspergillus*



flavus and *Aspergillus versicolor*. Skin involvement by *Aspergillus* can represent disseminated hematogenous infection, occurring mostly in immunocompromised hosts. Typical lesion is an area of rapidly increasing erythema with necrotic, often ulcerated, center. Our patient presented impressive cauliflower lesions over his body. Although smear and culture were compatible with *Aspergillus* sp., the patient's skin manifestations were very atypical from what is commonly described in literature.

**O-13 Factor V Leiden Thrombophilia, A Case Presentation.** Marinely Cruz-Amy, MD; Robert Hunter-Mellado, MD, FACP - University Hospital Ramón Ruiz Arnau, Bayamón, PR.

Hypercoagulable states represent a condition with multiple etiologies in which an interplay of acquired and congenital coagulation defects contribute to abnormal clotting. Several of the thrombophilic disorders are relatively prevalent, one person can have multiple defects, leading to thrombosis without obvious external stimuli. Factor V Leiden thrombophilia is the most common inherited form of thrombophilia and it is occasionally associated with the anomalous prothrombin G20210A mutations. In this report we present three Puerto Rican middle-aged females diagnosed with Factor V Leiden after debuting with abnormal clotting events. They all had in common being females, having been born in Puerto Rico, and having parents of European descent. The first two cases presented with deep venous thrombosis of lower and upper extremities and both had the association of Factor V Leiden and prothrombin G20210A mutation. The third case presented with cerebrovascular accident, evidencing arterial thrombosis, after receiving estrogen replacement therapy. This report adds Factor V Leiden as a cause of hypercoagulable states in Hispanic Puerto Rican patients.

**O-14 Successful Autologous Bone Marrow Transplantation (ABMT) in a Patient with Refractory Immune Thrombocytopenic Purpura (ITP).** Santa Merle, MD (Associate). Justiniano Castro, MD; Adry Fernández, MD; Jean Fradera, MD; Deana Hallman, MD; Alberto López, MD; Genoveva Martínez, MD; Eileen Pacheco, MD; Sixto Pérez, MD; Anzel Román, MD; Enriau Vélez-García, MD; Hematology and Medical Oncology Section, Department of Medicine, UPR School of Medicine, San Juan, Puerto Rico, 00936

ITP is an autoimmune disorder characterized by low platelet counts unrelated to any systemic illness. The

incidence is 100/ million persons/year. Its pathogenesis is related to the formation of specific autoantibodies and T-cell mediated platelet lysis. ITP usually responds to treatment with steroids and/or splenectomy and refractory cases are treated with immunosuppressive therapy. Completely unresponsive cases are rare; one such case is the subject of this report. A 17 year old female without history of systemic illnesses presented in February 2003 with severe thrombocytopenia (1,000/mm<sup>3</sup>) and spontaneous hematomas. Initial work up was normal, including HIV, ANA test, B12 and folic acid levels, imaging and cytogenetics studies. Peripheral smear, CBC and bone marrow aspiration were compatible with ITP. First line therapy with steroids and IV gammaglobulin was given. Splenectomy was performed because of persistent transfusion dependent thrombocytopenia. Further therapy included vincristine, high dose steroids and treatment for *Helicobacter pylori*. Other second line therapy alternatives were tried unsuccessfully such as: cyclophosphamide, rituximab, interferon, azathioprine, cyclosporine and plasmapheresis. Subsequently, the patient developed acute renal failure, hematuria, respiratory failure and severe peripheral neuropathy with foot drop. Mucosal bleeding and platelet counts of <10,000/mm<sup>3</sup> persisted; by May 2003 the patient was bedridden. The patient was transferred to the National Institutes of Health to enter a clinical trial consisting of high dose chemotherapy and ABMT. Seven months after the ABMT the platelet count increased to 100,000/mm<sup>3</sup> and has been sustained at levels >150,000/mm<sup>3</sup> after 15 months of follow up. To our knowledge, this is the first documented instance of successful ABMT in a patient with refractory ITP in Puerto Rico.

**O-15 Central Diabetes Insipidus, an Uncommon Cause of Hypernatremia in Elderly.** Rafael Chiong MD (Associate); Alfredo Ramírez Justiniano MD; Milton D Carrero, MD, FACP., and José Ramírez Rivera, MD., FACP, Dr. Ramón E. Betances University Hospital, Mayaguez, Medical Center.

