5/20/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Hem* ***Case Discussants****:Maddy (@MadellenaC) & Andrew (@ASanchez_PS)*

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

Scribing (Siva)

CC:61 yo female with progressive rectal bleeding and LLQ abdominal pain x 3 weeks.

HPI:

For the last 3 months her baseline bowel movement pattern had changed from a few times per week to having 2–3 BMs daily with no mucus.

Then, 3 weeks ago, BMs increased to 10 per day and ultimately began to be bloody a few days in. She would notice bright red blood in the toilet, ultimately progressing to occur with every BM. There was also dull LLQ abdominal pain that coincide with this. No nocturnal symptoms.

ROS:

Over these last 3mo was notable for progressive fatigue, nausea with reduced appetite, dizziness leading to falls, and 40 lb weight loss,

There was no fever, chills, night sweats, other cardiopulmonary symptoms, GU symptoms, or Neuro sx.

PMH:

COPD exacerbation [last 2 y ago].

Depression,anxiety.,

lung adenocarcinoma - Dx 9M ago

Ulcerative colitis Dx 1 mo ago

Meds:

Mesalamine

Enema with minimal effect

Sertraline

Clonazepam

Trelegy inhaler

Prednisone- declined

Pembrolizumab-last dose 2mon ago

Fam Hx: —

Social Hx:

NE USA,

Smoker, works in nursing home

Health Related Behaviors: last sexually active 5 y ago

Allergies: none

Vitals: T: 97.7 **HR:** 90 **BP:** 101/64 **RR:** 14 **Sat:** 93@ 2lt O2NC [at bl]

Exam: Gen: ill appearing

HEENT: dry mucous membranes **CV:** Normal **Pulm:** normal

Abd: soft,mild abdomen distended,LLQ tenderness,BRBPR with large clot noted,ext hemorrhoids noted. External hemorrhoid on DRE **Neuro:** nl **Extremities/skin:** nl

Notable Labs & Imaging:

Hematology: WBC:3.54 →2 Hgb:10.9→8 Plt:77k→57k MCV:87.6

Chemistry:

Na:131 K: 3.1 HCO3: 20 Cr: 0.66 BUN: 8 Glucose: Ca: 7.3 Mg:2

AST:143 ALT: 35 Alk-P: Bili: 0.6 Albumin: 2.4 Total Protein:

CRP:8.4 Ferritin-5718—>7227 ,tsat-15%.

Anion gap: 12

Fecal calprotectin: 1126 (high)(normal<250)

Enteric panel -negative,HIV-Neg,B/c -neg(24hrs)

CXR: calcified granuloma

CTA -1.5 cm indeterminate pulm nodule LUL

Proctocolitis, 14 cm splenomegaly

Hospital course- 100.6, 81/51 mmhg

Hapto<10,INR 1.5,fibrinogen 128,D dimer elevated,LDH 998,ferritin-7k,AST-450,TGS-390

Liver USG -normal,Flex sig- congested,granular,ulcerated mucosa 25 cm proximal to anus.

CMV PCR +ve with copy num 38.

Colon biopsy- acute cryptitis with crypt abscess ,crypt dropout and destruction, infectious evaluation -ve

Rx with methylprednisolone.

Dx: Pembrolizumab induced HLH with co existing colitis

Problem Representation: 61 yr female with h/o UC,lung adenocarcinoma rx with pembro presented with progressive rectal bleeding and LLQ abdominal pain dx as Pembro induced HLH with coexisting colitis.

Teaching Points (Seeme)

Approach to CC and HPI:

- Diarrhea can be acute/ subacute/ chronic.
-Inflammatory vs noninflammatory. Inflammatory diarrhea presents with blood (structural breech) or mucus and systemic fingerprint. Non-inflammatory diarrhea can be osmotic/ secretory diarrhea.
- Structural breech can be by cancer/ infection/ autoimmune disease (Ulcerative colitis or Crohn's disease)
- Here weight loss and blood in stool are indicative of inflammatory component
- Lesion can be localized by CT scan with contrast, strong urgency or rectal pain can be indicative of proctitis. Diverticulitis and structural abnormalities can be seen better with contrast.

Approach to PMH and exam:

-Subacute to chronic diarrhea can be by granulomatous infections- TB(works as nursing home),, strongyloides and syphilis worth considering too.
-Infections can trigger autoimmune disease like ulcerative colitis
-Smoking history can be linked to ischemia- pain +rectal bleeding

Approach to labs , imaging and exam:

-Bicytopenia makes us rule out MAHA-haptoglobin and PBS can be helpful- looking for schistocytes and trending can be helpful

-Histoplasmosis can cause granulomas and calcifications-immune checkpoint inhibitor seems to be the only clue here

- Splenomegaly can be seen with endemic mycoses. Proctocolitis can be caused by herpes viruses, chlamydia and gonorrhea as well

-Tissue and blood smears can be helpful. HLH can cause pancytopenia and splenomegaly. Infections can trigger HLH (TB and histo worth considering given nursing home history and lung findings).