

QUESTION

A 65-year-old man with a long history of hypertension and a recent diagnosis of type 2 diabetes mellitus presents to his primary care physician with a 2-week history of increasing fatigue, weight loss, and decreased appetite. He reports feeling "run down" and has noticed a persistent low-grade fever. He has no chest pain, shortness of breath, or changes in bowel habits. He is currently on lisinopril and metformin.

On physical examination, he appears mildly ill with a temperature of 37.8°C (100.0°F), heart rate of 98 beats per minute, and blood pressure of 145/90 mmHg. There is no tachypnea, crackles, or wheezes. The lungs are clear to auscultation. The abdomen is soft and non-tender. There is no lymphadenopathy. The patient's weight is 75 kg (165 lbs), down from 80 kg (176 lbs) 6 months ago.

Initial laboratory workup shows a hemoglobin of 12.5 g/dL, hematocrit of 38%, and white blood cell count of 10,500 cells/mm³ with a neutrophilic shift. Serum ferritin is 150 ng/mL, and serum iron is 150 µg/dL. The erythrocyte sedimentation rate (ESR) is 45 mm/hr, and the C-reactive protein (CRP) is 15 mg/L. A chest X-ray is unremarkable. A complete metabolic panel shows a normal renal function profile.

What is the most likely diagnosis?

A. Anemia of chronic disease

B. Iron deficiency anemia

C. Polycythemia vera

D. Vitamin B12 deficiency

E. Sideroblastic anemia

ANSWER



The patient's presentation and laboratory findings are most consistent with anemia of chronic disease.

The anemia is normocytic, and the ferritin is elevated, which is characteristic of anemia of chronic disease.

The ESR and CRP are elevated, indicating an underlying inflammatory process.

The chest X-ray is unremarkable, ruling out pulmonary causes of anemia.

The patient's history of hypertension and type 2 diabetes mellitus are likely contributing factors to the anemia.