2024 Hawai'i Chapter

Scientific Meeting

Honolulu Country Club

Saturday, March 9, 2024

In-person/Virtual

× *This activity has been designated for 6.0 CME credits and 6.0 MOC points*

Congratulations to the Hawaii Chapter Governor-elect Designee (GED), Ryon K. Nakasone, MD, MBA, FACP. Our new GED will complete a year of training as a Governor-elect and then will start their four-year term as Governor in the Spring of 2025. As Governor, Dr. Nakasone will serve as the official representative of the College for our Chapter, providing a link between members at the local level and leadership at the national level. In the meantime, Dr. Nakasone will be working closely with Dr. Evans (the current governor) and College staff to learn about the College and their duties as Governor. To learn more about the new GED, read their bio below.

We are pleased to announce that our chapter is in receipt of the Gold Level of the 2023 Chapter Excellence Award! The award recognizes truly extraordinary chapters that surpass excellence in chapter management. We are in the company of 54 other outstanding chapters. In order to achieve the Gold Level of the Chapter Excellence Award, chapters must meet nineteen Bronze criteria, seventeen Silver criteria and multiple Gold level activities. Criteria include such activities as having a legislative action plan or agenda, holding a volunteerism/community service activity, holding multiple stand-alone meetings, ha

2024 ACP Hawai‘i Chapter Laureate Award

It is with great pleasure and admiration that I nominate Dr. Lisa Camara for the prestigious Laureate Award. Dr. Camara exemplifies the highest standards of excellence in medical care, education, research, and community service, making her an outstanding candidate for this honor.

Dr. Camara's journey in medicine began in 1996 when she earned her Medical Degree from the John A. Burns School of Medicine at the University of Hawaii at Manoa. She completed her internship and residency training at the University of Hawaii Integrated Medical Residency Program in 1999 and went on to sever as their Chief Medical Resident. Since 2000, she has severed the community of Hawaii as a Primary Care Physician. Additionally, her expertise and compassion have earned her recognition as one of Hawaii's Best Doctors consistently over the years.

In addition to her clinical responsibilities, Dr. Camara is deeply invested in medical education. As an Assistant Clinical Professor of Medicine at the University of Hawaii, she has played a pivotal role in shaping the next generation of physicians. She served as the site coordinator and teaching attending for the University of Hawaii Internal Medicine Residency Program for 13 years and was Core Faculty for the Kaiser Permanente Hawaii Internal Medicine Residency Program. Her teaching efforts extend beyond the bedside, as she serves as a mentor for residents and medical students at various stages of their training.

Dr. Camara's commitment to research and scholarly activities is evident through her numerous presentations, publications, and involvement in academic conferences. As the Grand Rounds Chair at Kaiser Permanente Department of Medicine from 2000 to 2017, she coordinated presentations on diverse medical topics, inviting expert speakers, and ensuring the seamless execution of these sessions aimed at fostering continuous learning and professional development within the medical community. Notably, her presentation on "The Role of Social Media in Medical Education" underscores her innovative approach to advancing medical knowledge in the digital age.

Moreover, Dr. Camara's service to the medical community and the American College of Physicians (ACP) is exemplary. She joined ACP in 1996 and became a fellow of the college in 2011. She held multiple leadership positions within ACP, including Governor-elect and Governor of the Hawaii chapter (2017-2021). Her contributions include championing initiatives such as LGBTQ+ healthcare and open mic night where Physicians and Medical Students network and share their musical talents bridging the gap between teacher and learner.

Learning Objectives

Kamonkiat "George" Wirunsawanya, MD – Dr. Kamonkiat Wirunsawanya, aka Dr. George, currently practices as an endocrinologist at Straub and Pali Momi Medical Center. I am originally from Bangkok, Thailand and earned my medical degree from Rangsit University in Thailand. Afterwards, I came to the US to further specialize in internal medicine through a residency program at the University of Internal Medicine Residency Program, graduating in 2018 and completed my endocrinology fellowship at Boston University in 2020. My special interests are obesity management and the integration of technological advancements in diabetes treatment.

Doctor's Dilemma -

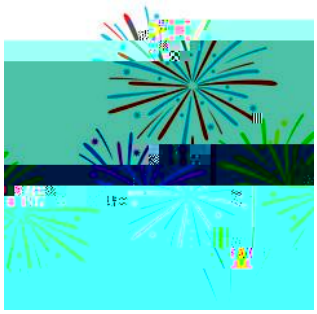
Javier Barranco-Trabi, MD - Chief Medical Resident, Tripler Army Medical Center, Honolulu, HI
Ethan Chun, MD Chief Medical Resident, Kaiser Permanente, Honolulu, HI
Joseph Go, MD - Chief Medical Resident, UHIMRP, Honolulu, HI
Helen Holmgren, MD - Chief Medical Resident, Kaiser Permanente, Honolulu, HI
Todd Nagamine, MD Chief Medical Resident, UHIMRP, Honolulu, HI
Yoshito Nishimura, MD - Chief Medical Resident, UHIMRP, Honolulu, HI
Jenie Ogle, MD Chief Medical Resident, Tripler Army Medical Center, Honolulu, HI

New Fellows -

Shiuh-Feng Cheng, MD, FACP
Daven Chun, MD, FACP
Brandy Kaneshiro-Yeung, MD, FACP
Jennifer Katada, MD, FACP
Jacqueline O King-Jodi, MD, FACP
Linda Kuribayashi, MD, FACP
Sian Yik Lim, MD, FACP
Marisa E. Rivera, MD, FACP
Travis Watai, MD, FACP