A 70-year-old man with hypertension, dyslipidemia and prostatitis, was admitted with progressive weakness, dry mouth and increased thirst for the last 24 hours after participating in a political meeting which lasted over 12 hours. For more than 20 years he has had increased urinary frequency as well as dry mouth. He drinks approximately 5 to 6 liters of water and urinates around 6 liters daily and had to get up 4 or 5 times per night to urinate. On physical exam the patient appeared alert, oriented and with good hydration. The heart rate was 76 x min and the blood pressure was 140/70 mmHg. The fasting glucose was 87

mg/dl; the serum sodium was 150 mmol/L, potassium 3.95 mmol/L and Chloride 112 mmol/L; the BUN was 15 mg/dL and creatinine was 1.3 mg/dL. The plasma osmolality was 286.9 mOsmol/l; the urinary sodium was 30.6 mmol/L; the urine specific gravity was 1.005; the creatinine clearance was 53 mL/min. Estimated water deficit was 2.73 liters. A brain MRI showed no pituitary abnormalities. In a water restriction test the patient lost 4 pounds in 6 hours; neither the specific gravity or the urine osmolality changed. After the administration of 4 mg of desmopressin intravenously serum osmolality dropped from 305 mOsmol/L to 280 mOsmol/L and urine osmolality increased from 108 mOsmol/L to 411 mOsmol/L. The patient was discharged with diagnosis of Partial Central Diabetes Insipidus. The clinical manifestation of hyponatremia are non specific and often subtle, particularly in the elderly. Mortality from hyponatremia in the elderly is high (10%-60%) as these patients often have other serious comorbidities. Coma and respiratory arrest may occur when extracellular fluid osmolality exceed 360-380 mOsmol. Maintenance of adequate fluid intake is the most important therapy. Life threatened in patients who cannot respond to their thirst drive because of dependence on a caregiver, or in post-surgical patients.

## POSTER PRESENTATIONS

**P-1 White Lung in a Young Male Patient.** Adamar Munoz, MD, Associate; Eduardo Cartagena, MD, Member; Armando Torres, MD, Member; Jose H. Martinez, MD, FACP; Juan L. Perez, MD San Juan Bautista Medical Center, Caguas, PR  
This is the case of a 29-year-old patient with no history of systemic illness that was a brief smoker of 1/2 pack of cigarettes per day for two months prior to admission. The patient is a construction worker that for the last several months has been working on sick buildings in New York City, many of them with pigeon's droppings. For two months the patient started to present with general malaise and weakness, low grade fever, and shortness of breath. Patient sought medical evaluation and treatment with primary care physician without improvement of symptoms. He arrived to our Institution and was hospitalized with the diagnosis of Interstitial pneumonia, suspected Pneumocystis and carinii pneumonia and suspected Tuberculosis. Chest CT scan showed opacification of the left upper lobe with left pleural effusion and a generalized reticulonodular pattern throughout the entire lungs. Acid-fast, HIV and tuberculin skin test were negative. Bronchoalveolar lavage (BAL) showed to be posi-

tive for Histoplasmosis' and patient was treated with itraconazole and supportive treatment. Patient started to present some mild clinical improvement but a new chest x-ray showed worsening of left pleural effusion with a white left lung. At the same time the patient started to present pleuritic chest pain, shortness of breath, cough and fever. A pleural tap showed exudative effusion with a pH= 7.0 and an assessment of empyema was made. A chest tube was inserted but it failed to drain the effusion. For this reason the patient was taken to surgery for a pleural decortication where an incidental finding of a left lung mass was made. A biopsy of the lung mass was performed which surprisingly showed bronchoalveolar carcinoma. This case shows the importance of looking for immunosuppression in patients with an infection that should be self-limiting in most of the cases.

**P-2 An Unusual Case of Invasive Adenocarcinoma of Common Bile Duct.** Rosangela L. Fernandez-Medero, MD, MPH (Associate); Alfonso Gonzalez, MD, Juan C. Roman, MD; Ferdinand Panelli, MD, FACP, - Saint Luke's Memorial Hospital, Ponce, Puerto Rico.

Cholangiocarcinoma is an uncommon neoplasm of the gastrointestinal tract. It accounts for less than 0.2% of all human malignancies. Its incidence has increased significantly in the United States over the past two decades, with a parallel increase in the associated mortality to about 2,500 to 3,000 deaths per year. It has three presentations: intraductal, intrahepatic and rarely in the distal common bile duct. Two thirds of the cases are ductal cholangiocarcinoma, which includes Klatskin Tumors. The rest are intrahepatic tumors which are often misdiagnosed as metastatic adenocarcinoma. We present a rare case of distal common bile duct cholangiocarcinoma. A 56 year old female patient admitted with abdominal pain, pruritus and jaundice of 2 weeks. Past medical history significant for Diabetes Mellitus, Systemic Lupus Erythematosus, and cholecystectomy on June 2004. On admission patient looked undernourished, icteric sclerae and benign abdomen. Laboratories included liver function test: Albumin: 1.7, Total bilirubin: 22.38, Direct Bilirubin: 18.23, ALP: 1597, TP: 5.4, ALT: 315, AST: 332. A Magnetic Resonance Cholangio-Pancreatography showed a mass in the head of pancreas causing severe dilation of intra and extra hepatic bile duct as well as pancreatic duct. Endoscopic Retrograde Cholangiopancreatogram demonstrated normal looking ampulla. Pancreatic duct had a distal stricture with proximal dilation up to 3mm; common bile duct showed distal stricture with proximal dilation up to 15 mm, and dilation of intrahepatic duct up to 6 mm. A 10 French, 9 cm plastic stent was placed in the

