



4/14/26 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Mengyu (@zhoumy07) Case Discussants: Ravi (@rav7ks) & Deb (@deboracloureiro)
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Varsha and CPS Fam <3)
CC: 35 y/F 5 days of Nausea and Vomiting, weakness and lethargy

HPI: 5 days of Nausea & vomiting couldn't keep any food down. Feeling Weak and dizzy. H/o chest pain (denied on admission).

ROS: No fevers, AP, chills, cough, dysuria, or SOB

PMH:
HTN
T2DM
Anxiety

Meds:
Metformin
1g BID
Losartan
Duloxetine
Hydroxyzine
Statin

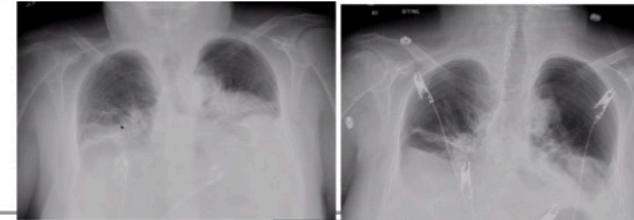
Fam Hx: N/A

Social Hx:
No alcohol,
occasional Vape
and Marijuana
use

Health-Related Behaviors:

Allergies: None

Vitals: T: Afebrile HR: 123 BP: 130/93 RR:16 Sat: 100 on RA
Exam: Gen: Alert and oriented
CV: tachycardia, no murmurs
Pulm: normal effort, 100% on RA
Abd: soft, Non Tender, non distended
Neuro: alert and oriented, NFND



Notable Labs & Imaging:

Hematology: WBC: 30,000 Hgb:14.9 Plt: 690
Chemistry: Na: 125 K: 2.7 Cl: 69 HCO3: 28 Cr: 1.7 BUN: 54
Glucose:1072 AST: 33 ALT: 45 Alk-P: 204 Albumin: 4.8
VBG: pH: 7.42 pCO2 44 HCO3: 28 Anion gap: 28
Lipase 373 HbA1c 9.5, LDH: 312
hsTrp 18 - negative, Beta-hydroxybuterate 26.3, Lactate 5.3

Gad 65 Ab and islet cell Ab negative, BNP: Negative

Course during hospitalization: Patient started on IVF, K replacement, insulin → Increasing SOB (on 3 L oxygen)

Imaging:

EKG: sinus tachycardia (in ED)

CXR: B/L moderate - large Pleural effusion, small volume left sided pneumothorax, pulmonary vascular engorgement

CTA chest: Large B/L Pleural effusion, small volume Left pneumothorax

Thoracentesis: B/L 700cc from L side and 800cc from R side

Left sided effusion - brown cloudy fluid: TC - 6485, 96% neutrophils, RBC 11,000, ph <6.5, Protein 0.7, LDH 182

Right sided effusion - pH 7.06, Protein 1.4, LDH 284

Rapid Response called, passed out briefly → Hypotensive, 1.5L IVF given, SpO2 84% on 6L, put on non-rebreather

Repeat CXR: increased size of left pneumothorax.

Left chest tube placed, thin brown fluid removed. (fluid showed gram + cocci - started on cefepime and vanc)

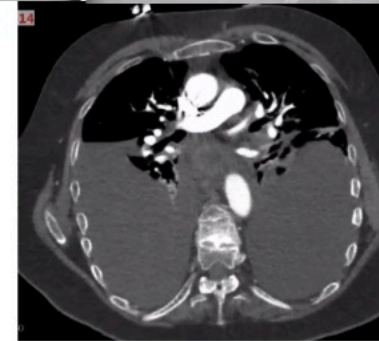
Post chest tube CXR- persistent pneumothorax and pleural effusion, larger on right

Repeat CTAP: shows features of esophageal rupture

Stent placed and repeat esophagogram showed no leak



Dx: DKA complicated by esophageal rupture and Pleural effusion



Problem Representation: 35 y old F with history of chest pain and DM presented with 5 days of nausea and vomiting, was found to have elevated glucose and pneumothorax with acidic pleural effusion.

Teaching Points (Glen)

- N/V: GIT vs CNS(increased ICP) vs renal vs Metabolic.
- N/V Complications: Ask about food intake, r/o aspiration.
- PMH: N/V from meds or anxiety or DKA.
- HTN in the young: Could have secondary cause e.g marijuana, endocrine abn etc
- Tachycardia, Hyperglycemia: Give fluids.
- Leukocytosis Of 30: stress vs pain vs infection[cellulitis, PNA] [are they immunocompromised] vs infarction vs malignancy(leukemias).
- Mixed Acid Base disorder: metabolic alkalosis > acidosis
- HHS vs DKA: Glucose level vs serum osmolality.
- CXR: diffuse opacities: B/L effusions > Pulm edema[from rehydration, cardiac], atelectasis. Correlate with exam findings.
- B/L Pleural Effusion: Transudative>Exudative. Bloody effusion r/o malignancy, boerhaeve syndrome.
- Pneumothorax: Could be structural changes from occasional vape. Also thin of emphysema, previous infections, vomiting.
- Acidic pleural fluid: Leak from esophagus.