2024 Chapter Awards

Distinguished Teacher/Mentor Award	Brandy Kaneshiro-Yeung, MD, FACP
Diversity Award -	Ashley Morisako, MD
Hospitalist Award	Sandra Loo, MD Helen Sim, MD
Resident of the Year Award -	Yoshito Nishimura, MD, PhD Arvin Tran, MD



New Members -

March Birthdays

PODIUM PRESENTATIONS

9:15 am Podium

Risk Factors Associated with One-Year Mortality After Osteoporotic Hip Fracture in Hawaii: Higher Mortality Risk Among Native Hawaiians and Other Pacific Islanders

Luke Taylor, MS3[1], Masako Matsunaga, PhD[2],
Hyeong Jun Ahn, PhD[2], Sian Yik Lim, MD[3]
[1] University of Hawaii John A. Burns School of Medicine, Honolulu, HI
[2] University of John A. Burns School of Medicine,
Dept of Quantitative Health Sciences
[3] Hawaii Pacific Health, Straub Clinic, Honolulu, HI

Introduction:

Osteoporotic hip fractures represent a serious health concern in older adults and are associated with significant morbidity and mortality. Hawaii is home to an ethnically diverse population and a steadily increasing elderly population. However, studies investigating mortality after osteoporotic hip fracture in Hawaii are limited. This study aimed to estimate mortality rates and identify specific risk factors associated with one-year mortality after osteoporotic hip fracture in Hawaii.

Methods:

hip fracture at a large multicenter health care system in Hawaii from 2011-2019. Kaplan Meier curve and log-rank tests were performed to examine survival probability by sex, age group, race/ethnicity, primary insurance, body mass index (BMI), and American Society of Anesthesiologists (ASA) score. After accounting for potential confounders, adjusted hazard ratios (aHR) and 95% confidence intervals (CI) were obtained from Cox proportional hazards regression models.

Results:

We identified 1755 cases of osteoporotic hip fracture. The cumulative mortality rate one year after fracture was 14%. Older age (aHR 3.50; 95% CI 2.13-5.76 for 90+ years old vs 50-69 years old), higher ASA score (aHR 5.21; 95% CI 3.09-8.77 for ASA 4-5 vs ASA 1-2), and Native Hawaiian/Pacific Islander (NHPI) ethnicity (aHR 1.84; 95% CI 1.10-3.07 vs Caucasian) were independently associated with higher mortality risk. Female sex (aHR 0.64; 95% CI 0.49-0.84 vs male sex) and higher BMI (aHR 0.35; 95% CI 0.18-0.68 for obese vs underweight) were associated with lower mortality risk.

Conclusion:

Identifying populations at higher risk for mortality after hip fracture is necessary to provide appropriate interventions. In our study, men, older adults, and NHPIs were associated with significantly higher mortality. NHPIs are an especially vulnerable group and comprise a significant portion of
population. Further research is needed to address the causes of higher mortality and interventions to reduce hip fractures and associated mortality in these populations.

1:30 pm Podium

A Case of Reversible Cerebral Vasoconstriction Syndrome (RCVS) in a Patient with Eclampsia

Weiming Du, MD[1], Chalothorn Wannaphut, MD[1], Yoshito Nishimura, MD, PhD[1],

1:45 pm Podium

2:00 pm Podium

Ockham's Razor and Bayes Theorem at work, a Case Series: Analyzing the sensitivity and specificities of Brugada, aVR Verecki, and Basel algorithm in the determination of Ventricular Tachycardia amongst a Multiracial population

Clarke Morihara, MD[1], Thanaboon Yinadsawaphan, MD[1], and Steven Azuma, MD[2]

[1] , Honolulu, HI

[2] , Honolulu, HI

Wide Complex Regular Tachycardias (WCT) defined as a regular rhythm, with rate greater than 100/min s). Differential diagnosis includes ventricular tachycardia (VT), Supraventricular tachycardia (SVT) with aberrancy, antidromic bypass tract tachycardia, ventricular pacing and EKG artifact. Emergency treatment of wide complex tachycardia may include synchronized cardioversion irrespective of the etiology of the tachycardia. The differentiation between VT and SVT with aberrancy is clinically important to timely initiate acute and chronic management and guide further work up and treatment. There are historically many algorithms which are being applied but these have multiple, complex steps which can be difficult to recall in an emergency situation. Recently one algorithm (Basel) has been proposed which incorporates history of myocardial infarction, congestive heart failure with left ventricular ejection fraction of -defibrillator (ICD), or cardiac resynchronization therapy (CRT). This clinical information would be often available to the treating physician who can act on the result. The Basel algorithm has only 3 steps, can be performed in shorter time than the prior algorithms, can be performed by medical students with comparable result to experienced cardiologists, and has similar sensitivity and specificity.

Currently there are several established algorithms which provide an organized method to assist physicians in the differentiation of WCT and the diagnosis of VT or SVT. The Brugada1 Criteria (1991), aVR Vereckei2 algorithm (2008), and the Basel3 algorithm (2022). The original Brugada algorithm showed a sensitivity of 98.7% and specificity of 96.5%. The aVR Vereckei algorithm showed a sensitivity of 96.5% and specificity of 98.2%. The Basel algorithm showed a sensitivity of 92% and specificity of 89%.

Of 16,800 EKG s from September 2022 through December 2023, 16 patients (incidence 0.1%) from a multiracial population who presented between September 2022 to November 2023 at a community hospital had an EKG exhibiting WCT. This multiracial population consisted of individuals from Japanese (n=7), Native Hawaiian or Pacific Islander (n=3), Filipino (n=4) Chinese (n=1), or Caucasian ancestry (n=2). Additionally, this population was also assessed for the presence of structural heart disease (n = 8) which included either history of ICD, CRT placement, myocardial infarction, or history of transthoracic echocardiogram with an EF < 35%.

