

2010 ACP Kansas Chapter Scientific Meeting Calendar of Events

Friday March 12, 3015 Sudler

- “Abstract Writing Session”—Dr. Luchi

Thursday, TBA

- Internal submission deadline for faculty review
- Submit to Gerri McPherson via email

Friday, TBA

- Drafts returned to residents from faculty review

Friday, June 4, 2010

- Final Internal Deadline for abstracts submission
- Submit to Gerri McPherson via email

Dates TBA

- practice sessions for posters and plenary presentations

Dates TBA

- Practice Sessions at MR
- Plenary round residents practice sessions with program directors—
time and location to be arranged by chief residents

Friday and Saturday, September 18-19,

- Kansas Chapter of the ACP Annual Meeting in Wichita

How to Write an Abstract

“The skills learned in writing an abstract and developing a presentation for ACP should be useful practical, everyday tools applied during residency.”

- 1) Start early
- 1) Select a topic
 - a. clinical vignette
 - leiomyosarcoma of the IVC
 - lead toxicity from a retained bullet presenting 20 years later
 - histoplasmosis presenting as a laryngeal mass
 - cutaneous necrosis – cryoglobulinemia and hepatitis C
 - Mollaret’s meningitis (recurrent HSV meningitis)
 - Secondary syphilis with a negative RPR
 - disseminated nocardiosis in a patient with pulmonary fibrosis
 - mandibular necrosis in association with bisphosphonate use
 - b. research project
 - cAMP and PCD
 - rheogenic effects of IVIG
 - c. what makes a good abstract?
 - interesting case
 - interesting case that teaches a diagnostic or therapeutic lesson to internists
 - interesting case that brings to light a medical advancement
 - research which enhances the understanding of a particular medical subject
- 2) Talk to the appropriate attending
 - participated in care of patient
 - will help supervise writing the abstract (we will help a lot too)
 - will be a co-author
- 3) Start early
- 4) Writing the abstract
 - a. “clarity of presentation is everything”

b. lessons learned here should be applied to your daily practice as a resident

- MR
- CPC
- core lectures
- presentations on rounds

c. follow the instructions on the ACP website for style and organization:
READ THEM BEFORE STARTING!

d. <http://www.acponline.org/srf/abstracts/guide.htm>

e. for example:

- title should be in caps
- first author should be the presenting author (that's you! – required for credit as scholarly activity)
- author names are recorded as first then last with, for example, MD
- there may be more than two authors
- make sure it fits in the box
- etc.

f. Organization

- Introduction:
- Case Report
- Discussion

g. “Just Do It” –

- write a rough draft and don't sweat it
- then revise it and send it to your faculty member and the chiefs

h. due date for internal review

i. We are going to help

- resident abstracts will be divided up among Program Directors, etc
- we will help you to revise them – do not fear!!
- Reviewed drafts are returned to residents by June 13th
- Nag faculty members without mercy for response
- These usually take several revisions – be patient and hang in there!

Selection of abstracts for the plenary session (money round)

Review of abstracts by ACP

- Scientific Planning Committee
- Equal representation from KC and Wichita
- blinded review
- graded on content, quality of writing, relevance and links to literature best are selected for the ‘money round’ (or ‘plenary session’ for the more refined)

Developing your Power Point and poster presentations
we will have a common template this year, with the KU logo
work with individual attendings and members of the program leadership

Intra-Cerebral Hemorrhage Due to Rituximab: Role of CD20 Antigen and Adhesion Molecules in Intravascular Lymphoma.

Anne P. O'Dea MD; Siddhartha Ganguly MD; Department of Medicine, University of Kansas Medical Center, Kansas City, KS.

Background: Intravascular lymphoma (IVL) is a rare variant of diffuse large B-cell lymphoma characterized by predominant growth of neoplastic cells within the lumina of blood vessels. This malignancy is characterized by a rapidly progressive and ultimately fatal course, with the exception of a subset of patients achieving remission after combination chemotherapy. Rituximab, a monoclonal antibody directed against the CD20 antigen on B-lymphocytes, in combination with CHOP chemotherapy (R-CHOP) has been used successfully in some patients with IVL.

Case Report: A 22 year-old African American woman presented with new onset seizures and visual field defect. MRI of her brain revealed multiple cortical infarcts thought to be secondary to a CNS vasculitis. However, a stereotactic brain biopsy showed CD20+ neoplastic large B cells occluding the lumina of several brain capillaries. Following diagnosis of IVL, it was decided to treat the patient with R-CHOP. Three hours following infusion of Rituximab, she complained of severe headache, developed mental status changes, and subsequently became comatose. CT scan revealed multifocal intra-cerebral hemorrhages. After three days, she regained consciousness and had a full neurological recovery.

