UTAH CHAPTER
AMERICAN COLLEGE OF PHYSICIANS

2022 ANNUAL ACP STUDENTS/RESIDENTS & FELLOWS CLINICAL VIGNETTE COMPETITION

DATE: Thursday, October 20th, 2022

LOCATION: U of U Department of Internal Medicine Grand Rounds: School of Medicine Classroom A

TIME:

CASE PRESENTATIONS :	12:00 to 12:45 PM
AWARDS AND CLOSING	12:45 to 1 PM

INVITED: ALL MEDICINE, PRELIMINARY AND TRANSITIONAL HOUSESTAFF, MEDICAL STUDENTS, AND FELLOWS IN DEPARTMENT OF MEDICINE, AND THEIR GUEST.

1. Submit your abstract of an internal medicine patient case that you would like to enter into the competition such as an unusual presentation of a common disorder, an uncommon disorder or something you found very interesting. Abstract must be **less than 400 words.**
2. Deadline: Must **submit by midnight on October 3rdth, 2022**. Submit with the information requested below. Email your completed abstract to Cami Bills at contact@utahacp.com.
3. You must be able to attend Grand Rounds on Thursday, October 20th in order to be selected as a finalist (for those with clinical duties during this time, we will help arrange coverage as able).
4. After we receive your abstract, a copy of the abstract without your name will be reviewed by 3 Internists. Judging will be based on the interest of the case, the clarity of presentation, originality, and importance Four abstracts will be selected for presentation at Internal Medicine Grand Rounds on Thursday, October 20th
5. On **Friday, October 7th, 2022,** we will contact the 4 individuals whose abstracts are selected, so they can prepare a 10-minutes or less presentation (PowerPoint) for Grand Rounds. We will also coordinate practice sessions prior to the Grand Rounds event.
6. The final 4 presenters will have until **NOON October 14th, 2022** to send their **FINAL** presentation to Cami Bills (contact@utahacp.com) (Recommend 5-8 slides highlighting the case).
7. All four who present at the Vignette Competition will receive a ***cash prize*.** The winning presenter will receive $600 towards a trip to the ACP 2023 Internal Medicine Conference in San. Diego, CA.
8. Format of abstract**: write your name; write an interesting abstract title, introduction; case presentation; and discussion. A form to complete and an example abstract is attached below.**

RETURN ABSTRACT TO:

Cami Bills, ACP Utah Chapter Staff
Emily Signor, MD, ACP Residents/Fellows Committee, Utah Chapter
Email: contact@utahacp.com
Email: Emily.signor@hsc.utah.edu

Your Name: _____
E-Mail Address: _____
Your Phone #: _____
Year of Training: MS3 MS4 RESIDENT R1 R2 R3 FELLOW 1 F2 F3 F4

ACP Clinical Vignette Abstract (400 Words Maximum)

Type an Interesting Title Here _____

Type Your Name Here _____

Identification:

Chief Complaint:

History:

Physical Abnormalities:

Lab Results:

Differential Diagnosis:

Case Presentation:

Discussion:

Conclusion:

PLEASE SEE EXAMPLE ON NEXT PAGE

A Little Robitussin Should Put That Cough Out…

Steven H. Lofgran, M.D.

CASE PRESENTATION: Patient is a 49-year old woman, previously in good health until five years ago, when she developed a bothersome cough, varying from dry and hacking, to productive of white sputum. Proton-pump inhibitors, bronchodilators, and oral steroids had little effect, and her cough progressively worsened. ENT workup with laryngoscopy was unrevealing, as was evaluation with EGD by a gastroenterologist. Patient also underwent bronchoscopy by a pulmonologist, which revealed mild bronchial scarring, but otherwise no evidence of disease. Chest x-ray and CT studies yielded little information.

Over the previous two years, patient had also noted a 70 pound weight loss, early satiety, a "heavy" sensation in her abdomen, and intermittent, drenching night sweats. She also began to notice the onset of abdominal pain, which she initially attributed to coughing. She returned to her primary care physician, who noted profound hypersplenism on exam. An abdominal CT was performed, which noted splenomegaly, measuring 23.6 x 8.0 x 29 cm, as well as scattered lymph nodes in the retroperitoneum, the largest measuring 1.2 cm. She was referred to Hematology clinic for evaluation of possible lymphoma.

PHYSICAL EXAM ABNORMALITIES: Our exam was notable for massive splenomegaly extending across midline and into the pelvis. CBC was essentially normal, as were chemistries and sedimentation rates. Examination of the peripheral blood smear revealed striking aniso- and poikilocytosis, with abundant teardrop cells, and occasional nucleated red cells. A leukocyte differential count revealed numerous premature cells. Platelets were morphologically abnormal, with frequent large platelet forms noted.

DIFFERENTIAL DIAGNOSIS: Presumed diagnosis was myelofibrosis. A peripheral blood sample was positive for the JAK-2, V617F point mutation. A bone marrow aspirate and biopsy was performed. Although no aspirate could be obtained, adequate core biopsy samples were harvested, which revealed hypercellularity, with marrow reticulin fibrosis and dilatation of marrow sinuses. Staining confirmed the presence of marked reticulin fibrosis.

TREATMENT: Myelofibrosis (agnogenic myeloid metaplasia) with massive splenomegaly, gastric compression, gastroesophageal reflux, and chronic cough due to continued aspiration. Because of symptomatic splenomegaly, a splenectomy was successfully performed, and further workup for stem cell transplant is pending.

CONCLUSION: In recent years, it has become apparent that myelofibrosis can be considered a curable disorder with stem cell transplantation (attenuated preparative regimens followed by infusions of allogeneic stem cells have proven to be successful in at least 50% of patients so treated). Current research suggests a role for tyrosine-kinase inhibitors for treatment of JAK-2 mutation positive myelofibrosis.