common bile duct. A Whipple's procedure was performed after ERCP. Tumor pathology reported an adenocarcinoma of common bile duct, moderately differentiated involving head of pancreas extending beneath ampullary mucosa and upward beneath the bile duct mucosa. Local lymphatic penetration and metastasis to four lymph nodes of seven perigastric nodes was present. Patient had a good post operative recovery and was discharged home with hematology oncology and radiation oncology follow up.

### **Use of Contrast Echocardiography in the Evaluation of a Bloody Pericardiocentesis.**

**P-3** José Escabi-Mendoza, MD, FACC; Martínez-Díaz, MD, FACC; Eric Aviles, MD; Manuel Angel Figueroa-González, MD, Luis Rodriguez-Ospina, MD, FACC.

We report two patients with cardiac tamponade that presented with a bloody pericardiocentesis immediately upon needle insertion. Case 1: An 81 year old male arrived with complaints of progressive dyspnea even at rest, increase abdominal girth and leg swelling since 2-4 weeks prior to his evaluation. He presented with tachycardia, hypotension, pulsus paradoxus (23 mmHg), (+) Kussmaul sign, pericardial friction rub and severe peripheral edema. His chest radiography presented with a huge cardiomegaly. The electrocardiogram revealed a sinus tachycardia with low voltage. By echocardiography he had a large pericardial effusion with findings indicative of hemodynamic compromise: right ventricle collapse, reciprocal respiratory variations of the ventricular inflow velocity by more than 25% and a plethoric inferior vena cava. Case-2: A 74 year old male with history of a recurrent idiopathic pericardial effusion. He underwent two separate therapeutic pericardiocentesis in the preceding months. He presented again with shortness of breath, pleuritic chest pain, hypotension, jugular venous distension, and pulsus paradoxus of 15 mmHg. Upon echocardiography he presented evidence of right ventricle collapse, paradoxical septal motion, and a significant ventricular inflow velocity variation with respiration, compatible with cardiac tamponade. In both cases echocardiographic guided subcostal pericardiocentesis was performed. Both presented with bloody fluid without evidence of clot formation. In the first case a bolus of Definity (r) contrast was injected causing a cloudy appearance within the pericardial sac viewed with echocardiography. This finding confirmed the proper location of the needle. This patient had an immediate hemodynamic improvement with the pericardiocentesis. However, in the second case, the operator decided to introduce the pericardial catheter to proceed with fluid removal. After removal of a persistent

bloody fluid without noticing hemodynamic improvement the operator performed a hematocrit determination of the fluid that was similar to his peripheral blood hematocrit. He then proceeded to inject Definity(r) solution through the pericardial catheter, with evident visualization of the contrast within the intracardiac chambers, confirming an erroneous intracardiac placement by muscle perforation. For this reason he was immediately taken to the operation room where an emergent pericardial window was performed. Both patients recovered completely. Conclusion: the use of Definity(r) contrast is a fast, effective and safe method to verify the correct position of the pericardiocentesis needle in the case of a bloody pericardial fluid. The benefit of such intervention clearly results from avoiding further delay of a therapeutic pericardiocentesis, when time is of essence in a patient with hemodynamic compromise.

### **Cutaneous Leukocytoclastic Vasculitis Due to Skin Fungal Infection in an HIV Positive Patient.**

**P-4** Rosángela L. Fernández-Medero, MD, MPH - Associate; Belkiz Torres, MD Associate; Alfonso González, MD; Gabriel Martinez, MD, FACP; Orlando Vazquez-Torres, MD, FCCP, FACP - Hospital Episcopal San Lucas/PSM, Ponce, Puerto Rico.

Leukocytoclastic vasculitis is a histopathologic term commonly used to denote a small-vessel vasculitis. Many causes exist for this condition, but is not found in as many as 50% of patients. Because the condition is presumed to be rare, in the United States the incidence is unknown. Infections may directly trigger an inflammatory vasculitic process, for example bacterial and viral infections. In addition the inflammatory response around the blood vessel has been associated with certain systemic fungal diseases. Also a leukocytoclastic vasculitis, predominantly involving the skin, may be a minor component of many other infections like subacute bacterial endocarditis, Epstein-Barr virus and HIV. We report a case of a 36 years old inmate HIV + male patient that presented with a one day history of generalized rash with sparing of palms and soles, associated with sore throat, nausea and vomits x 3. He was admitted one month prior due to anemia with similar skin rash. He denies history of allergies. On physical exam patient presented generalized erythematous rash described as maculopapular rash in different healing stages, and hyperemic pharynx. The patient was admitted for IV antibiotic and antifungal therapy considering a possible fungal infection. On admission he had leucopenia of 1.7 and anemia of 8.9 mg/dl. His CD 4 count was 1.3 and viral load 56,738 copies. The blood cultures were negative for