Discussion: Angiotropic Intravascular B-Cell Lymphoma (IVL) is a rare variant of diffuse large B-cell lymphoma. This type of lymphoma is characterized by predominantly intravascular spread of neoplastic B-cells. Skin, CNS, lungs, and kidneys are common organs of involvement. In the brain, it presents as multiple infarcts and the diagnosis is often delayed due to delay in obtaining a tissue sample. Unfortunately several cases had been diagnosed only after autopsy. In our case, the diagnosis was delayed by almost four months. Any progressive CNS lesion without a definitive diagnosis merits prompt stereotactic brain biopsy. Neoplastic cells in IVL universally lack surface CD29 (B1 integrin sub-unit) and CD54 (ICAM-1) antigens, which are essential for lymphocyte trafficking and transvascular migration. It is the absence of these surface molecules in IVL that are thought to contribute to its intravascular and disseminated distribution pattern. The neoplastic cells are strongly positive for CD20 antigen. Rituximab or anti CD20 antibody has been successfully used in other variants of diffuse large cell lymphoma. In our patient, it is possible that the interaction between Rituximab and CD20+ IVL cells caused a localized tumor lysis and cytokine release that led to rupture of capillary endothelium and multifocal intracerebral hemorrhages. Rituximab has been used in the treatment of primary CNS lymphomas, however there have been no cases reported in the literature of this drug leading to acute intracerebral hemorrhage. Thus, this case highlights an important and life-threatening complication of utilizing this agent in the treatment of IVL. Additionally this case provides insight regarding alternative treatment regimens including initial cytoreduction with combin

A Frog in my Throat: An Atypical Presentation of Disseminated Histoplasmosis in a Patient Receiving Infliximab.

Danielle Stebbins MD; Sally Rigler MD, MPH; Kathryn Welch MD, Glenn Mackay MD; Dept. of Medicine, Univ. of Kansas, Kansas City.

Background: Infliximab, a Tumor necrosis factor-alpha (TNF- α) antagonist, is a recent addition to rheumatoid arthritis (RA) treatment options. Despite efficacy, TNF- α antagonists are known to impair host defenses, and opportunistic infections can arise during treatment. However, atypical manifestations and rapid progression of infection may threaten timely diagnosis and successful treatment in such patients.

Case Report: A 63 year-old white man with RA, treated previously with methotrexate, hydroxychloroquine, and prednisone, was started on infliximab for continued active disease. Several months later he reported dysphagia and unintentional weight loss. Oral candidiasis was noted and he was treated empirically with fluconazole with initial improvement. Symptoms soon recurred, and esophagogastroduodenoscopy (EGD) revealed erythema and nonspecific mild edema of the pharynx for which anti-reflux therapy was initiated. He returned several weeks later reporting a sense of throat fullness and stating that he was now blowing food out of his nose after eating. On exam, he had developed obvious hoarseness but had no findings of the visible oropharynx. A prompt computerized tomography (CT) scan showed a thickened epiglottis and surrounding adenopathy. Direct laryngoscopic exam found an ulcerative mass compressing the trachea and esophagus, requiring tracheostomy for rapidly impending airway compromise. Further evaluation revealed widespread adenopathy, pulmonary nodules, and a colonic mass. Grocott stains demonstrated Histoplasmosis. Lipophilic amphotericin B was initiated, with rapid clinical improvement. He transitioned to oral antifungal therapy and following extended outpatient treatment had complete resolution of symptoms.

Discussion: This case illustrates a unique presentation of disseminated Histoplasmosis in a patient on anti-TNF- α therapy. Literature review did not reveal any similar cases presenting as an airway-compromising mass. The association between infliximab use and disseminated Histoplasmosis has recently been recognized from post-marketing surveillance reports, and the manufacturer now suggests caution regarding use in endemic areas. Physicians must maintain a high index of suspicion for development of Histoplasmosis in patients treated with TNF- α antagonists, and they should remain alert to the possibility of unusual manifestations and rapidly progressing threats.

A Gunshot Wound Wreaking Havoc Twenty Years Later.

Leigh M. Eck MD; Delva Deauna-Limayo MD; Department of Medicine, University of Kansas Medical Center, Kansas City, KS.

Background: Lead toxicity, also termed “plumbism”, is symptomatically characterized in adults with abdominal pain, headache, irritability, joint pain, fatigue, anemia, peripheral neuropathy, and deficits in short-term memory and concentration. Although risk of exposure to lead has decreased immensely during the twentieth century, it continues to pose a significant hazard.

Case Report: A 47-year-old African American woman with a previous extensive evaluation for a 4-month history of abdominal pain, nausea, vomiting and neurologic changes (dysarthria and seizures) was given a diagnosis of acute intermittent porphyria (AIP). Multiple readmissions for reoccurrence of symptoms despite hematin therapy resulted in transfer to our institution.

Review of her laboratory data revealed elevated levels of δ -aminolevulinic acid but near normal levels of porphobilinogen inconsistent with the diagnosis of AIP. This, coupled with the patient’s history of gunshot wound inflicted twenty years previously and the presence of normocytic anemia, led to a heavy metal screen which revealed a lead level of 111mcg/dL (<26mcg/dL).

Concentrations of heme precursors, such as elevated δ -aminolevulinic acid as seen in this patient, can be increased at blood lead levels as low as 15mcg/dL. Chelation therapy with EDTA and succimer resulted in the resolution of her gastrointestinal complaints and improvement of her neurological symptoms. Surgical removal of the bullet fragments was performed to eliminate the underlying source of the lead. Monitoring of lead levels directed further chelation therapy.

Discussion: Lead intoxication is relatively uncommon in adults. Although this patient presented with typical symptoms of lead intoxication, the diagnosis was overlooked due to the lack of pathognomonic symptomatology associated with plumbism. In patients with retained bullet fragments and an array of physical complaints, plumbism should be considered. This case contributes

to the reports in the medical literature of elevated lead levels in patients with retained bullets.