8/20/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Padmavathi* ***Case Discussants****: Rabih & Javier*

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

Scribing (Eyron):

CC: 80 y/o male presenting to the ED with hematuria and melena

HPI:

1 month prior, developed b/l LE rash, non-painful, circumferential without weeping - initially c/f vasculitis, skin bx did not show vasculitis.

Initial workup showed:

Hb 12.6, Cr 1, INR 3.2 Na 135 UPCR 239 UA 1+ blood, 11-30 RBCs, ANA 1:160, C3, CRP, mildly elevated IgG anti-GBM antibody

Started on Prednisone and before follow up, presented with one week of hematuria, four days of melena, diarrhea a/w nausea and vomiting

PMH:

CAD, HTN, mechanical AVR, ascending aortic aneurysm repair, CVA, COPD

Meds:

Warfarin 30 mg weekly
Bupropion
HCTZ
ACEi

Fam Hx: NC

Social Hx: (+) tobacco and EtOH

Allergies: None

Vitals: T: 100.4 F **HR**: 103 **BP**: 177/87 **RR**: 22 **Sat**: 92% on RA

Exam:

CV: Tachycardic, regular rhythm, no murmur

Pulm: Decreased BS on the right, diffuse inspiratory crackles

Extremities/skin: B/l LE purpuric rash

Notable Labs & Imaging:

Hematology:

WBC: 10.7 Hgb: 8.2 Plt: 107

Chemistry:

Na: 129 K: 4.8 BUN: 121 Cr: 9.39 (Bl 1) PT 98.1 INR 14.3 PTT 86.8

Procal 3.07 ntProBNP 49k

HCV viral load negative |BCx negative

VBG high anion gap metabolic acidosis

UA 18 WBCs, >187 RBCs, UPCR 982

Trop I mildly elevated

Imaging:

EKG: No ischemic changes | Echo: EF 40-45%

CXR: Diffuse opacification of the right lung, patchy left lung opacities

CT A/P: no acute abnormalities

Renal US: no obstructive process

EGD: 3 mm clean based duodenal ulcer, hiatal hernia w/o bleeding

Tx with steroids and dialysis, INR correction

Repeat autoimmune testing: anti-GBM and ANCA negative; (+) ANA, elevated C3, C4 normal

Kidney biopsy:

LM focal necrotizing crescentic GN | EM no immune complex deposition | IF negative

Dx: ANCA-negative, pauci-immune glomerulonephritis

Problem Representation: Elderly male p/w lower extremity rash, hematuria, and melena. Labs showed new significant renal impairment requiring HD. Autoimmune workup was negative for anti-GBM and ANCA with normal complement levels. Kidney biopsy ultimately revealed pauci-immune crescentic glomerulonephritis

Teaching Points (Javi Fan :)

Hematuria + melena = **Bleeding:**

- ***Pause***. Consider mimics, frame the problem first
  = blood in the perineum
- ***Systemic*** [vessel-related] ***vs. local*** [tissue-related] ***vulnerability***

Bleeding into the skin -> **purpura:**

- ***Palpable vs. non palpable***, unusual appearance [well demarcated lines] -> nature of the disease
  = systemic hemorrhagic diathesis?

Inflammation of unknown origin: Imade = Infection above else.

- ***Empiric Abx?*** Sepsis, neutropenic fever, decompensated cirrhosis
- The **severity and duration of disease** dictates the **velocity** of pursuing Dx hypothesis and empiric management.

*Problem representation: foreground >> background. **Frame** the problem with the present, **understand** the problem better with the past.*

Hematuria: PVR [obstruction risk] >> Dx clarity.

- ***Pulmonary + renal syndrome***. Is this *renal -> pulmonary* [edema]? *X -> pulmonary + renal* [heart]? *Pulmonary & renal* [microvasculature]?
- The more **severe** the organ damage is, the likely it's the **source**.

Glomerular bleeding: GN? [90% AI, 10% ID -> *IE risk factors*] **ARN?**

- ***Complements*** [nl -> IgA, AAV, anti-GBM, MGRS]
- ***Kidney Bx*** -> for DDx & understand *glomerular vulnerability* for ARN [IgA nephropathy is the MCC].