The three algorithms were separately applied to 16 EKG s by a cardiologist and 2 medical interns. The sensitivity and specificity of each algorithm to detect VT with was applied to a multiracial population. The sensitivity (Brugada 100%, aVR Vereckei 100%, Basel 100%) and specificity (Brugada 88.9%, aVR Vereckei 88.9%, Basel 79%) appeared to be similar to that of published data. We conclude the Basel algorithm is quicker, easier to apply, and more clinically relevant than the other algorithms. This may apply to hospitalists and first responders.

2:15 pm Podium

Findings from the First Systematic Survey of Surfer's Myelopathy Patients

Sarah Bellatti, MS[1], Joo Won Choi, MS[4], Jessica N. Wilson, PhD[1],
Ferdinand Hui, MD[2], Stacy C. Brown, MD[3],
[1] Medicine, Honolulu, HI
[2]
[3] Neuroscience Institute, Honolulu, HI

Objective: To describe the presenting symptoms and circumstances of myelopathy (SM) based on systematically collected survey data in a prospective cohort study.

Background: SM is a rare, non-

POSTER PRESENTATIONS

Poster #1

Finding A Way with the Wayfinder Patient Navigation Program: Addressing Chronic Disease Disparities for COFA Migrant Populations in Honolulu

Sylvia Nguyen, MS[1], Kiara Arakawa-Taum, MS[1],
Christie Izutsu, MD, FACP[2], Bryan Brown, MD MHS[3,4]

[1]

[2] Universi i Department of Medicine, Honolulu, HI

[3]

[4]

Historical events such as US thermonuclear weapon testing within their home lands left many Compacts of Free Association (COFA) citizens, including those of Chuukese, Marshallese, Pohnpeian, Yapese, and

Poster #2

Femoral Artery Occlusion as a Presentation of Mitral Valve Endocarditis

Brianna Delamare, DO[1], Robert McMurray, MD[2], David Peterson, DO[2], Jeremy Docekal, MD[2], Shaun Martinho, DO[2], Anthony Katras, MD2, Neil Stockmaster, MD[2], Derrick, Thiel, MD[2], Edwin Kamau, PhD[2], Viseth Ngauy, MD[2],

[1]

Poster #4

Key Principles for Stroke Genetics Research Involving Indigenous People in Hawai‘i and the Pacific Islands

Christine Anne T. Galang, MS[1], [2], Selena Vanapruks, MS[1],
Alex Ueoka[3], Chaye N. Kauhola[2], Leah Dowsett, MD[4],
Keolu Fox, PhD[5], Kazuma Nakagawa, MD[2], Stacy C. Brown, MD[2]

[1]

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[5]

Poster #5

BAL-DFA negative PJP pneumonia

1

Poster #8

IgG4-Related Disease: A Polyclonal Disease Masking a Monoclonal Diagnosis

Samuel Hunt, DO[1], Dakota Rodgers, MD[1], Troy Denunzio, DO[2], James Nguyen, MD[2]
[1] Tripler Army Medical Center Internal Medicine Residency Program, Honolulu, HI
[2] Tripler Army Medical Center, Honolulu, HI

IgG4-related disease (IgG4-RD) is an auto-

Poster #9

A Palliative Care Approach to Skin Cancers: A Case of Advanced Squamous Cell Carcinoma

Ralina Karagenova, MS2[1], David J. Elpern, M.D. [2]
[1]

[2] The Skin Clinic, Williamstown, MA

Introduction: Palliative care can improve symptoms, quality of life, and caregiver burden of patients with end-stage conditions1. Its use, however, remains unexplored in non-melanoma skin cancers and outpatient dermatology practices. We present an elderly woman with squamous cell carcinoma who benefited from a palliative care approach.

Case presentation: An 87-year-old woman with history of dementia and squamous cell carcinoma presented with a recurrence of an exophytic tumor of the scalp measuring on the mid-parietal scalp. The lesion was debulked, cultured, and a Xeroform dressing applied. Her daughter-in-law was instructed on how to change the dressings. Pathology showed a moderately differentiated squamous cell carcinoma extending to the base of the specimen. The patient later underwent outpatient Mohs micrographic surgery that showed carcinoma invading into the calvarium. Treatment options included intralesional 5 Fluorouracil (5FU) or topical 5FU and a short course of radiotherapy2. Chemotherapy with pembrolizumab may be a choice for healthier patients3, but was not suitable for this patient. In the end, the patient and her family decided they wanted to forego invasive or other treatments with the goal of supporting her quality of life at her home of many decades. Two months later the patient had a seizure and died. The tumor had eroded the calvarium and exposed her brain. She spent the last few months of her life comfortably at home being attended by her family and a visiting nurse.

Discussion: Squamous cell carcinoma can rarely present with extension to the skull and in this case, its localization, recurrence, and late diagnosis were poor prognostic factors4. There is a role for structured palliative care guidelines for life-limiting cutaneous conditions. Such patients will benefit from the interdisciplinary approach that palliative care offers.

