How to write a Clinical Vignette (CV) abstract

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FAQs for submission of CV abstracts

What is a clinical vignette?

- One or more cases that illustrate a new disease entity, or a prominent or unusual clinical feature of an established disease
- Summary of pertinent patient history, physical findings, laboratory data, or management description
- Take home/teaching point/s

Is this case worth submitting?

- Rare, unusual presentation
- Lesson it teaches:
  - Awareness of a condition
  - Diagnostic strategy
  - Cost-effective approach
  - Change in management
  - Unusual complication or
  - “twists in the story”

FAQs for submission of CV abstracts

Can I use the same vignette for different meetings?

- YES!
- Presentation of original work at the chapter meeting may, however, jeopardize presentation before another society

Is the title important?

- Important, relevant, and innovative
- Short, interesting, and descriptive

Authorship of case reports?

- Major contribution to the writeup
- No longer just because they were involved in the management of the patient!

FAQs for submission of CV abstracts

What else do I need to know?

Abstracts must be reviewed and signed by your Program Director

What format should I use?

- Type in the abstract submission form
- Size 10 font or greater
- Title, name of presenting author should be first
- 2-4 paragraphs
- Introduction
- Case
- Discussion/Conclusion

Hemophagocytic Lymphohistiocytosis secondary to suspected SARS-CoV-2 infection

Hemophagocytic lymphohistiocytosis (HLH) is a rare syndrome precipitated by overactivation of macrophages and CD8+ T cells. There are familial and acquired variants of the condition with the latter commonly triggered by viral infections and certain malignancies. Clinically, it is ch**aracte**rized by acute onset of fever, multiorgan failure, hepatosplenomegaly, elevated ferritin and triglycerides, and evidence of hemophagocytosis. With treatment, the overall mortality from HLH is 40-75%.

A 24-year-old man with no known past medical history developed headache and fever that progressed over twelve days to abdominal pain, diarrhea, jaundice, oliguria, and dyspnea. His initial symptoms began four days after exposure to an individual with possible SARS-CoV-2. On presentation, examination was significant for temperature of 39.9˚C, O_2 saturation of 93% on six liters of O_2 via nasal cannula, scleral icterus, and hepatomegaly. Laboratory evaluation was notable for white blood cell count of 12.2/mm^3, hemoglobin of 13.7 g/dL, platelet count of 55/mm^3, aspartate aminotransferase of 3093 IU/L, alanine aminotransferase of 865 IU/L, INR of 2.6, creatinine of 5.32 mg/dL, ferritin of >50000 ng/mL, triglyceride level of 1152 mg/dL, and fibrinogen level of 62 mg/dL. A computed tomography (CT) scan of the abdomen revealed hepatosplenomegaly. A bone marrow biopsy showed hemophagocytes. The patient's HScore was calculated to be 285 points, indicating >99% chance of having HLH.

Investigation of predisposing factors for HLH included the following: 1) viral panel negative but with SARS-CoV-2 antibody positivity; 2) positron emission tomography/CT negative for increased uptake suggesting malignancy; 3) bone marrow biopsy gene analysis negative for lymphoma; and 4) HLH familial gene sequencing panel negative.

The patient required a brief course of intubation and continuous renal replacement therapy for respiratory and renal failure, respectively. HLH was treated with a five-day course of anakinra and intravenous immunoglobulin, followed by eight weeks of dexamethasone and etoposide, and twelve weeks of ruxolitinib with recovery to his baseline level of health, including his renal function.

HLH should be considered in the differential diagnosis of patients with acute onset of multiorgan failure, especially in those with known viral infection, including that by SARS-CoV-2, or known malignancy. After confirmation of HLH, early treatment of the underlying cause and immune activation is paramount to prevent death.

AMERICAN COLLEGE OF PHYSICIANS – MD CHAPTER

MULHOLLAND MOHLER VIRTUAL RESIDENTS MEETING
May 6, 2021

3rd PLACE CLINICAL VIGNETTE

Institution: MedStar Health Internal Medicine Residency Program

Program Director's Name: Stephanie Detterline, MD, FACP

WOULD YOU LIKE SOME ICED TEA? A CASE OF OXALATE NEPHROPATHY

INTRODUCTION: Oxalic acid is an organic acid found in many foods like spinach, nuts, and tea. Oxalate is excreted by the kidneys, and in excess can lead to renal tubular deposition and acute kidney injury (AKI). We present a case of AKI requiring hemodialysis (HD) due to oxalate nephropathy from copious iced tea ingestion.

CASE PRESENTATION: A 59-year-old man presented to the emergency department with bilateral lower extremity weakness, dry mouth and nausea for one month and decreased urine output for a week. He had a history of coronary artery disease, atrial fibrillation, type 2 diabetes mellitus, stage 3a chronic kidney disease, and laparoscopic sleeve gastrectomy. Examination revealed urinary retention requiring indwelling catheterization. Labs showed hyperkalemia (6.6mEq/L), AKI with BUN 105mg/dL, creatinine 7.86mg/dL (baseline creatinine 1.24 one month prior), normal anion gap metabolic acidosis, microscopic hematuria, proteinuria. Further labs showed low complement C3 (82mg/dL), normal C4, negative hepatitis panel, ANA, ANCA, protein electrophoresis, anti-glomerular basement membrane antibody. Renal ultrasound unremarkable. Differentials for AKI included bladder outlet obstruction, post-infectious glomerulonephritis (dental infection 5 weeks prior), acute tubular necrosis (ATN) or acute interstitial nephritis due to amoxicillin (prescribed after dental infection). Due to worsening renal failure and uremic symptoms despite supportive treatment, kidney biopsy was performed, and patient started on HD. Biopsy results revealed ATN and intra-tubular oxalate concretions consistent with oxalate nephropathy. Subsequent dietary history revealed that after dental infection, patient drank about 2 liters of iced tea daily. He was advised to stop iced tea and required outpatient HD, with eventual return of renal function after 8 weeks allowing liberation from dialysis with a residual serum creatinine of 1.9mg/dL.

CONCLUSION: Our case highlights the importance of thorough dietary history in cases of AKI. Given the popularity of iced tea, patients and physicians must be aware of the potential for acute oxalate nephropathy.

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