10/02/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Kris (@)* ***Case Discussants****: Reza (@) & Rabih (@)*

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

Scribing (Lukas):

CC: 84 yo old female p/w fever and hemoptysis for 3-4 days

HPI: 2 days prior dizziness followed by a fall with a head injury. cCT shows no abnormalities, cleared by neurosurgery outpatient clinic.

ROS (+): increased thirst, urinary frequency without gross hematuria, episodes of hemoptysis, unintentional weight loss

PMH:
T2DM
Arterial hypertension
CAD
CKD III
Chronic hepatitis B

Meds:
Forxiga
Metformin
Amlodipin
Aspirin

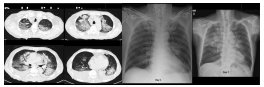
Vitals: T: 37,3°C **HR**: 91 **BP**: 162/70 **RR**: 18 **Sat**: 98% on RA
Exam: Gen: E4V5M6 **Neuro**: legs and hands tremor, otherwise unremarkable

Day 1: WBC: 13,7 seg 83,8% Hgb: 8,1 Plt: 425k // Na: 142 K: 2,9 Cl: 105 BUN: 39 Cr: 2.8 eGFR 21.7 (her baseline = 50) Glu: 168 LDH: CK 164 Trop 0.034 ng/mL CK-MB: 1,8 ng/mL CRP: 13,49 mg/dL Pt: 10,6 s PT control: 11,0 s INR 1,03 aPTT patient 27,8 sec Neg. influenza A/B, Covid19: positive (38,9 CT value)
D-dimer: 1970 ng/ml Lactate 20,7 mg/dL **UA**: pH 5,5 , protein 2+, 3+ urine glucose, 3+ occult blood, neg for: bili, leukocytes, nitrite; sediment: RBC numerous, WBC H10

CXR: left perihilar/left lower lung patchy air-space opacity, suspicious for developing pneumonia or inflammatory infiltrate
Chest-CT: patchy left lower lobe air-space opacities/infiltrates
EKG: NSR non specific ST change
Abdomen-CT: cholelithiasis without obvious acute intra-abdominal abnormality on the provided images
EGD: showed ulcer with stigmata of bleeding with polyp in stomach
Course: empirical antibiotics given for suspected CAP → Ceftriaxone and azithromycin + Transamin 1A Q6H for hemoptysis and hematuria



Day 2: CBC: Hb 6,8 g/dL, Hct: 20,7%, Reticulocyte 7,2 MCV 82,8; Ferritin 216 ng/mL, TSH: 1,58
Vitamin B12: 193,13 Folic acid: 5,81
Prostate Echo: prostate calcification **Urine cytology:** negative for malignant cells
CXR: progression of pneumonia
HRCT: suspected pulmonary hemorrhage; bilateral multifocal GGOs and consolidative opacity with small to moderate bilateral pleural effusion concerning for DAH vs multifocal pneumonia
Course: switched Tazocin → Meropenem + tocopenin; consistent bleeding: Hb: 8,1 (day 1) → 6,8 (Day 2) → 2U pRBC → 9,4 (Day 3) → 8,2 (Day 5) → 6,7 (Day 8)
Colonoscopy: internal hemorrhoid, diverticulosis, polyps
Thoracocentesis: color yellow, hazy appearance, specific gravity 1.018, Rivalta positive, RBC 58/CMM, WBC 180/CMM, pleural effusion malignancy negative
IGD: < 47 IU/mL, beta2 microglobulin: H 4850 ug/L, IFE: absence of monoclonal protein pattern
IgG: 1300 mg/dL, IgA 254 mg/dL IgM: 72 mg/dL, C3 94 mg/dL, C4: 37 mg/dL
SPEP: Albumin 2,6 g/dL ; alpha 2 1,0 g/dL
Autoimmune-Panel: ANA: 1:80, Anti-Cardiolipin/Anti beta2 glycoprotein 1 IgG/IgM all < 9,4 p-ANCA (MPO) > 134 IU/mL
C-ANCA: < 0,2 IU/mL ; glomerular basement membrane AB < 1:10
Bone marrow: no leucemia



Final-Dx: MPA

Problem Representation: 84 yo woman p/w with fevers, recurrent hemoptysis, therapeutic resistant anemia and unintentional weight loss with gastric ulcerative bleeding and GGOs in the CT and p-ANCA (MPO) turned out to be MPA

Teaching Points (Lourenço)

- **Fever:** think of IMADE**.** In the acute setting, prioritize infections.
- **Coughing up blood**: try to clarify if its hemoptysis or pseudo-hemoptysis (e.g., GI bleed, nasal bleed).
- **Unintentional weight loss**: always a chronic finding. So it puts the timing of the disease onset into question.
- **Polydipsia >> polyuria or polyuria >> polydipsia?**: usually it's the latter. The former occurs in the context of primary polydipsia. One of the most common causes of polyuria and polydipsia is hyperglycemia (which is not present in this patient).
- **Bleeding syndrome**: think of platelet disease VS coagulation factor disease VS vessel wall disease. Always look at the medication (e.g., aspirin).
- **Pneumonia is almost always a presumed diagnosis**: to confirm the diagnosis, either grow a bacteria in a culture or see improvement after treatment.
- **Non-resolving pneumonia**: whenever a presumed pneumonia doesn't get better with antibiotics, think of non resolving pneumonia (e.g., atypical organisms, non-infectious etiologies such as alveolar hemorrhage).
- **Causes of DAH**: whenever we see DAH, try to see if there's anything else. If there's disease elsewhere (e.g., airway disease), then it can point to cancer or infections. If there's only DAH or vascular disease, it most likely is autoimmune in nature.
- **DAH + GN**: it's always autoimmune in nature. Think of SLE, IgAV, AAV and anti-GBM disease.
- **AAV**: MPA is a pure vascular disease (≠ GPA and EGPA causes airway disease, due to the formation of granulomas in the tissues).
- **Grandpas need CPR <3**