10/23/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Zakariyya Gardee (@) **Case Discussants**: Rabih (@) & Reza (@)

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

Scribing (Lukas):

CC: ED 24 yo female p/w drowsiness and fluctuating levels of consciousness accompanied by her husband

ROS (+): nausea and vomiting, blurred vision, lower back pain, increased urinary urgency and frequency with fevers

HPI: 8 weeks prior emergency c-section at 28 weeks, prior 3 weeks of feeling unwell, then developed pulmonary edema and renal failure (peak Cr 6,1 mg/dL, urea 109 mg/dL (39 mmol/L) assoc. Hypertension, proteinuria, hematuria, elevated cholesterol)
Full workup: negative for ANA, anti GBM, MPO, PR3, hiv, syphilis, HepB/C, complement, ASO, anti-DNase B

PMH:
Prior uneventful pregnancy

Meds:
Prednisone
Azathioprine 150 mg daily
Tacrolimus 10 mg twice daily

Fam Hx:

Social Hx:

Health-Related Behaviors:

Allergies:

Vitals: T: 38° **HR**: 120/min **BP**: 135/85 **recap**: 3s
Exam: Gen: fully alert but lethargic, unwell sleepy
CV: wnl **Pulm**: wnl **skin**: dry mucosal membranes, no edemas
Abd: soft, diffuse tenderness in lower back, esp. Over right flank area
Neuro: no focal neurological deficit, no neck stiffness

Post delivery
Renal biopsy: most of glomeruli sclerosed, acute tubular necrosis, severe inflammation, positive staining for IgA but negative for C3, C1Q and other immunoglobulins; vasculature normal
Course: Discharged on immunosuppressant medication including steroids, azathioprine, tacrolimus

cCT contrast: wnl **US**: IVC small
Nephrology Consult: suspected chronic missed IgA nephropathy, eval for kidney transplant
Labs: Na: 119, K: 6,6 Urea: 106 mg/dL Cr: 5,2 mg/dL
WBC: 7 CRP: 6 Hb: 8,8 PLT: 130 (previously wnl)
ALT: 117 AST: 133 ALP: 133 gGT: 306 tBili: wnl INR: wnl PTT: wnl LDH: slightly elevated
VBG: pH, bicarb: wnl, ketones negative, glucose: highly elevated
Repeat Labs: LFP stable; gGT 300 → 900
CT A/P C+: mural enhancement of second and third parts of the duodenum, gallbladder wnl, subtle wall enhancement, minimal amount of pericholecystic fluid, mildly prominent intrahepatic bile ducts, CBD 7 mm, subtle enhancement intrahepatic part, can't rule out beginning cholangitis, recommended follow up
Labs: Lipase 2,000

Dx: drug-induced acute pancreatitis complicated by hyperosmolar hyperglycaemic state

Problem Representation: 24 yo female under immunosuppression p/w reduced general state to the ED with prior emergency c-section 8 weeks ago with hyperglycemia, diffuse abdominal tenderness and AKI

Teaching Points (Lourenço)

- **Starting with a BANG:** in a young person with drowsiness and vomiting, think of metabolic causes. However, whenever there's headache or eye pain / blurred vision, think of intracranial hypertension. Head imaging, fundoscopy and LP STAT
- **Tumble in the washing machine**: to layer in the background, first try to clarify the foreground. In a patient with a recent delivery, specially in the context of AKI, HTN and proteinuria, consider urgent causes such as PE / eclampsia and TMA associated with pregnancy.
- **Metabolic disarray**: in a patient with many metabolic abnormalities, it's justified to pursue these as valid justifications for AMS in a patient without focal deficits (but keep low threshold to do LP). Steroids and CNi are frequent pharmacological causes of acute hyperglycemia.
- **Go up, go down, go to the right, no to the left**: the 4 main causes of pancreatitis are stones, alcohol, elevated triglycerides and hypercalcemia. In a patient with elevated lipase, beware of AKI and hyperglycemia (mimics of elevated lipase).
- **It was the Tacrolimus all along**: it causes direct pancreatic toxicity and induces elevated triglyceride levels.