10/10/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Austin (@)* ***Case Discussants****: Austin (@) & Meghna(@)*

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

Scribing (Varsha):

CC: 70Y/F comes in due to concern for blood sugar

HPI: Over the past few years, home glucose readings have steadily increased. CGM 2 -3x a day. Frequent values in 200 and PP in 250s or higher. Her sugar values improves after walking and worsens when she is home/ snacking

PMH:
T2DM x 20 yrs, c/b neuropathy, A1c 9-11
HTN x 20 yrs
PAD
Arthritis
Pulmonary Langerhan cell histiocytosis

Meds:
empagliflozin
metFORMIN
amlodipine-olmesartan
aspirin 81
atorvastatin
celecoxib
DULoxetine
Fish Oil
multivitamin

Fam Hx:

Social Hx: lives alone, self employed (doordash), good social support

Health-Related Behaviors:
Tobacco smoking 50pkyr, quit 2 yrs ago, no alcohol/substance

Surgical hx:
hysterectomy

Vitals: T: wnl **HR**: 79 **BP**: 120/64 **RR**: 14 **Sat**: 95% RA **Weight**: 63Kg, BMI: 26 -27, weight trend 130 - 140 pounds
Exam: Gen, HEENT, CV, Pulm, Abd, Neuro: Normal
Extremities/skin: no wounds/lesion

6 years ago, her sugars were doing well. Medication history → compliant as per EMR and patient. Reports change in diet - ice cream, soda→ maybe once a week. Eye exam and vision → normal

Notable Labs & Imaging:
Hematology: normal
Chemistry: normal
Cr: 0.97 A1c: 9 C Peptide: normal
Lipid: LDL 54, TG 200s, TSH: 2
UA: no albuminuria,
glucosuria (consistent with SGLT2 inhibitor)

Imaging:
CT: pancreas was normal, no mass

		Hemoglobin A1C
Ref. Range & Units		<5.7 %
07/27/26	08:00	8.9 ▲ ✲
11/10/25	16:30	9.1
06/16/25	14:23	9.2
03/20/25	10:45	11.0 ▲ ✲
03/05/25	15:37	11.0
12/03/24	09:15	9.3 ▲ ✲
01/12/24	09:19	6.8 ▲ ✲
11/06/23	07:53	7.1 ▲ ✲
10/22/22	15:50	7.4 ▲ ✲
04/28/22	12:22	6.8 ▲ ✲
07/27/21	11:03	6.9 ▲ ✲
10/29/20	09:00	7.3 ▲ ✲
03/12/20	14:10	6.6 !
10/10/19	15:47	6.2 !

Patient retired at the end of 2024, used to work 9-5/5 day a week job. Currently is not as busy/as active → more sedentary.

Added to her current meds and A1c improved during follow up.

Dx: **Slowly progressive worsening of T2DM due to lifestyle alterations**

Problem Representation: 70Y/F presents with high sugar readings on her home CGM for the past few years. Compliant with meds and denies any significant alteration in diet. Upon further review, her weight trends and BMI were relatively stable. Labs were as expected,and CT was normal. Further history reveals significant lifestyle change → post retirement, contributing to worsening of T2DM.

Teaching Points (Ramaswamy)

Approach to uncontrolled blood sugars - How does age change the calculus of her disease; Age is a surrogate for vulnerability -> chronic Dz, side effects of treatments, complications; PMHx + medication reconciliation; *DM -> do not anchor without evidence*

Understanding timeline of symptoms -> differentiate between ongoing symptoms vs new onset; associated factors include frequency of patient care; *regular follow-up + sudden symptoms -> vs sporadic follow-up -> expected uncontrolled symptoms - changes based on the situation*

A1c -9 to 11 -> OHA probably not as helpful worth transitioning to insulin. May also be a type of DM -> not responsive to OHAs

Associated PMHx -important to consider -< LCH may have some effect
HY Physical exam in this case -> signs of insulin resistance, BMI, neuropathy, skin

Blood sugars not controlled *-> Check diet, medication compliance (how the prescriptions are being filled); If nothing has changed -> assess for ongoing underlying insult.*

Hyperglycemia *- Substance (supplements, vitamins [steroids], endogenous cortisol -> Cushing's, insulin receptor Abs] vs structure (pancreatic cancer)*

Ask about current life circumstances which helps identify potential signal to change in disease status

Diet control - Protein intake first before carbs helps reduce postprandial spikes + walk soon after

Complications screening -> retinopathy immediate