bacteria and fungi. A skin biopsy was performed reporting Leukocytoclastic Vasculitis due to fungal infection. The GMS and PAS stains were positive for oval spores and hyphae. The skin culture for fungi showed few growths of *Candida parapsilosis*, which is an important non-albicans species that infects bloodstream of hospitalized patients mostly due to indwelling catheters. Various infections may be associated with vasculitis, including viral hepatitis and upper respiratory tract infections, particularly those caused by beta-hemolytic streptococcus. Leukocytoclastic vasculitis has been also associated with systemic fungal infection but as a result of a skin limited infection has been poorly documented. HIV infection may also be associated with some cases of cutaneous vasculitis. Ascertaining whether a drug or an infection is responsible for the disease is sometimes impossible because the occurrence of vasculitis postdates infection and the administration of the drug used as treatment. The specific cause of the Leukocytoclastic Vasculitis in this case was established as skin limited fungal infection by *Candida parapsilosis*.

**Acquired Cystic Renal Disease Complicated with Renal Cell Carcinoma .**

**P-5** Sarahi Rodriguez-Pérez, MD (Associate), José Ramirez-Rivera, MD, FACP; Francisco Jaume-Anselmi, MD, FACP; Efraim Flores De Hostos, MD, FACP - Hospital de la Concepción-Ponce School of Medicine Consortium, San German.

The development of acquired renal cystic disease in patients undergoing hemodialysis may be complicated by renal cell carcinoma. The following case illustrates this circumstance. A 73-year-old man with end stage renal disease in chronic hemodialysis was admitted to the hospital because of hematuria and a right flank pain. An ultrasonographic examination of the abdomen showed rupture of a right renal cyst. Thirteen years before admission, he was referred for evaluation because of proteinuria, microhematuria and a serum creatinine of 3.2 mg/dL. Renal biopsy showed chronic tubulointerstitial nephritis. Eleven years before admission hemodialysis was started. Eight years before admission recurrent episodes of hematuria developed. At this time diffuse cystic renal disease was noted in an ultrasonographic examination. Four years before admission abdominal CT scan showed a dense left renal lesion, suggesting neoplasia and a left nephrectomy was performed. There was parenchymal atrophy and multiple cortical cysts. Microscopic examination demonstrated chronic glomerulonephritis and cystic disease but no renal carcinoma. Two months before admission the abdominal CT reported atrophic changes of the right kidney with

multiple masses. He was scheduled for nephrectomy suspecting renal cell carcinoma. On physical examination the temperature was 37°C, the pulse was 68 beats per minute, respiratory rate 18 breath per minutes and blood pressure 130/85 mmHg. The right flank was tender. The rest of the physical examination was within normal limits. The Hb 14.4 g/dl, Hct 45.4%, WBC 11,800/mm<sup>3</sup>, Plts 294,000/mm<sup>3</sup>. The urine was red, with abundant red blood cells. The BUN was 47 mg/dl and the creatinine 9.7 mg/dl. A right laparoscopic nephrectomy was performed. Microscopic examination demonstrated renal cystic disease associated with multifocal cystic renal cell carcinoma, clear cell type, nuclear grade II. There was no extra renal extension or renal pelvis involvement. The patient was discharged 2 days after surgery to continue hemodialysis. Staging is the most consistent variable that determines prognosis of renal cell carcinoma. Patients with end stage renal disease who have been on hemodialysis for three to five years should undergo yearly screening with ultrasonography. Once the ultrasonogram becomes positive for cysts, the more sensitive contrast enhanced CT scanning should be performed yearly to screen for the possible occurrence of renal cell carcinoma.

**A Case of Uterine Intravascular Leiomyoma Tosis. 5 Cardiac Masses, Pulmonary Embolism and Tricuspid Val VB Involvement.**

**P-6** Hernan A. Gomez, MD (Associate). Alma Corbala, MD. (Associate). Milton D. Carrero, MD, FACP. and Raul Garcia-Rinaldi, MD., FACC. by invitation. Dr. Ramon E. Betances University Hospital, Mayagüez Medical Center.

A 44 year old woman previously asymptomatic presented with fatigue. A pelvic CT scan showed an enlarged uterine fundus and large adnex. masses. Her physical examination was normal except for a 3rd heart sound and a mild respiratory distress.

