7/1/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Renzo(@)* ***Case Discussants****: Maddy(@MadellenaC) & Rahul(@RahulPotapath1)*

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

Scribing (Gillian)

CC: 74 yo woman from Peru presents to the ED with CC progressive SOB and cough

HPI: presents 1 week prior to admission with non productive cough associated with subjective fevers, generalized malaise, self mitigating with OTC medications without improvement. 3 days before presentation she developed progressive dyspnea worsening and now occurring even with minimal exertion

ROS (-): weight loss (6 months), hemoptysis, orthopnea, rashes, upper respiratory symptoms

Fam Hx:

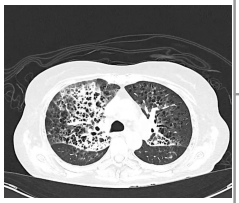
Social Hx:
Originally from Lima
Housewife
No recent travel history
4x sexual partners, not sexually active in the last 7 years

Health-Related Behaviors:
18 pack years, quit 3 years ago

Allergies:

Vitals: T: 37 **HR**: 100-110 **BP**: 130/80 **RR**: 18 **Sat**: 85-87% RA **BMI**:

Exam: Gen: alert with mild respiratory distress
HEENT: no lesions in ear or nasal mucosa
CV: rrr, no murmurs, no increased jvp
Pulm: bibasilar crackles, no wheezing
Abd: soft, nontender, nondistended
Neuro: a&o, no focal deficits
Extremities/skin: no peripheral edema



Notable Labs & Imaging:

Hematology:
WBC: 18k Hgb: 5.3 (previously 10.6) Plt: 350k

Chemistry:
Na: 134 K: 6.7 Cr: 9.2 (previously 1.4) BUN: 257 Glucose: 140 CRP: 40
proBNP: 15k

Urinary sediment: normal without casts or hematuria

Hematologic workup: No schistocytes, hemolysis

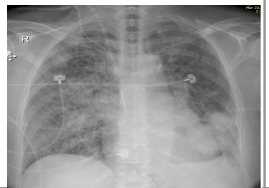
Clinical course: went to ICU, HD, blood transfusions.
3 months ago presented for abdominal pain with creatinine of 1.4, hemoglobin 10.6

Serologies: c-ANCA: positive, p-ANCA: negative complement: normal GBM: negative

Biopsy: necrotizing granuloma, TB workup negative (GeneXpert, Ziehl Neelsen)

Imaging:
CXR:
CT Scan: necrotizing masses, COPD changes

Dx: c-ANCA vasculitis



Problem Representation: 74-year old F from Peru presents with progressive SOB and cough, inflammatory syndrome (fevers, malaise, leukocytosis), AKI (creatinine 9.2), and anemia (hgb 5.3) found to have c-ANCA positivity and necrotizing granulomatous lung masses consistent with GPA.

Teaching Points (Hafsa Saeed)

Approach to dyspnea ; wide bucket (cardiovascular, lungs,hematologic and neuromuscular]
Dyspnea on excretion (respiratory and cardiovascular)
Understand the host this includes underlying predispositions to the presenting complaint (including exposures), time course of the disease can help categorize the problem(pertinent hx of tobacco use in this case could be predisposition for several cardiorespiratory pathologies)
SOB plus cough prioritises the respiratory system
Acute course —> inflammation/infection, in terms of acute SOB query about ie acute pneumonia or mass causing acute obstruction,
It is important to corroborate the hx with physical exam especially the vitals to see if there is discrepancy
Health related behaviour; multiple sexual partners, take detailed hx ie is the patient on PrEP, check HIV status of the patient, it can predispose to opportunistic infection ie PJP
Physical exam; hypoxia —> is there a problem at the alveolar level (exudate vs transudate vs ie hemorrhage
Labs and physical exam prioritize ie infections (obtaining both chest and abdominal ct can help make progress) abdominal CT is important in helping to rule out ie infections, masses causing obstruction—-> SOB , rule out TB, histoplasmosis, pjp , blastomycosis etc
Anemia (hb 5.3) hemolysis ??? obtain a PBS as well as hemolytic markers(LDH,haptoglobin and bilirubin), understanding the time course and ruling out hemorrhage
Hyperkalemia —-> excretion vs cellular shift (plus kidney dysfunction prioritise an excretion problem
Elevated creatinine —-> what is the baseline, evaluate the time course, obtain UA , In the presence of anemia plus AKI ??? TMA picture
>>>? Is the involvement of both renal and respiratory system separate cause or a pulmonary renal syndrome (glomerulonephritis, ANCA vasculitis vs infections) obtain repeat UA { look for microscopic hematuria and rbcs cast
Unifying involvement could also be due to infective endocarditis with septic emboli
3 patients with c ANCA vasculitis(wegener's granulomatosis) can present without upper respiratory system.