3/29/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Kris Ling* ***Case Discussants****: Kirtan (@KirtanPatolia) & Magnus*

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

Scribing (Sarah B)

CC: 42-year-old female presenting with shortness of breath for two days.

HPI: She was discharged 2 days ago from ER for UGIB, melena, and hematemesis, with symptomatic anemia requiring blood transfusion and was discharged under stable condition. Since discharge has had progressive dyspnea for 2 days, initially DOE and now at rest with diaphoresis and dizziness, prompting presentation to ED.

ROS: Hematemesis, melena

PMH:
CKD IV, HFmrEF (EF 47.8%), (MVP w/MR), APLS, SLE

Meds:
Captopril, carvedilol, aspirin, folic acid, azathioprine, prednisolone, hydroxychloroquine, etoricoxib (NSAID), febuxostat

Vitals: T 36.2 **P** 68 **RR** 18; **BP**: 137/72 **Sat** 97% on RA
Exam: HEENT: Conjunctiva: pale (+), sclera: icteric (-), neck rigidity (-)
Chest: symmetric expansion, coarse breath sounds **Heart**: regular heart beats, systolic murmur (+) best heard at apex **Abdomen**: flat, normoactive bowel sound, no localized tenderness
Extremities: ROM Intact, no legs pitting edema

Notable Labs & Imaging:

Hematology:
HGB 8.6, PLT 30, WBC 3 (N 63%, L 22%, Eo 3%, Mono 11%): low, ABG: metabolic acidosis

Chemistry:
Na: 133 K: 5.4 Cr: 8.4 (baseline 4.5) BUN: 115 AST: 1052 LT: 1104 ALP: 81 TBili: 0.8 Dbili: 0.3 Alb: 3
UA: SG 1.015, pH 5.5, 3+ protein, 2+ blood, trace leukocytes,
NT-proBNP: >35000(H), D-dimer: 8687 (H), HCV/HBsAg/HAV IgM negative

Imaging & Advanced Labs:
CXR: Diffuse bilateral alveolar infiltrates consistent with pulmonary edema, cardiomegaly
EKG: NSR, no ischemic change, Chest CTA: no PE
Abdominal US: congestive liver, thickened gallbladder wall (5mm)
Echo: RA LA LV enlargement, Impaired global contractility of LV, LVEF 33.8 % (baseline LVEF 47.8%), regional wall abnormality c/w CAD, LV diastolic dysfunction, MV thickening w/severe MR & TR, systolic pulm art pressure: 66.3 mmHg
PT 13 (H), aPTT 57.5 (H), INR 1.28 (H), Tbili 0.7, Dbili 0.2, LDH 370, haptoglobin <30 (L)
Stool FOB/transferrin (+), fibrinogen 358.2 (nl)
Peripheral Smear: anisocytosis, polychromasia
Anti-cardiolipin IgG >150 (H)/ IgM >15.5 (H), anti-beta2 glycoprotein I IgG 138.6 (H)/IgM <9.4 (nl)
Lupus anticoagulant positive, ADAMTS-13 activity 71.8% (nl)

Dx: Catastrophic antiphospholipid syndrome

Problem Representation: A 42-year-old female with PMH of APLS presenting with dyspnea and UGIB found to have elevated NT-proBNP and d-dimer, prolonged PT/aPTT, high anti-cardiolipin/beta 2-glycoprotein antibodies, and lupus anticoagulant consistent with catastrophic APLS.

Teaching Points (Glen)

-ACUTE SOB: Cardiac, resp, metabolic. Look for predisposing factors(e.g congenital HD, family hx, substance hx)
-Hx of UGIB: Recurrence? How was it managed? Were they managing wrong problem?
-UGIB: Caused by varices and erosive dx(e.g gastritis) risk higher with steroid use, APLS
-Other comorbidities: Decompensation of HF? APLS risk of PE?

-Exam: Signs of anaemia
-Pancytopenia: Lupus?
-Multiorgan failure: Heart, liver, renal. Imp to r/o APLS/TMA (Thrombotic microangiopathy)
-Infectious workup: Pt on immunosuppression and might show signs
-HLH, Ischemia: Non miss. Get ferritin, echo

-Murmur: Could be MVP but important to rule out endocarditis
-ALF: From HF, ischemia, infectious?
-DHF causing rest of organ failures? triggers could be ischemia, myocarditis, anaemia
-SLE: Uncontrolled due to low cell counts, CKD could be from lupus nephritis. Can cause endocarditis, pericarditis. Imp to rule out flare with complement proteins etc

-Coag Profile & Hemolysis: DIC? (causes very high INR),Liver failure? APLS? TMA?
-Fibrinogen: can be nl or high in DIC
-APLS: Lupus anticoagulant and IgG(anticoagulant and anti B2 glycoprotein) ones you worry about. Tx with heparin or warfarin and Eculizumab.