9/22/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Ethan (@)* ***Case Discussants****: Ravi (@) & Kirtan(@)*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Nguyen):

CC: 50 yo F presents with progressive dyspnea on exertion for 1 month

HPI:
Dizziness, dry cough, fever, generalized weakness, insomnia
Depressed mood, lost her mother last month.
Weight loss more than 3 kg over 3 months

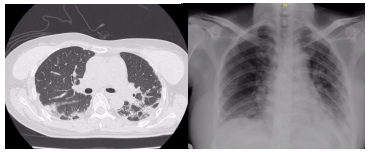
ROS: No chest pain, no productive sputum

PMH:
T2DM, CVA without deficits

Meds:
ASA
Insulin
Glipizide

Vitals: T: 36.6 **HR**: 96 **BP**: 108/82 **RR**: 14 **Sat**: 88% on RA -> 98% on 3L NC
Exam: Chest: bilateral lower lobe coarse breathing sound, otherwise normal

Notable Labs & Imaging:
Hematology: WBC: 9.7 Hgb: 12.6 Plt: 243k MCV: 87
Chemistry: Na: 129 K: 3.6 Ca: 7.8 BUN: 18.9 Cr: 0.54
Glu: 195 AST: 310 ALT: 239 ALP: 144 T. Bili: 0.5 T. protein: 7.3
Alb: 3.54 CRP: 3 Procal: 0.1
Hepatitis panel (-)
BNP: 65 hs-TnI: normal
CXR: Bilateral lower infiltration
EKG: Normal **Echo**: Normal



Was given CTX + azithromycin → still febrile so changed to Zosyn

CT Chest: Bilateral subpleural and peribronchovascular consolidation, predominantly in the lower lobe, bronchiectasis in the lower lobes, mediastinal LAD, no pleural effusion
Ddx: OP? CTD with ILD? Atypical PNA?



1 week → Worse SOB, O2 non rebreathable mask
ABG: pH 7.4 O2 73 HCO3 26.2. *Accessory muscle use → intubation*
ID screen: Negative HIV, WBC 6 **Blood cultures:** negative
Lab trend: Cr: 0.25 AST: 238 ALT: 169 ALP: 123
LDH: 509 CK: 60 Myoglobin: nl
Liver US: patent vasculature, no mass lesions
Aspergillus Ag: 3.48, Legionella urine Ag (-), Mycoplasma IgM (-), Chlamydia Ab (-), EBV (-), CMV PCR 38, Covid/flu (-), sputum PJP (-)
Bronchoscopy: TB (-), legionella (-), PJP (-), CAP panel (-), CMV (-), EBV (-), fungus Cx (-), aerobic anaerobic Cx (-), aspergillus (-), CRYPG (-), gram st (-). Repeat Aspergillus Ag (-)
Myositis panel: MDA5 3+; Ro52 3+; ANA, dsDNA, RF (-)
Diagnosis: Anti-MDA5-associated dermatomyositis with rapidly progressive ILD
She has severe respiratory failure requiring invasive mechanical ventilation, later complicated by pneumomediastinum and subcutaneous emphysema and passed away

Problem Representation:Middle age women with subacute symptoms, respiratory failure and elevated liver enzymes. Infections workup negative, myositis panel positive.

Teaching Points (Mattia)
Different symptoms: non localizing Vs localizing

Exertional dyspnea not always exertional hypoxia
DDx: think overlap!
CV: is the CV system able to accommodate for increased demand?
Pulmo: increase in pulmonary pressure?
Metabolic: increased requirement of oxygen
Hematologic
Toxic
Other symptoms present pointing to one or the other? Helping narrowing to a specific system?

If hypoxemia is present the A-a Gradient use to define the actual problem.
- When giving oxygen look at the response to it

Once lab is there and something pops up, then go back to the bedside (eg high liver enzymes→ Check for OTC medications)

Which systems are involved in the current presentation? (eg here: liver and lungs)
- Ground glass infiltrates (GGO) Main question: what is filling the alveoli? Blood? Proteins? cells?(neoplastic/not neoplastic)
  - Infections vs autoimmune/inflammation vs cellular (neoplastic/not neoplastic)

Define the time course: Acute? Subacute?acute on subacute? Chronic? Chronic with an acute flare?

Update the problem representation once new data appear
- Here: is there a pathogen/agent/immunological reaction capable of affect both lungs and liver?(since the differential for lower lobe infiltrate is very wide)

Labs pearls:
Low BNP
BNP negative heart failure due do exhaustion of capacity to produce it
Other causes of low BNP: Obesity (increased clearance

LDH Elevation: pay attention when interpreting it (if it is elevated), since it is expressed by many cells