7/22/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Ravi (@)* ***Case Discussants****: Sharmin & Eyron*

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

Scribing: (Sana)

CC 29 y/o transgender M->F ptn presented to the ED w/ progressively worsening b/l LLE and facial swelling over the preceding several weeks.

HPI: Reported that her legs are becoming increasingly heavy and difficult to move, w/ the swelling extending to her knees. Noted new puffiness around the eyes, most prominent in the mornings.

ROS: Fatigue and malaise over several weeks. No loss of wt., reports feeling tired when trying to move her legs. Denied CP, SOB, orthopnea or paroxysmal nocturnal dyspnea. Has not noticed changes in UO or color. No dysuria or hematuria.

PMH:
Chronic b/l DVT
I/V drug use
Untreated chronic Hep C

Meds:
Anticoagulants (unspecified)
Estrogen based hormone therapy

Fam Hx: -

Social Hx:
Intermittent housing instability

Health-Related Behaviors:
I/V drug use (active)
Tobacco use

Allergies: -

Vitals: T: 98.4 **HR**: 88 **BP**: 128/78 **RR**:16 **Sat**: 98% on RA
Exam: Gen: Mildly uncomfortable, appears volume overloaded.
HEENT: Periorbital edema, no LAD, fullness over lt. supraclavicular region.
CV: nl **Pulm**: nl **Abd**: nl **Neuro**: AOx3, nl
Extremities/skin: 2+ pitting LLE w/ redness over the shins. No rashes, petechiae or purpura. Track marks present.

Notable Labs & Imaging:

Hematology:
WBC: 11.2 (N 72%; L 18%) Hb: 10.8 Plt: 278 MCV: nl

Chemistry:
Na: 137→135 K: 4.3 Cl: 102 HCO3: 24→23 BUN: 29→32
Cr: 1.39 →1.52 T.protein: 5.2 Alb: 2.5 LFTs: N
UA: 3+ protein Spot Protein:Cr: 23,000
T.cholesterol: 312 LDL : 218 Trig: 264 ESR: 82 CRP: 48
ANCA, Anti-GBM, Anti-PLA2R negative C3 & C4 : N ANA: low titre +

Imaging:

Started on ABx d/t concern for cellulitis.

CT Neck: 8mm supraclavicular abscess
Venous Duplex: Acute on Chronic DVT

Started on anticoags; ABx for supraclavicular abscess given.

HIV & HBV: -ve HCV: elevated

Ptn eloped on D6 and returned 3d later w/ new c/o foamy urine, worsening periorbital edema. No JVD.

Renal Biopsy: Amorphous, eosinophilic extracellular deposits w/ apple green birefringence on Congo red staining.
IHC: +ve for AA amyloid

Dx: Amyloidosis

Rx w/ diuretics, rivaroxaban and referred for Hep C treatment

Problem Representation: 29 y/o transgender ptn w/ h/o of I/V drug use and untreated Hep C, presenting with progressive b/l LLE and periorbital edema. Exam notable for lt. supraclavicular swelling and track marks over the skin. Labs notable for UA 3+ protein with spot P:Cr 23K and hyperlipidemia. Renal biopsy showed extracellular glomerular and capillary deposits w/ apple green birefringence on Congo red staining and IHC +ve for AA amyloid.

Teaching Points (Glen)

-Subacute Anasarca: Increased hydrostatic pressure(HF) vs low albumin(nephrotic) vs increased capillary permeability. Associated symptoms will help.
-Hypercoagulable State: prev DVT, estrogen therapy.

-Exam findings: HF less likely. Supraclavicular fullness(?2 problems going on e.g with SVC syndrome). B/L Redness over the shins ?due to swelling. Further investigations: UPCR, U/E.

-Labs: High Cr(?baseline) rule out RPGN,renal venous thrombosis. Low albumin and 3+ protein(?nephrotic syndrome esp with history of HepC), membranous nephropathy presents with massive proteinuria and associated with DVTs.

-Next Steps: send autoimmune w/o (e.g ANA) and complement proteins, blood cultures, lower extremity USS, anticoagulation before potential kidney biopsy.

-Neg w/o for nephrotic syndrome labs: low likelihood of vasculitis, primary membranous nephropathy.

-Secondary Amyloidosis: Suspect it in patient with chronic inflammation and M/C organ to be affected is the kidney.