4/11/26 Simplicity in Complexity VMR @CPSolvers

"One life, so many dreams" ***Case Presenter:*** *Kirtan (@KirtanPatolia)* ***Discussant:*** *Jeffrey*

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

Scribing (Sarah B)

CC: 69-year-old-woman with 1 week of dyspnea and left sided painless vision loss

HPI:

Dyspnea has been gradually progressing over 2 weeks and is primarily exertional. She denies orthopnea, PND, LE edema, and has never experienced this before. No chest pain, cough, fever, hemoptysis.

3 days before presentation woke up with no vision in left eye. Right eye has no complaints. No blurred vision in right eye. No trauma, no pain. No headaches, no rashes, no edema, no joint pain/synovitis.

ROS:

2x weeks of black stools

PMH:

T2DM: well-controlled now (A1C 7%), but has complications including L-sided diabetic retinopathy-R eye unaffected

HTN: well controlled on amlodipine

SLE: unclear when diagnosed, unsure of medications

Meds:

Amlodipine

Metformin

Fam Hx:

N/a

Social Hx:

unremarkable

Health-Related Behaviors:

No marijuana, drugs, or smoking

Retired teacher, no pets, stays at home.

Allergies: N/a

Vitals: nl Exam: Gen: well-rested, comfortable.

HEENT: No temporal tenderness, no wasting. Conjunctival pallor. No scleral injection or icterus. Oral cavity nl. No LAD.

CV: nl **Pulm**: nl **Abd**: nl **Extremities/skin**: nl, no edema or rashes.

Neuro: CN intact. Left eye without vision–unable to count fingers, no pupillary response including the consensual response. R eye PERRL, normal limits of visual acuity.

Notable Labs & Imaging:

Hematology: WBC: 3 (baseline 5, 1 month ago) Hgb: 8 (baseline 10) Plt: 130 (baseline 200) MCV: 86

Trends: 2-3 for hospitalization, never required transfusion. PLT dropped to 70 but never below.

Hemolytic w/u: haptoglobin nl, reticulocytes: low, folate: 1, ferritin 4000 **Chemistry**: Normal BMP and LFTs. Troponins: nl

Imaging/Advanced Labs:

EKG: 3x EKGs all within normal limits.

CTPE: no PE, normal lung parenchymal damage or LAD.

GI consulted for EGD and colonoscopy: no mass lesions, vascular lesions, or bleeding source. EGD: grade IV esophagitis. H. pylori negative. Esophageal biopsy positive for *Candida albicans*.

TTE: normal

Fundoscopy: R eye: nl; L eye: anterior chamber normal, posterior difficult to visualize, OCT: acute L retinal detachment without other obvious signs of vitritis (e.g. no dense fluids). W/u inconclusive of cause so recommended MRI Orbits, which was negative for optic neuritis. Highest concern was for DM-related retinopathy/retinal detachment.

Patient suddenly, at day 6 of hospitalization, became hypotensive and fluid unresponsive. Transferred to ICU for pressors. AxOx3.

Rheum Consulted:

ESR: 145 CRP: 300 ANA 1:80, ENA: dsDNA-, anti-Sm 5 (+), C3/4 nl, UA nl; ANCA, RF, CCP nl, CK nl. D-dimer >1000.

Glucose 50 (stayed low, required dextrose infusion).

Blood cx: serial negative; Empiric antibiotics/fungals were started. Repeat echo: no change in EF, increase in mild pericardial effusion without tamponade.

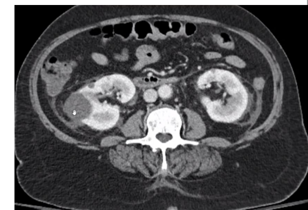
CT Chest: nl.

Repeat CBC: HGB 5, MCV nl, WBC 1.5, Plt 20. BMP/LFTs normal.

Ferritin 5000. HLH markers otherwise normal or only slightly elevated.

Peripheral Smear: no schistocytes, blasts, etc. x 2

CTAP: nl except kidneys. Kidneys/Adrenals: concern for bilateral adrenal hemorrhages and adrenal vein thrombosis.



APLS serologies: nl, TTP labs normal, Factor V leiden/PNH/other w/u negative. JAK2 mutations neg.

Free LC/paraproteins negative/normal.

Infectious workup: negative/normal, AFB cx: negative

PET: normal. Increased uptake in bone marrow.

Bone Marrow Biopsy: dyspoiesis in all cell lines consistent with MDS. All staining for AFB, GLS, silver staining etc. negative. Grade II fibrosis also consistent with MDS.

Dx: Myelodysplastic syndrome with U2AF1 mutation