6/3/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Ravi Singh (@rav7ks)* ***Case Discussants****: Steph(@StephVSherman) & Zaven (@sargsyanz)*

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

Scribing (Lukas)

CC: 68 yo male with multiple comorbidities presents with unwitnessed syncope

HPI: the patient was walking to the kitchen and fell; he was down for 1 day; was found by neighbor; no prodomi, no bowel-bladder incontinence;

ROS (+): unintentional weight loss for last 2 months, fatigue

ROS (-): no fever, no dyspnea, no CP, fatigue, night sweats, chills

PMH:
ESRD secondary to diabetes
CKD III allograft
Hypertensive nephrosclerosis
2015 renal transplant
CLL 08/2017
AV fistula aneurysm
HFpEF EF 50% with grade 2 diastolic dysfunction on 10/8/2019

Meds:
Acyclovir
ASS
Lasix/Furosemide
Hydralazine
Metoprolol succinate
Pravastatine
Tacrolimus
Tamsulosin
Mycophenolic acid
Ibrutinib
Nifedipine

Vitals: T: nl **HR**: 78 **BP**: 130/88 -> 100/75 [standing] **RR**: 20 **Sat**: 99%
Exam: Gen: alert, oriented 3x, in no apparent distress
HEENT: oral mucosa dry, no cervical or supraclavicular lymphadenopathy
Neck: no jvd
CV: no chest wall tenderness, RRR, no MRG, no peripheral edema
Pulm: CTA b/l, no rhonchi or wheezes; symmetrical expansion
Abd: soft, nontender on light/deep palpation, non distended, normal bs in all 4 quadrants; no tenderness on palpation over right lower quadrant renal transplant; no organomegaly noted
Skin: no rashes, decreased turgor
MSK: no joint swelling, deformity
Neuro: AOx4, no focal deficits noted
Psych: tearful, labile mood

Hematology:
WBC: 9,6 RBC: 3,9 Hgb: 10 HCT 33,8 MCV: 86,9 MCH: 25,4 MCHC: 29,2 RWD: 14,6 Plt: 150

Chemistry:
Na: 144 K: 4,2 Cl: 110 HCO3: Cr: 3,4 (baseline 1.5) BUN: 83 Glucose: Ca: 8,9 Mg:
AST: 48 ALT: 42 Alk-P: 306 tBili: 1,1 Albumin: Total Protein: CPK: 149
Trop: 0,104 ; CO2: 24,6 ; Acetaminophen level: <1 ; Prograf: <2
Utox: neg ; Hep panel: neg **UA**: neg PCR-BK: neg

CT head:CT head: No evidence for acute calvarial or intracranial injury/pathology.
Renal ultrasound: Showed the size of transplant kidney was 10.7 x 5.8 x 4.3 cm with normal renal cortex and no demonstrated mass, cyst or hydronephrosis.
CT abdomen: similar to ultrasound
Course: fluids were given (hold of antihypertensives and lasix) -> BUN and CR worsened. Transplant nephrology was involved. Suspicious for acute cellular or antibody mediated graft rejection.
Final Test: Biopsy: No signs of rejection; extensive infiltration of renal parenchyma with atypical lymphocytes with high ki67 expression, suggestion Richter-Transformation of DLBCL in a patient with a known history of CLL positive for CD5 and CD23
Dx: DLBCL (after Richter Transformation from prior CLL)
Rx: continued Ibrutinib, Tacrolimus, Prednisone 5 mg daily and weekly Rituximab; discontinued Mycophenolate

Problem Representation: 68 yo old male with CC syncope presents

Teaching Points (Hans)

Syncopy.fall: Transient loss of consciousness d/t transient hypoperfusion of brain. Causes often cardiogenic, orthostatic(hypovolemia) vasovagal, metabolic, (hypoglycemia), meds; distinguish from seizure (syncopy no postictal state) **Fall:** walking and remaining upright symphony of neuro and musculoskeletal
AKI and low GFR in the presence of medications that lower Bp and fluid status (lasix)

Weight loss: Energy balance intake vs energy need

AlkPhos isolated high: hepatobiliary get GGT if of bone metastases?

No improvement of kidney function with fluids: renal damage from rejection?

Biopsy: infiltration of B-lymphocytes CLL underwent Richtertransformation.

Dx: DLBC lymphoma with organ penetration.