References:

1. Thompson LL, Chen ST, Lawton A, Charrow A. Palliative care in dermatology: A clinical primer, review of the literature, and needs assessment. J Am Acad Dermatol. 2021;85(3):708-717. doi:10.1016/j.jaad.2020.08.029
2. Milena F et. al. A Short course Accelerated RadiatiON therapy (SHARON) dose-escalation trial in older adults head and neck non-melanoma skin cancer. Br. J Radiol. 2022 Jun 1;95(1134):20211347.
3. Burtness B, Harrington KJ, Greil R, et al. Pembrolizumab alone or with chemotherapy versus cetuximab with chemotherapy for recurrent or metastatic squamous cell carcinoma of the head and neck (KEYNOTE-048): a randomised, open-label, phase 3 study [published correction appears in Lancet. 2020 Jan 25;395(10220):272] [published correction appears in Lancet. 2020 Feb 22;395(10224):564] [published correction appears in Lancet. 2021 Jun 12;397(10291):2252]. Lancet. 2019;394(10212):191([)-3f11 Tm(7()-3(102(z)5 0 1

Poster #10

Chronicles of Insomnia: A Case of Non-24 Hour Circadian Sleep Rhythm Disorder in a Patient with Unilateral Blindness

Kristen A. Kircher, DO[1], Janet N. Myers, MD, FACP[2]
[1] Kaiser Permanente Hawaii Internal Medicine Residency Program, Honolulu, HI
[2] Kaiser Permanente Group, Honolulu, HI

Chronic insomnia is a common yet debilitating symptom that is often treated with cognitive

Poster #12

m&M: A Practical and Universal Equation to Calculate Ventilator Mechanical Power

Philip M. Lee, MS[1]

Poster #13

An Uncommon Presentation of Cyclic Neutropenia in an Adult Active-Duty Male

Roy Levit, MD[1], Nicholas G Richwagen, MD[1,] Kelly Sun, MD[2], Ryan M Jones, MD[2]
[1] Tripler Army Medical Center Internal Medicine Residency, Honolulu, HI
[2] Tripler Army Medical Center Honolulu, HI

Introduction:

Cyclic neutropenia is a rare hematological disorder characterized by recurrent neutropenia, typically diagnosed in childhood. It occurs roughly in 1 of 1 million individuals. Presented is an unusual case of cyclic neutropenia in a 21-year-old active-duty male who was deployed to Japan. This case is particularly unique as the patient presented in adulthood, which is a rare occurrence.

Case presentation:

The patient presented with recurring fevers, hip pains, oropharyngeal ulcers, and lymphadenitis, with each episode lasting approximately one week. His vitals were stable and physical exam confirmed an oropharyngeal ulcer. Laboratory evaluations revealed severe Neutropenia (ANC 0.1) and a positive streptococcal infection during episodes, which required treatment with antibiotics. This infection happened soon after moving from his childhood home and being deployed to Japan for the first time.

The patient displayed a periodicity of neutropenia every 3 weeks raising suspicion of cyclic neutropenia. Genetic testing confirmed a heterozygous pathogenic mutation in the ELANE gene, confirming the dieldhood1o-2(E g)13(

Poster #14

A Case of Cyclic Thrombocytopenia, Navigating a Diagnostic Difficulty

Roy Levit, MD1; Karen J Shou, DO2; Jeffrey L Berenberg, MD, MACP2
[1] Tripler Army Medical Center Internal Medicine Residency Program, Honolulu, HI

Poster #15

Empyema due to Streptococcus intermedius: Uncommon consequence of Periodontal Diseases

Sharina C. Macapagal MD[1], Christian John Capirig MD[1],
Andrew Pham MD[1], Titus David MD[1], Yoshito Nishimura MD, PhD, MPH[1]
[1]

Introduction:

S. intermedius infection is uncommon in previously healthy people without apparent predisposing factors. Despite being an oral commensal bacterium, it can cause complicated infections that can present as liver, brain, and lung abscesses. Herein, we present a rare case of empyema due to S. intermedius in a healthy man.

Case Presentation:

An 82-year-old male with a history of hypertension and non-toxic multinodular goiter presented to the emergency room with a two-week history of dyspnea associated with intermittent fevers, chills, undocumented weight loss, dysphagia, and productive coughs. Despite a five-day course of Azithromycin, his symptoms persisted. No hemoptysis, night sweats, palpable lymphadenopathy, chest pain, or exposure to sick contacts were reported. He is a former tobacco smoker and denies illicit drug use. He traveled to Japan and Guam a month before his emergency room presentation.
Physical examination showed sinus tachycardia, tachypnea, and hypoxia without fever. While he had good dentition, there were dental caries. His left lung demonstrated decreased breath sounds with dullness to percussion and egophony.

Initial work-up revealed neutrophil-predominant leukocytosis of 32,400 (92.4% neutrophils and 3.8%

Poster #16

Keeping up with the Jones? A case of adult, acute rheumatic fever with carditis

Brett W. Mathews, MD[1], Yuree J. Lin, MD[2], and Philip A. Verhoef, MD, PhD[1,2]
[1]

Poster #17

A Case of Metastatic Intrahepatic Cholangiocarcinoma Without Risk Factors

Destinee Morris, MD[1], Andrew Landau, DO[1], Yula Geniza, MD[1],
John Lee, MD[2], Pedro Manibusan, DO[2]
[1] Tripler Army Medical Center Internal Medicine Residency Program, Honolulu, HI
[2] Tripler Army Medical Center, Honolulu, HI

Introduction: While intrahepatic cholangiocarcinoma is rare in high income countries such as the United States, its incidence has been increasing over the past four decades worldwide (1). Cholangiocarcinoma is an aggressive malignancy arriving from bile duct epithelial cells that can be subdivided into intrahepatic and extrahepatic lesions. Recognized risk factors for intrahepatic cholangiocarcinoma include primary hepatobiliary disease such as primary sclerosing cholangitis, cholelithiasis, cholecystitis, hepatolithiasis, chronic liver disease, genetic disorders, toxic exposures, infections, and metabolic syndrome. However, many patients do not have any of these risk factors (2). We describe a case of metastatic intrahepatic cholangiocarcinoma in a patient with no risk factors.

