9/28/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Kuchal (@AgadiKuchal)* ***Case Discussants****: Youssef (@saklawiMD) & Magnus*

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

Scribing (Truth & CPS team):
CC: weakness, unintentional weight loss
HPI:
31 y/o F, 4 mo **postpartum**, breastfeeding, no PMH, originally from **Ghana** (now in the Bronx), p/w 4 mo of **progressive weakness**, poor PO intake, and **unintentional weight loss** →now unable to walk. 1 week of **dry cough**. Remote Quantiferon was **indeterminate (2023)** and never treated. ***Diagnosed with disseminated TB*** → **started RIPE.** Did **not** get better. Later worsening **pancytopenia (WBC went down to 0 at one point)**.

HLH Rx: dex + anakinra + IVIG; RIPE continued.
Blood culture : **C. tropicalis bacteremia** → later **angioinvasive Candida on skin bx** → micafungin
CRRT for worsening **renal failure** (held for hypotension)
Escalating pressors (NE, VP, phenylephrine)
Intubated for **hypoxemic resp failure**
ROS:
No fever/chills/night sweats. No abd pain or diarrhea. No chest pain or SOB. No urinary sx.

PMH:
C-section 4 mo ago

Meds:

Social Hx:
Lives with aunt and two children.

Health-Related Behaviors:
No tobacco, alcohol, drugs.

Vitals: T: 98.6 **HR**: **140** **BP**: 119/62 **RR**: **22** **Sat**: 97%
Exam: Gen: Cachectic, alert, borderline hemodynamics w/o frank shock.
HEENT: nl **CV**: nl **Pulm**: nl **Abd**: nl **Neuro**: nl
Extremities/skin: nl

Notable Labs & Imaging:
Labs:
Na **122** / K **2.9** / Cl **80** / CO2 **23**
Alb **2.3** | AST **58** | ALP **239** | TBili **1.1**
VBG: **7.47** / 42 / **31**, lac **2.5**
WBC 9.4 | Hgb **8.5** | Plt **598**
Troponin: neg | UA: pyuria | COVID/flu: neg
Ferritin **> 50,000** Fibrinogen **100**
Cytokines: **IL-6, IL-10, IL-8 markedly** ↑
BMBx: **scattered hemophagocytes**, no lymphoma.
≥5/8 HLH-2004 criteria.

Imaging:
EKG: ST 123, QTc 400
CT chest: large L pleural effusion, bilateral micronodules, L upper lobe ground glass opacities
CT A/P: ascites + hepatic steatosis
Pleural fluid: AFB+ on broth culture + MTB PCR.
New TTE: LVEF 25–30%, global hypokinesis; same on repeat

Problem Representation: 31 y/o postpartum F immigrant from Ghana with no known PMH who presents with chronic, progressive weakness and unintentional weight loss - is found to have +MTB PCR and worsening pancytopenia with hyperferritinemia, bilat micronodules, L pleural effusion, and LVEF 25-30% with global hypokinesis.

Teaching Points (Jahanvi)
-Weakness postpartum: Focal deficit (Neuro) or generalised fatigue causing weakness.
-PP makes vulnerable to: thyroid ds, myocardial ds, hypercoagulability, iron def, endocrinal.
-Explore CT lung nodules, combined with hyponatremia (**TB affects the adrenals)**
-Pleural effusion-tap- malignancy/infection. (AFB+ points to disseminated TB)
-Elevated ferritin, worsening cytopenia, hemophagocytic picture on BM bx points to HLH picture/ granulomatous diseases. (TB could be a trigger)
-**HLH** (pri (familial)/sec- sec to what? Which organism ? macrophages activated by organism and further activated T cells– eventually causing end organ damage)
-**2 causes of HLH**: Mycobacterial/histoplasma/intracellular bact (strep, mycoplasma), Viruses (Herpes, EBV, CMV, HSV), Fungal, autoimmune (lupus, adult onset still's disease), lymphoma
- Differentials of low EF here- Myocarditis, PP cardiomyopathy, stress induced cardiomyopathy.
-Hypoxic resp failure – could be due to ARDS, infectious process in lungs.
-Candida- usually on skin or guts
- Low EF - shall we start GDMT? - No need, since stress is one of the differential (catecholamine [stress] / cytokine [septic] associated cardiomyopathy)- Myocytes get stunned— LVOT like picture (hence vasopressors worsen the case, like in HOCM)
-If patient is not recovering by the treatment we offer, always think about underlying causes.
- Types of takotsubo: Normal, reverse, and global hypokinesis.