4/13/26 Mainstream Monday with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Dan Mathew* ***Case Discussants****: Youssef (@saklawiMD) & Seeme (@youucantsee_me (IG))*

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

Scribing (Julia)
CC: lightheadedness and fatigue

HPI: 47 y.o. female presenting with sudden onset lightheadedness and fatigue. 3 weeks prior she had watery diarrhea and vomiting. She was not tolerating anything my mouth during this time. Over the past 2 weeks she was having ice craving and severe menstrual bleeding.
At this presentation, she is having persistent bleeding, lightheadness and fatigue. Denies current diarrhea or vomiting.

ROS: neg for CP. No other symptoms.

PMH:
T2DM
HTN
HLP
Schizoaffective disorder

Meds:
Forxiga
Semaglutide
Carvedilol
Losartan
Clozapine
Fluoxetine

Fam Hx: none

Social Hx:
lives alone, denies substance use

Health-Related Behaviors:
denies travel

Allergies:

Vitals: T: afebrile **HR**: 83 **BP**: 141/75 **RR**: 18 **Sat**: 100 **BMI**:
Exam: Gen: well-appearing, not in acute distress
HEENT: nl **CV**: nl **Pulm**: nl
Abd: **tenderness of the lower abdomen. DRE negative. Blood visualized on the vaginal vault**

Notable Labs & Imaging:
Hematology:
WBC: 3.5 Hgb: **6.5 → 8** (after pRBC) Plt: 188 MCV:

Chemistry:
Na: 132 K: 3.6 Cl: HCO3: 23 Cr: **3.3** (Baseline 0.9) Albumin: 3.9 Total Protein: 9.7 (protein gap 6) Serum Iron 28 TIBC 420 Transferrin sat 70% Ferritin 18
She was given IV fluids → improving symptoms but creat mantains elevated

HIV neg Hep C neg
UA: 1+ protein. Occasionally white casts. No red cell cast
Lambda markedly elevated 2500 K/Lambda ratio < 0.01 SPEP/UPEP: abnormal monoclonal protein

Imaging:
Renal US: no obstruction
Pelvic US: high complex right adnexal mass (6.4 cm) with internal vasculity and multiple uterine fibroids
CT abd/pelvis: adnexal lesion and diffuse, innumerable lytic lesions on the axial skeleton
Pelvic MRI: no suspicious adnexal mass.
Bone marrow biopsy: monotypic lambda-restricted plasma cell population

Dx: Lambda-restricted Multiple myeloma

Problem Representation: 47 year-old female with PMHx of T2DM and HTN presenting with symptomatic severe anemia, AKI, anc lytic bone lesions in the setting of a significant serum protein gap and monoclonal light chain elevation.

Teaching Points (Magnus)

Lightheadedness
Brain vs. blood (quality (anemia) vs. quantity (heart))

Diarrhea
Time-course, osmotic vs secretory, localization

Persistent menstrual bleeding
Structural (malignancy, fibroids), perimenopausal

Protein gap
Polyclonal vs. monoclonal (MM -> get SPEP, Ig, light chains)

CRAB -> BARC (when arranging in order of prevalence)
Bone
Anemia
Renal
Calcium