Case Presentation: A 43-year-old male presented to his primary care physician with two weeks of persistent right upper quadrant abdominal pain for 2 weeks. He described the pain as a sharp, stabbing pain that starts under his right rib cage and radiates to right upper back when he takes in a deep breath. He also endorsed intermittent nausea and decreased appetited. He denied changes to his bowel movements. He had never smoked or drank alcohol. He had no history of gallbladder or liver disease. Family history was negative for gastrointestinal disease or disorders. His exam was notable for tenderness to palpation in the right upper quadrant with mild guarding with palpation. His vital signs were unremarkable. His labs revealed elevated alkaline phosphatase (495), alanine transaminase (167), and aspartate transaminase (108) and negative hepatitis panel. Right upper quadrat ultrasound showed a right hepatic lobe mass with enlarged porta hepatitis lymph nodes and dilated common bile duct measuring 7mm. CT liver showed right hepatic lobe masses with adjacent lymphadenopathy and nodular liver contours consistent with cirrhosis. Interventional radiology performed liver biopsy and resulting pathology showed poorly differentiated adenocarcinoma. Gastroenterology performed esophagogastroduodenoscopy (EGD) with endoscopic ultrasound (EUS), colonoscopy, and lymph node fine needle aspiration (FNA). His EGD and colonoscopy were unremarkable and EUS showed enlarged porta hepatis lymph nodes. FNA of periportal lymph nodes showed no malignant cells on pathology. PET scan revealed multiple hypermetabolic lesions in the liver, mediastinum, lungs, and abdominal wall consistent with metastatic cancer. He was diagnosed with stage IV metastatic intrahepatic cholangiocarcinoma. He was seen by oncology and initiated on treatment with cisplatin, dury0 612 ete6(al)-07 Tm-2(e)9(l

Poster #18

Poster #19

Catastrophic Antiphospholipid Syndrome: A Rare, Life-Threatening Complication in Systemic Lupus Erythematosus

Kevin Edward Nebrejas, MD[1], Manasawee Tanariyakul, MD[1], Kuo-Chiang Luo, MD[2]
[1]
[2]

A 33-year-old Micronesian woman presented as an inter-island transfer to our institution following a recent biopsy-proven diagnosis of class IV lupus nephritis (LN). She was initially treated with mycophenolate mofetil (MMF), hydroxychloroquine (HCQ) and prednisone, but developed hemoptysis with acute hypoxic respiratory failure requiring intubation and mechanical ventilation. CT scan of the chest demonstrated diffuse bilateral reticulonodular infiltrates and bronchoscopy revealed diffuse alveolar hemorrhage (DAH).

Laboratory evaluation revealed renal failure (SCr= 4.4mg/dL), hyperkalemia, metabolic acidosis, elevated anti-dsDNA, and low C3 and C4. Furthermore, the patient exhibited hemolytic anemia with blood smear consistent with microangiopathic hemolytic anemia (MAHA). ADAMTS13 level was normal. She was started on rituximab and pulse methylprednisolone. With improving respiratory status, the patient was later extubated. However, she subsequently developed neuropsychiatric symptoms with behavioral change and visual hallucination. MRI brain demonstrated diffuse punctate foci of acute to subacute infarction with narrowing of bilateral ACA, MCA, and left PCA.

Her hospital course was further complicated with widespread venous thrombosis (VTE) which initially presented as clotting of the guidewire during femoral non-tunneled dialysis catheter placement for continuous renal replacement therapy (CRRT). Imaging revealed VTE of upper and lower extremities of the left basilic

Digital Poster #20

Confusion After Car Crash- An Unusual Presentation of Primary CNS Lymphoma

Jadon Neuendorf, MD[1], Sable Neuendorf, MS[2]

[1] Honolulu, HI

[2] California University of Science and Medicine

Introduction:
Primary central nervous system lymphoma (PCNSL), a non-Hodgkin lymphoma, is a rare condition with a rising incidence in the elderly population over the last two decades. The cause for the rising incidence is largely unknown, however aging of the global population and increased availability of and advances in diagnostic imaging are suspected to play a role. The most common clinical presentation of PCNSL involves focal neurologic deficits due to intracranial lesions. However, generalized neurocognitive changes may be present and falsely attributed to the aging process. Considering that PCNSL can involve different parts of the central nervous system, clinical presentation can be highly variable and vague systemic symptoms may be the presenting chief complaint.

Case Presentation:
We present a case of a 73 year-old male who presented to the emergency department status-post motor vehicle collision due to suspected confusion while driving. Elicited history included nine weeks of intermittent fevers with chills, night sweats, decreased appetite, weight loss, gait instability, and episodes of inattentiveness. The patient's family member had observed these inattentive episodes during meals but shared that the patient was arousable from them without difficulty. There was no reported seizure-like activity and the patient had no somnolence or weakness after these episodes. There were no reported vision changes or headaches. The patient reported he was up-to-date on his health screenings, his only recent travel was to California, and he had no unusual exposures.

