

Writing Paper

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Write a medical case report on an ED visit. Use the information provided below. Interpret the presented case. Complete this writing task in 220-240 words.

- **Patient data:** 12 y.o., African - American F; ht 157cm, wt 38 kg (BMI 15.4 kg/m², 16th percentile)
- **Reason for admission:** fainted today
- **Immediate past history:** dizzy (main symptom); off food, tired, weak (all of these for 6 wks). Mom noticed yellow colour of the eyes and whiteness of the palms (observed in the last 2 wks).
- **PMH:** asthma, eczema, seasonal allergies, cataract of L eye
- **FH:** anaemia, rheumatoid arthritis, Crohn's disease, heart disease
- **VS on admission:** BP: 110/68, HR 100 (ref. range: 60 – 100), RR 22 (ref. range: 12 – 18), T 37.1°C.
- **Physical exam:** yellow colour of the sclera, whiteness of the conjunctiva and nail beds; no lymphadenopathy; liver and spleen not enlarged; no bruising
- **Investigations:** low Hb; low reticulocyte count; RBC: significant anisocytosis, macro-ovalocytes and teardrop cells; WBC and PLT normal; *vit. B12 level:* 142 pg/mL (ref. range: 211 – 911); folate levels: normal
- **Diagnosis:** pernicious anaemia
- **Treatment:** vit. B12 1000mcg IM (symptoms improved; expected increase in Hb and reticulocyte count a week after the injection)
- **Further management:** consultation with specialists in endocrine and CNS disorders for children (autoimmune disorders in family – maybe coexisting disorders? – this proved negative)
- **Discharge:** 8th day (receive Vit. B12 injections weekly for 1 month, then monthly)
- **Follow-up:** symptoms / subside completely

Case report - model answer

A 12-year-old underweight African American girl presented to the Emergency Department following a syncopal episode. She gave a 6-week history of decreased appetite and general malaise, with the chief complaint of vertigo. Her mother had noticed yellowing of the eyes and pallor of the palms in the last two weeks. Past medical history is significant for asthma, eczema, seasonal allergies and cataract of the left eye. Family history is positive for anaemia, rheumatoid arthritis, Crohn's disease, and heart disease.

On admission her vitals were normal except for mild tachycardia and tachypnoea. Physical examination disclosed a jaundiced sclera with pallor of the conjunctiva and nail beds. There was no lymphadenopathy, hepatosplenomegaly, or bruising observed. Diagnostic tests showed low haemoglobin and reticulocyte count. Blood smear showed red blood cell morphology with significant anisocytosis, macro-ovalocytes and teardrop cells. Leukocytes and thrombocytes were normal. Further investigations showed that B12 level was low while folate levels were normal. She was diagnosed with pernicious anaemia.

She was administered Vit. B12 1000mCg intramuscularly with improvement in clinical symptoms and an expected increase in haemoglobin and reticulocyte count a week after the injection. Given the family history of autoimmune conditions, Paediatric Endocrinology and Neurology were consulted to further evaluate for coexisting disorders. This proved negative. The patient was discharged home on the eighth day with directions to receive Vit. B12 injections weekly for 1 month and then monthly. On a follow-up, a complete resolution of symptoms was noted.

(240 words)

Source: <https://www.oatext.com/12-year-old-with-dizziness-anemia-and-jaundice.php>

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