Labs on day of admission:

BMP: Sodium:	135.9 meq/l	CBC: Hemoglobin:	8.4 g/dl
Potassium:	4.04 meq/l	Hematocrit:	25.9%
Chloride:	104.7 meq/l	WBC:	13,4000/ul
Bun:	7 mg/dl	Platelets:	319,000/ul
PTT:	43.3 sec	Glucose:	108 mg/dl
INR:	1.42		

An echocardiogram showed five large masses in various portions of the right atrium and ventricle. One large mass moved in reciprocal manner across the tricuspid valve. Cardiothoracic services were consulted and emergency open heart surgery was performed. The patient underwent

excise 0 5 cardiac masses, 2 of them fused to chordae of the tricuspid valve. A huge tumor mass was extracted from the pulmonary artery. The tricuspid valve wa5 repaired with PTFE neo-chordae. She recovered well from the operation. The cardiac and pulmonary artery masses consisted of bundles of benign smooth muscle, positive for progesterone markers suggestive of uterine origin. She underwent total abdominal hysterectomy; removal of three masses from the inferior vena cava and a paracolic mass. The patient recovered well. The pathology in all specimens was the same: bundles of smooth muscle tissue positive for progesterone markers. The uterus had evidence of intravascular leiomyomatosis. Intravascular leiomyomatosis is a rare condition. . Smooth muscle tissue of uterine origin, invades the veins of the uterus and extend into the vena cava, the right heart or the pulmonary artery or embolize to these structures. Surgical excise is required to retrieve the obstructive symptoms. Operation can be performed in a simple of2 stages. To achieve a cure, all masses in the abdomen, pelvis, heart and lungs must be resected.

**P-7 Hemobilia and Pseudoaneurysm After Laparoscopic Cholecystectomy, a Rare Cause of Upper Gastrointestinal Bleeding (UGIB).** Dagmary Purcell MD (Associate); Wilfredo Pagani, MD; Lopez-Myere, MD- VA. Medical Center and San Juan City Hospital (SJCH)

A 20 year-old woman without systemic illness underwent laparoscopic cholecystectomy on 5/25/04. On 9/26/04 she was admitted with UGIB requiring 3 units of packed red blood cells and she underwent endoscopy and colonoscopy which were negative. A Meckel Scan was non-diagnostic. She went home, but returned two days later with intractable epigastric pain. She complained of colicky abdominal pain irradiating to the back. Physical exam revealed mild icteric sclera, dry oral mucosa, epigastric, and right upper quadrant (RUQ) tenderness, voluntary uarding without rebound tenderness, viceromegally, masses, or abdominal bruits. Liver function tests, amylase, lipase were elevated, and coagulation parameters were normal. An abdominal ultrasound showed a non-dilated biliary tree and no stones. She received saline infusion and bowel rest. On day 2. she developed ntractable RUQ abdominal pain, jaundice and massive UGIB (bright red) with clots requiring saline resuscitation, multiple transfusions, and ICU transfer. An emergency endoscopy failed to reveal a source of bleeding” A bleeding scan was negative. Magnetic Resonance Cholangiopancreatography showed normal intrahepatic ducts without irregularities or filling defects.

She had intermittent episodes of hematemesis with clots and melena, associated with jaundice and RUQ pain. Angiography showed a 7.1 mm x 6.4 mm saccular pseudoaneurysm involving the right hepatic artery close to the l-cation of the surgery staples used to close the cystic duct. She underwent coil embolization of the hepatic artery. Follow up angiogram from the common hepatic artery showed collateral circulation filling the aneurysm in a retrograde fashion from the gastroduodenal artery. She required a second coil embolization to occlude the feeding artery as documented on follow up angiogram.

Hemobilia or bleeding from the hepatobiliary tract is a rare cause of upper GI bleeding. Gallstones, trauma, iatrogenia, arteriovenous malformations, inflammation, hepatic abscess, chole-cystitis, and tumors may cause hemobilia. Nowadays the frequent use of laparoscopic cholecystectomy and Inter-ventional procedures raised iatrogenic cases to the most frequent etiology of hemobilia. With a success rate ~f 80% to 100%, angiography and embolization is the first line therapy for hemobilia.’

**P-8 Ventricular Fibrillation as the First Manifestation of Hiperaldosteronism.** Yamila Delgado, MD, Eduardo Quesada, MD, Miguel Magraner, MD, FACP., Internal Medicine Residency Damas Hospital, Ponce, P.R.