On admission, the patient appeared appropriately nourished, although lethargic. He was noted to have a waxing and waning level of alertness, occasionally becoming inattentive and disoriented. He demonstrated a sluggish affect and slowed speech. Physical exam was notable for trauma to his right knee and a superficial laceration to his scalp, but was otherwise unremarkable. There was no cervical or axillary lymphadenopathy and no focal neurologic deficits. A noncontrast head CT was obtained due to the mechanism of injury which showed no intracranial bleed, however hypodensities were noted in the bilateral frontal lobes and left parieto-occipital lobes. The radiology impression indicated possible vasogenic edema. An MRI brain with and without contrast was obtained which showed multifocal enhancing lesions involving the anterior corpus callosum and left occipital lobe. These findings were concerning for a multifocal glioma or possible lymphoma and the radiology impression indicated the pattern was not typical of metastases, infarcts, or infection. EEG was negative. An infectious work-up including lumbar puncture with CSF testing was unremarkable and CSF cytology was negative for a clonal B or abnormal T-cell population. CT imaging of the chest, abdomen and pelvis was unremarkable and MRI of the spine did not demonstrate any lesions. Ultimately, a brain biopsy was performed and demonstrated Stage IE diffuse large B-cell lymphoma and a diagnosis of primary CNS lymphoma was made.

Discussion: Considering the variability in clinical presentation of PCNSL, clinicians should maintain high suspicion for this condition within a differential diagnosis for the elderly population in whom symptoms may be mistaken for age-related cognitive decline or other systemic illness.

Poster #21

A rare presentation of sarcoidosis as a large pulmonary mass

Sorawit Ongsupankul, MD[1], Witina Techasatian, MD[1], Bradley Fujiuchi, MD[1], Steven Namikim MD[1], Chalothorn Wannaphut, MD[1], Thanaboon

Poster #24

FOXO3 Genotype Mitigates the Effect of Low Bioavailable Testosterone on Mortality: The Kuakini Honolulu Heart Program.

Ayumi Sakamoto, MS[1], Randi Chen, MS[2,3], Brian Morris, DSc, PhD[2], Aida Wen, MD[2], Timothy Donlon, PhD[3], Richard Allsopp, PhD[2], Brad Wilcox, MD[2,3], Kamal Masaki, MD[2,3]

3 Kuakini Medical Center, Honolulu, HI

Introduction:

Studies have found that age-related decline of testosterone is associated with increased risk of all-cause mortality. The gene FOXO3 regulates numerous homeostatic pathways, and the minor allele (G) of SNP rs2802292 has been associated with longer lifespan compared to major allele homozygote (TT). We studied whether bioavailable testosterone levels predict all-cause mortality in an older Asian male population, and are the first to examine its interaction with FOXO3 genotype.

Methods:

The Kuakini Honolulu Heart Program is a longitudinal cohort study of Japanese-American men in Hawaii since 1965. Serum testosterone was measured at Exam 4 (1991-93) when subjects were 71-93 years old. Bioavailable testosterone levels were calculated and quintiles were used for analysis. After excluding those missing data on hormone levels or FOXO3 genotype, our analytic sample included 3,138 men who were followed for mortality until December 31, 2022 (32 years). We also performed stratified analyses by FOXO3 genotype.

Results:

Age-adjusted mortality rates were significantly higher in lower quintiles of bioavailable testosterone (Q1=110.5, Q2=98.4, Q3=97.6, Q4=98.0, and Q5=93.5 per 1,000 person-years of follow-up, p for trend=0.0012). Multivariate Cox regression adjusted for baseline age, cardiovascular risk factors, prevalent chronic diseases (coronary heart disease, stroke, cancer, dementia) and FOXO3 genotype found an increased risk of total mortality in Q1 (HR=1.20, 95% CI=1.07-1.36, p=0.003), using Q5 as reference. There was a significant interaction with FOXO3 genotype (p=0.029). When stratified by FOXO3 genotype, we found a significant association between bioavailable testosterone and total mortality in the FOXO3 TT group (HR=1.34, 95% CI=1.14-1.59, p<0.001). However, in FOXO3 G allele carriers, there was no significant association between bioavailable testosterone and mortality. Mortality was not associated with bioavailable estradiol levels.

Conclusion:

Low bioavailable testosterone was associated with increased total mortality in older Japanese-American men with FOXO3 TT genotype, but not in those who were FOXO3 G allele carriers. The findings suggest a potentially protective role of the longevity-associated FOXO3 G allele by mitigating the adverse effects of low testosterone.

Poster #25

Bilateral renal vein thrombosis and chylous ascites in PLA2R-associated membranous nephropathy: a case report

Kazushige Shiraishi, MD[1], Chesta, MD[1],
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[2]
[3]

Chylous ascites is seldom seen with adult nephrotic syndrome, and its etiology and management in nephrotic syndrome are unclear, whereas renal vein thrombosis is a well-studied complication of nephrotic syndrome. Despite a single previous case report from an autopsy showing the coexistence of chylous ascites, nephrotic syndrome, and renal vein thrombosis, there have not been any cases showing these three phenomena in a single patient. We are presenting the first case of membranous nephropathy with bilateral renal vein thrombosis and chylous ascites that was successfully treated with anticoagulation and rituximab. Here, we report a rare case of PLA2R-associated membranous nephropathy complicated by bilateral renal vein thrombosis and chylous ascites successfully treated with anticoagulation and rituximab.

A 65-year-old African American male with a history of hypertension and peripheral arterial disease presented with acute onset abdominal pain and hematochezia, in addition to progressive lower extremity edema for one year. Four days prior to admission, the patient developed acute onset abdominal pain and hematochezia associated with abdominal distention on the day of admission. Except for blood pressure of 158/73 mmHg, his vital signs were within the normal limits. His abdomen was distended with periumbilical tenderness without rebound or guarding. He had bilateral pitting edema extending to the thighs. Rectal examination revealed bright red blood. Laboratory analysis showed hemoglobin 10.3 g/dL, creatinine 1.9 mg/dL, albumin 2.0 g/dL, cholesterol 222 mg/dL, and triglycerides 245 mg/dL. Twenty-four-hour urine chemistry revealed protein 6452 mg/24hr, creatinine 0.4 gm/24hr. The findings were consistent with nephrotic syndrome. Abdominal CT scan with contrast showed nonocclusive bilateral renal vein thrombosis with a moderate amount of ascites. Paracentesis revealed chylous ascites with cholesterol 10 mg/dL and triglycerides 131 mg/dL. The patient was started on an intravenous continuous heparin infusion for renal vein thrombosis and underwent endoscopy and colonoscopy for hematochezia, which did not reveal an active source of bleeding. Workup for nephrotic syndrome was positive for anti-PLA2R antibody. Rituximab successfully controlled the disease activity with improvement in renal function.

