

QUESTION
 A 65-year-old male patient with a long history of hypertension and hyperlipidemia presents to the clinic with a 2-week history of increasing fatigue, weight loss, and intermittent fevers. He reports that he has been unable to complete his usual activities of daily living. He has no cough, hemoptysis, or chest pain. He has no recent travel history and no contact with anyone who has been ill. He is currently on lisinopril and atorvastatin. His medical history is significant for type 2 diabetes mellitus, chronic kidney disease, and a recent diagnosis of atrial fibrillation. He is a former smoker and has no alcohol use.

Physical Examination	Vital Signs	Investigations
Temperature: 38.2°C Heart rate: 102 bpm Blood pressure: 145/90 mmHg Respiratory rate: 18 breaths/min Oxygen saturation: 96% on room air Weight: 75 kg (10% weight loss) General: Cachectic, appears unwell HEENT: No lymphadenopathy, no oral lesions Lungs: Clear to auscultation Cardiac: Regularly irregular rhythm, no murmurs Abdomen: No hepatosplenomegaly, no lymphadenopathy Extremities: No edema, no clubbing Neurological: No focal deficits	Hemoglobin: 10.5 g/dL Hematocrit: 32% Hemoglobin A1c: 7.8% Creatinine: 1.8 mg/dL ESR: 45 mm/hr CRP: 12 mg/L Tumor markers: Negative	CXR: No infiltrates, no masses CT scan: No pulmonary nodules, no lymphadenopathy PET scan: No areas of increased FDG uptake

ANSWER



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 The patient's presentation is consistent with a diagnosis of...