This a female patient, 50 years old, with history of diabetes mellitus and hypertension in treatment with metformin (500 mg BID) and atenolol (50 mg BID), who comes to emergency room with asthenia and dizziness. Patient was also receiving alternative medicine (Dragon Blanco) that has not +icorice among its componepts. During the emergency workup presents syncope and three episodes of ventricular fibrillation, being defibrillated and treated with amiodarona (150 x 2) and one drip 1mg/m/x 6h. Then, 0.5 mg IV x 18 h. Patient was admitted to intensive care unit. Physical exam: Vitals: 160/90 mm Hg, RR: 15, Pulse: 83; Cardiovascular: systolic murmur irradiated to neck. Rest of the exam: unremarkable. Labs: .Na: 138, K: 1.6, Cl: 84, BUN: 17, Creat.: 1.1, Gluc.: 148, Renin: <0.15, Aldosterone: 20.1. Aldosterona-Renin ratio: 133. Chest X-Ray: cardiomegaly. EKG: RBBB, long QT segment and prominent broad V wave compatible with severe hypokalemia. CT SCAN Abdomen/Pelvis: 3.2 cm right adrenal mass, likely adenoma. Patient was discharged with the presumptive diagnosis of primary aldosteronism. Due to the diagnosis of diabetes mellitus, hypertension and the three episodes of ventricular fibrillation, surgical treatment was not realized until stress test and eventual coronary angiography is done. Medical literature

reviewed reports 9 references of the search ventricular fibrillation and hyperaldosteronism. Of those, only two are linked with primary aldosteronism, one of them with fatal course. The presentation of this case is particular because unusual and emark the importance of an adequate diagnosis of secondary hypertension.

**P-9 Myxedema: A Rare But Fatal Complication of Untreated Hypothyroidism.** Tania C. González-Rivera, MD, Associate Carlos González-Oppenheimer, MD, FACP, UPR, School of Medicine

**Introduction:** Myxedema is an uncommon but life-threatening form of untreated hypothyroidism with severe physiological manifestations. **Objective:** To describe the medical management of myxedema based on a case report of a patient. A 31 year old male patient with hypothyroidism since 3 months of age was brought to the Emergency Department due to slow mentation of approximately 3 months of evolution. The patient had been taking levothyroxine 225 mcg daily until 2001 when he decided to cease taking his medication. He progressively gained about 30 pounds two months prior to admission. He also developed constipation, cold intolerance, lower extremity edema, thinning of hair and general malaise. At the time of admission, patient presented with a temperature of 35°C, heart rate of 48 beats' per minute, slow mentation, bald spots, muffled voice, non-pitting edema of lower extremities and delayed relaxation phase of deep' tendon reflexes, especially at the Achilles tendon. He received treatment with hydrocortisone and levothyroxine and showed great clinical improvement with respect to his alertness. The patient was discharged home after 3 days. **Discussion:** Myxedema is characterized by mucopolysaccharides deposition in tissues such as the dermis and muscle. The acute state of myxedema coma is usually precipitated by low climate temperatures, infection, other systemic illnesses or drug therapies. Although it is becoming less common everyday, it is very important for physicians to recognize the signs and symptoms of this medical emergency.

**P-10 Unusual Presentation of Antiphospholipid Syndrome.** Yesenia Santiago MD; Grisell Ortiz MD; Carlos González MD. UPR School of Medicine, San Juan, Puerto Rico

Antiphospholipid syndrome is a rare condition associated to high mortality rate and characterized by multiple thromboembolic phenomena involving different organs. This disease presents a challenge to the clinician due to atypical and at times bizarre presentations that often

misleads initial diagnosis. Antiphospholipid syndrome presents a wide range of complications with associated mortality of up to 50%, despite adequate therapy, this making early diagnosis mandatory. A case of a 19 year old woman with past history of bronchial asthma. The patient reports left foot pain of one month evolution that progressed to involvement of bilateral legs with associated weakness, limited ambulation, numbness and paresthesias; these symptoms were evaluated at multiple health facilities. Finally the patient was referred to this institution for evaluation of suspected Guillain-Barre syndrome. On initial evaluation, the patient presented cyanosis of left foot, with diminished distal pulse and coldness to palpation with a positive Homman's sign; Lower extremity Venous Doppler was without evidence of thrombus. The patient admitted due to persistence of symptoms, then developed fever, uncontrolled high blood pressure, abdominal pain, nausea, vomiting and urinary tract infection. Eventually she developed multiple neurological deficits of 72 hours evolution, deficits of multiple cranial nerves with dysphagia, paresthesias and paralysis. The patient was transferred to MICU. Laboratories revealed positive serology for collagenous disease. Multiple imaging studies were performed. Patient complicated with nosocomial pneumonia, bacteremia, extra vascular hemolytic anemia, UTI, gastrointestinal bleeding and ileus. The patient was treated with high dose IV steroids, enoxaparin, warfarin, hydroxychloroquine, cyclophosphamide, wide spectrum antibiotics, and multiple antihypertensive therapy. She was discharged home after fiftyseven days of hospitalization with persistence of paraplegia at the level of T7. **Discussion:** Antiphospholipid syndrome is a medical challenge usually occurring in young female patient without prior history of systemic illness that can progress to serious life threatening events. The clinical presentation of this young patient was unusual, with rapid deterioration and marked multiple neurological symptoms, demonstrating that diagnosis and management must be prompt and aggressive to prevent multiple complications that might accompany this disease and lead to fatalities. This presentation will offer the opportunity to learn about the diagnosis, progression and management of the catastrophic Antiphospholipid syndrome for future cases.

