9/28/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: (@Eyron)* ***Case Discussants****: (@RezidentMD) & (@ABRezMed)*

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

Scribing (Zach R):
CC: 65 y/o M p/w **diffuse B/L LE pain** (PCP visit)
HPI: Pain worse in thighs after exercise (doing since PT). No assoc sx; denies new trauma/injury. Attributes pain to meds: atorvastatin ↑ 40 -> 80 mg 1 mo ago (only recent change); A1C at goal
Clinic exam: unremarkable; extremities non-tender, full range of motion, full strength & sensation
-> atorvastatin d/c'd, advised exercise only as tolerated
1 wk later: worsening pain, now primarily L-sided, from L hip radiating down L leg, achy, worse after PT. No improvement off atorvastatin; Tylenol PRN *-> sent for XR*
3 days later -> ED: persistent, worsening, unbearable pain, **now involving abdomen (mostly LLQ)**, radiating down leg

ROS: **Positive -** L testicular pain, new L leg swelling.
Negative - otherwise neg

PMH:
HTN
T2DM
DLD
Prostate CA s/p robotic prostatectomy (3 mo prior)
Meds:
Losartan
Atorvastatin
Insulin
Ozempic
Farxiga (dapagliflozin)

Fam Hx:
non contributory
Social Hx: neg

Health-Related Behaviors:

Allergies:

Vitals: T: 36.7°C (98°F) **HR**: 102 **BP**: 117/64 **RR**: 20 **Sat**: 96% on RA **BMI**:
Exam: Gen: nl **HEENT**: nl**CV**: nl **Pulm**: nl **Neuro**: nl
Abd: soft, generalized tenderness; no rebound/guarding
GU: tender L scrotum; also mild swelling & mild pain in pubic symphysis
Extremities/skin: L hip & femur TTP, mild L LE swelling; B/L 2+ DP pulses, sensation intact, full range of motion; RLE nontender. Reproducible pain on external + internal ranging of LLE

Notable Labs & Imaging:
Hematology:
WBC: **27.07 (H)**, 92% N Hgb: 14.8 Plt: 414 MCV: 88.6
92% neutrophils, 2.7 % lymphocytes 0.9 reactive lymph
Chemistry:
Na: 132 (L) K: 4.5 Cl: 94 (L) CO2: 28 Ca: 9.5 Mg: BUN: 36 (H) Cr: 0.9
Glu: 339 (H)
AST: ALT: ALP: T. Bili: T. protein: Alb:
ESR: CRP: LDH:
AG: 15 Lactate: 1.5 D-dimer: 1561 (H) BCx: drawn
UA: SG >1.030, glucose 4+, ketones 1+, occ bacteria; LE/nitrite neg, WBC 0-2
Imaging:
XR hip & femurs (clinic): minimal L hip arthrosis; no acute abnormality
XR L femur (ED): no acute bony abnormality; mild L hip degenerative change
Scrotal US: scrotal wall thickening (5 mm) c/w cellulitis; no torsion, nl flow **CT**
CT A/P: 10.1 cm abscess in prostatectomy bed w/ mass effect on bladder + 10.7 cm L iliopsoas abscess; small ascites; L inguinal LAD, likely reactive
BCx: Grp B β-hemolytic Strep Abscess Cx: Grp B Strep + Staph lugdunensis
-> IVF + empiric broad-spectrum abx; ID & Urology consulted -> IR CT-guided placement of 2 drains w/ purulent output -> abx de-escalated to IV ceftriaxone + Flagyl -> transition to Augmentin 875 mg BID per ID -> sepsis physiology resolved
Final Dx: Sepsis 2/2 Grp B Strep pelvic/prostatectomy bed & iliopsoas abscess w/ bacteremia

Problem Representation: 65 y/o M w/ T2DM, 3 mo s/p robotic prostatectomy for prostate CA, p/w subacute progressive L hip/leg pain -> LLQ abd & L testicular pain w/ L leg swelling, iliopsoas abscess with slow brewing bacteremia

Teaching Points (Krishi)

-DDX for general LE pain: tissue disruption, plumbing (thrombus), or vascular insufficiency (arterial you would expect distal pain). Statistically, focal and distal diseases are less likely in bilaterality. Diffuse can be two separate focal processes.
-Statins= myositis association though data suggests no difference with placebo; recognize power of patient's bias of self-investigation. Muscle symptoms common but necrotizing myopathy is very rare (for which d/cing statin is not enough and will need anti-inflammatory therapeutics). Usually not exercise-associated.
-In light of new symptoms, discriminate between new etiology, progression of prior, or distraction.
-Normal DPs do not exclude peripheral arterial disease.
-**Vasculopathies** can cause pain: diabetic vasculitis, diabetic neuropathy, diabetic myonecrosis (unilateral usually), infection risk with SGLT2 and disease pathology alone, gential symptoms with necrotizing sx.

PAIN:
-Diffuse abdominal pain: peritoneum, organ, referred from genitals.
-Hip pain: retroperitoneum (referred from nerves, vasculature, GU), intra-articular= general a CT fares well, consider CTA and Doppler.

-**High white count**: ischemia, infection, hypercortisolism. Note this is out of proportion to vitals. Pus can hide under pressure.
-Hip pain nature can be elucidated with palpation directly, weight bearing (intra-articular). Can be consequence or cause of pain.
-HypoNa and necrotizing fasciitis do have an association
-Inflammatory markers can be confounded by many factors unless very high.
-Iliopsoas abscess is great mimicker of hip pain. Do not be lulled by remote prostatectomy which is risk factor. Time course can be highly variable in infectious context.
-Initial L side dominance was perhaps idiosyncratic.