Chylous ascites is a rare complication of nephrotic syndrome. Its prevalence, characteristics, and management in the context of nephrotic syndrome are unclear due to the rarity. Some literature attributed chylous ascites in nephrotic syndrome to possible bowel edema. In our case, we hypothesize that the renal thrombosis increased renal lymphatic pressure, leading to leakage of lymphatic fluid into the peritoneal space, similar to chylothorax seen with central venous thrombosis. The case illustrates the importance of considering nephrotic syndrome as

Poster # 27

Left-sided hepatic hydrothorax

Toshiaki Takahashi, MD[1], Reed McCardell Malone, MD[1], Luke Taylor, MD[1],

Poster #28

Androgenic Steroid Misuse in Military Personnel: A Case Study and Policy Implications.

Confesora Valdez A. MD[1], Robert Leimbach, MD[1]
[1] Tripler Army Medical Center, Honolulu, HI

Introduction: Androgens are potent drugs that require a prescription. Self -administration of androgens without a medical prescription is considered abuse for invalid, unproven, or off-label reasons. Moreover, the use of androgenic anabolic steroids (AASs) presents a multifaceted challenge within the military community, mainly because they are thought of as physical and performance enhancers, offering a revitalizing tone. Neglecting the potential health repercussions of anabolic steroid usage can result in significant adverse outcomes, encompassing hormonal disruptions, cardiovascular complications, and psychological issues, all of which have the potential to erode the operational readiness and long-term welfare of military personnel. AAS is widespread across

Poster #29

A Rare Case of Osteomyelitis Pubis with Abscess Formation

Cindy T. Vuong, MD[1], Raquel Tello, MD[2]

[1]

Poster #31

Poster #33

Beyond Syncope: A Rare Case of Complete Heart Block due to Isolated Cardiac Sarcoidosis

Thanaboon Yinadsawaphan, MD[1], Ashwin Venkataraman, DO[3], Witina Techasatian, MD[1],
Clarke Morihara, MD[1], Steven Namiki, MD[1], Sorawit Ongsupankul, MD[1],
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Conclusion: This case underlines the necessity of thorough investigations of complete AVB etiology. Diagnosis of CS warrants additional managements of complete AVB, including corticosteroids and an ICD.

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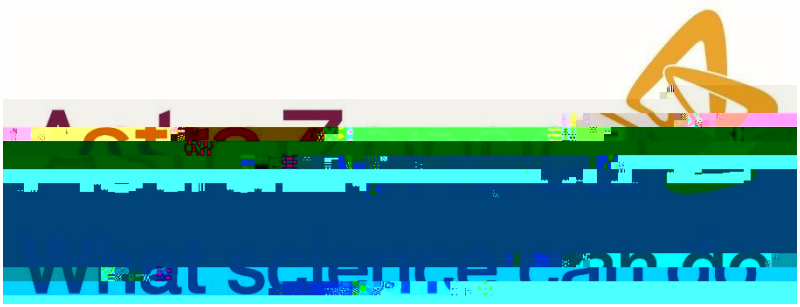

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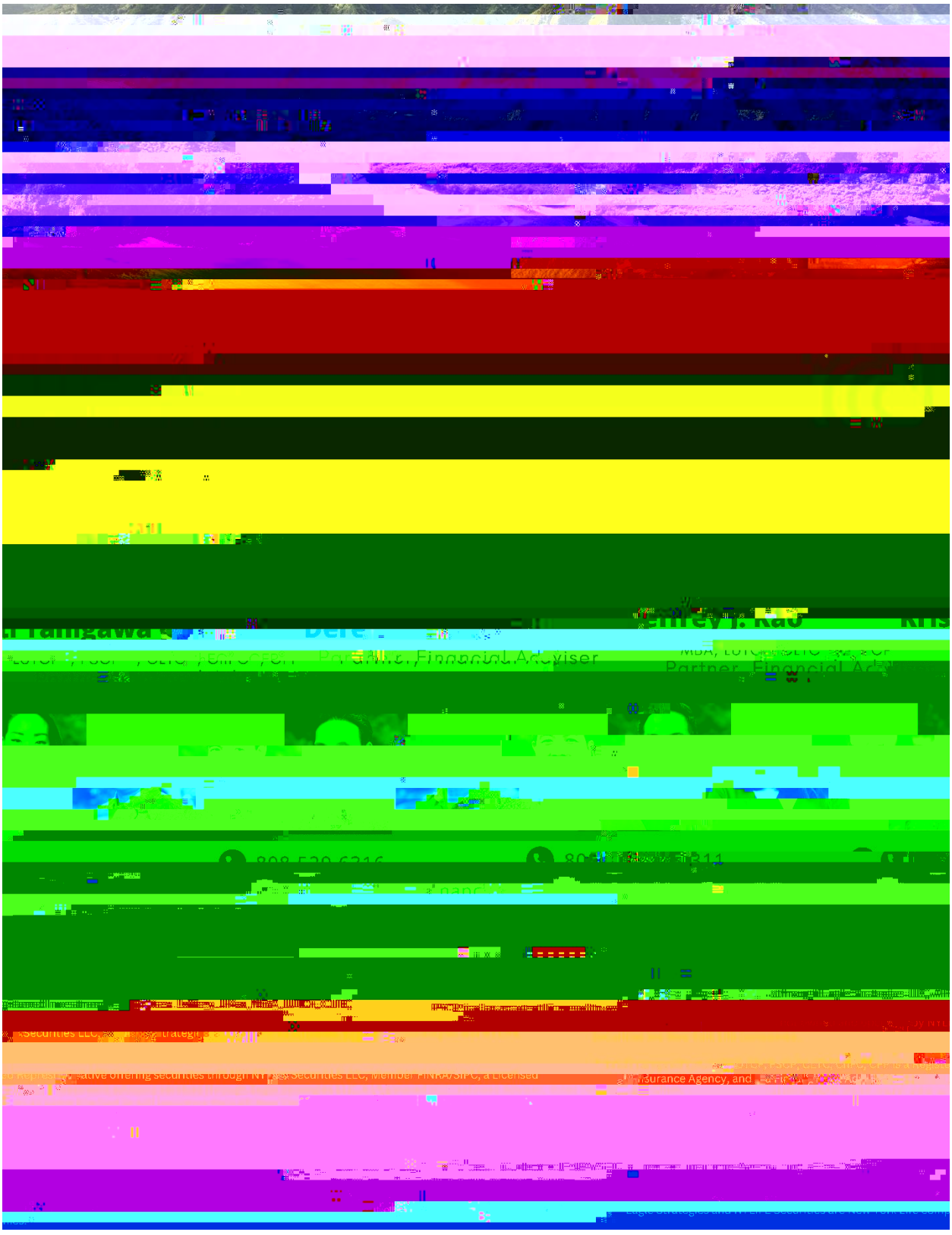