**P-11 Paraduodenal Abscess: A Bilobulated Fluid Collection With Enhancing Walls Causing Gastric Outlet Obstruction in an 86 Y/O Hispanic Man .** Nelson Matos, MD, Francisco Lefebre, MD, Jose Carro, MD; Jose Gutierrez-Nuñez, MD, FACP, Doris H. Toro, MD -Veterans Affairs Hospital, Internal Medicine Program, San Juan Puerto Rico.

Case of an 86 y/o male puertorrican male, with CAD, gastritis, GERD, hypothyroidism, that underwent an upper endoscopy with antral biopsy with findings consistent with esophagitis and a colonoscopy with polypectomies. Two months later patient was admitted for evaluation of abdominal pain 6/10 which interrupted his sleep that began in right lower quadrant area that gradually irradiates to epigastric area that was associated with nausea. He was discharge with diagnosis of exacerbation of gastritis secondary to ferrous sulfate supplementation and diet noncompliance. Two weeks later patient is readmitted with 2 to 3 days of fever, shortness of breath and productive cough of green sputum with leukocytosis with shift to left. Patient was started on vancomycin and cefepime as empirical treatment for pneumonia. Initial blood cultures were *Bacteroides hetiotomomicro*. 24 to 48 hours after admission pulmonary embolism was suspected and patient was started on heparin developing coffee ground. Anticoagulation was discontinued. Patient underwent upper endoscopy revealing severe esophagitis with esophageal ulcer, stomach was filled with food, normal pylorus, small duodenal bulb ulcer, duodenal fullness, and a duodenal lipoma. In the next several days, the patient developed progressive abdominal distension, pain and succussion splash therefore gastric outlet obstruction was suspected. Nasogastric tube was placed draining over 3 liters of gastric contents. Abdominal CT revealed a bilobulated fluid collection with enhancing walls adjacent to antrum producing mass-effect upon cystic duct with distention of the gallbladder and stomach outlet obstruction. Patient underwent a percutaneous drainage of purulent material with growing a Gram negative bacillus. The patient was started on intermittent nasogastric suction, total parenteral nutrition, ciprofloxacin and metronidazole to cover intrabdominal pathogens. After complete drainage a follow up CT scan showed resolution of obstruction and improvement of symptoms. Discussion: paraduodenal abscess should be considered in the differential diagnosis of gastric outlet obstruction.

**P-12 Non-Hodgkin's Lymphoma Presenting as Ulcerative Colitis.** Liliam M. Garcia-Ortiz, MD, Associate; Francisco Jaime-Anselmi, MD, FACP; Raul Márquez-Santiago, MD, FACP; Jose Ramirez-Rivera, MD, FACP -Hospital La Concepcion-Ponce School of Medicine Consortium, San German

A 26-year-old woman was hospitalized because of persistent diarrhea, 30 lbs weight loss and palpable rectal mass. Nine months before admission recurrent abdominal pain led to a colonoscopy that was diagnostic of ulcerative colitis and she was treated with mesalamine with partial relief of symptoms. Three months before admission, she developed dyspnea, rectal pain and bleeding. A repeated colonoscopy was again suggestive of ulcerative colitis. After balsalazide disodium failed to control her symptoms, prednisone 40 mg daily was prescribed. She stopped prednisone after 6 days because of generalized swelling. On physical examination, she weighed 80 lbs and was 62" height. The temperature was 35.6 °C, pulse 130 beats/min, respiration 18/m and blood pressure 120/80 mmHg. No adenopathy. The abdomen was soft with diffuse pain on palpation. Perirectal tissues were indurated with erythematous skin. Digital examination was very painful and a 2cm mass was palpable in the left aspect of the anal canal. The remainder of the physical examination revealed no abnormalities. The hemoglobin was 10.5 g/dl, hematocrit was 31.6% and white cell count was 6,800 /mm<sup>3</sup>. The stool showed moderate leukocytes and was positive for occult blood. One day after admission, a sigmoidoscopy was performed and biopsies were taken. A pelvic MIR showed a large heterogeneously enhanced soft tissue mass. There was narrowing of the rectosigmoid lumen with dilatation of the preceding colonic loops. The right inguinal lymph nodes were enlarged. A colostomy was recommended but the patient refused. In the sixth hospital day, sudden intense generalized abdominal pain developed. The abdomen was tympanic, with guarding and diffuse rebound tenderness. CT demonstrated free air in the abdominal cavity. The exploration 3 hours later showed fecal material throughout the abdominal cavity. A solid mass filled one-third of the left pelvis. Partial colectomy, peritoneal lavage and colostomy were done. She was aggressively treated for sepsis responding favorably. The biopsy of the anal mass as well as the microscopic examination of the surgical specimen and the immunohistochemical analysis confirmed a high, grade diffuse B-cell lymphoma. She received chemotherapy and radiotherapy. Colon reconnection is planned. Acute lesions of ulcerative colitis usually

begin at the anal verge and involve only the mucosa and submucosa. When induration of the perirectal areas develop a different pathology should be suspected.

**P-13 Multiple Sclerosis Originating in Childhood Associated With Seizures and Hallucinations.**

Eugen Luis-Rosell, MD; Jose Ramirez-Rivera MD, FACP. Central del Caribe, School of Medicine, Bayamon, PR

Multiple sclerosis, is an idiopathic inflammatory disease of the Central Nervous System with symptoms that rarely begin before age 10 or after age 60. The presentation may vary from isolated motor or sensory impairment to seizures or psychotic disturbances. We present a case who at 7 years of age complained of double vision, paralysis of the right face and imbalance. At that time he had supranuclear facial palsy, mild ataxia, diplopia and lateral nystagmus; the uvula deviated to the right, there was dysynergia and dysmetria of right arm and the deep tendon reflexes were 3+ in lower extremities. Head CT scan showed nodular densities 'with low attenuation areas in the white matter of the left frontal and left parietal lobes compatible with multiple sclerosis. Symptoms disappeared gradually without treatment. At 12 years of age he had dizziness, diplopia, and weakness of right extremities. At 24 years of age he developed seizures and visual and auditory hallucinations that led to the diagnosis of Epilepsy and Schizophrenia. At age 28 he was admitted with a sudden onset of paraparesis. An MRI done on February 7, 2004 showed extensive subcortical and periventricular white matter changes (signal intensity), predominantly at left frontoparietal region. This case presented symptoms at a very young age and telescopes a wide variety of presentations, first motor impairments and later seizures and hallucinations which could be related to multiple sclerosis.

**P-14 Acute Renal Failure in a Man With a Small Farm.** Ricardo Cestero Rivera, MD (Associate); Jose Ramirez-Rivera, MD, FACP; Francisco Jaume Anselmi, MD, FACP; Oliver Guerrero Dujarric, MD; Hospital de la Concepción-Ponce School of Medicine Consortium, San German.

A 69 year-old man developed malaise, myalgia, abdominal discomfort, jaundice and a decrease urine output four

days prior to admission. He has diabetes mellitus, arterial hypertension and hyperlipidemia. In January 2004 he sustained an acute myocardial infarction. In July 2004 he had successful implantation of a stent to the circumflex coronary artery. 'He has a small farm where he eats unwashed fruits which he stacks in a tool-shed. On physical examination, the patient was disoriented and acutely ill. The temperature was 37.2, pulse 82/min, blood pressure 124/64 mm/Hg, respiratory rate 20/min. The sclerae were icteric. No rash was evident. There was no jugular venous distention. There were crackles at the right base. There was tenderness over the right upper quadrant, but no rebound or visceromegaly was noted. There was bilateral pitting edema of the ankles. The hemoglobin was 12 g/dL and the Hct 38%. The white cell count was 10,000/mm<sup>3</sup> with 87% neutrophils, 9% bands, 3% lymphocytes and the platelets were 92,000/mm<sup>3</sup>. The Na was 125 mEq/L, K 5 mEq/L, CL 91 mEq/L and HC03 20.4 mEq/L. The blood sugar was 118 mg/dL, creatinine 6.2 mg/dL, BUN 104 mg/dL, AST 162 U/L and ALT 141 U/L. The total bilirubin was 2.4 mg/dl and the creatine kinase level 211 mg/dL. The urinary sediment showed 25-27 white-cells and 30-35 red-cells. Prominent pulmonary markings with normal size kidney and prostate were seen by imaging studies. The bladder contained 250 ml of cloudy urine. He was started on cefoxitin IV q 8hr and metronidazole 500mg IV q 8hr because of suspected sepsis. On the second day of hospitalization hemodialysis was initiated and IV ampicillin 1 gm every 6 hours was added to cover the possibility of leptospirosis. By the third hospital day urine output increased to an average of 44 ml/hr. On the 10th hospital day the hemogram and blood chemistries were normal. The BUN was 17 mg/dL, creatinine 0.7 mg/dL and the total bilirubin .1mg/dL. He was discharged the following day. Leptospira antibody titer on the second day of admission was 1:1,600. One month later the titer was 1:400. Leptospirosis is an underdiagnosed infection transmitted from animal to humans. The source of exposure is contaminated water and soil. In a patient with acute renal failure, jaundice and thrombocytopenia, the possibility of leptospirosis should always be considered.