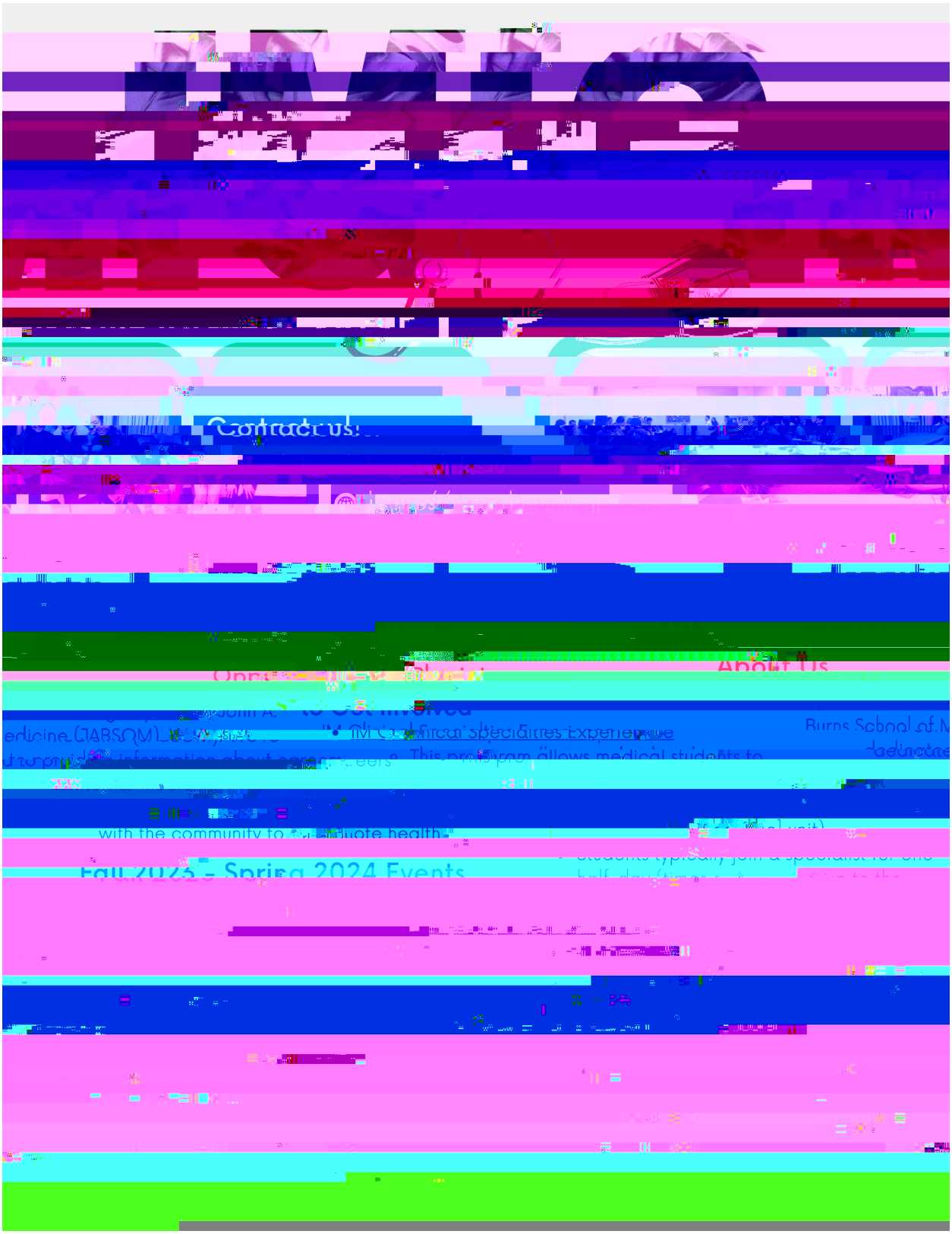
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