9/18/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Shafaq* ***Case Discussants****: Rabih & Reza*

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

Scribing (Eyron):

CC: 65/M presents with worsening shortness of breath

HPI:

Associated with non-productive cough

Also with several days of watery diarrhea exceeding 7 bowel movements daily, as well as abdominal cramping with diffuse tenderness

PMH:

Ulcerative Colitis

ILD

COPD

Meds:

-

Fam Hx: -

Social Hx: -

Health-Related Behaviors: -

Allergies: -

Vitals: Sat: 88%

Notable Labs & Imaging:

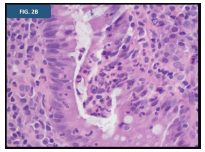
Colonoscopy:

Pancolitis without dysplasia, marked erythema, edema, friability in the sigmoid and descending colon

Rectum: diffuse erythema, friability c/w chronic, active proctitis

c/w moderate to severe UC with extensive mucosal inflammation

Bx: active mucosal injury, crypt abscesses with neutrophilic infiltration



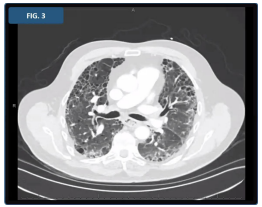
D/c on mesalamine and budesonide -> returns with recurring sx

Stool PCR: (+) C diff toxin

Started on oral vancomycin, now requiring 2L of supplemental O2

BCx: (+) C. perfringens | ANA (+)

CT Chest: bilateral subpleural honeycombing and fibrotic changes



Started on IV vancomycin, metronidazole

Dx: C. diff colitis and C. perfringens bacteremia iso UC flare

Problem Representation: 65 yo male p/w relapsing respiratory and gastrointestinal symptoms with underlying colitis ulcerosa and rapid progressive CT chest imaging findings turns out to be C. perfringens bacteremia

Teaching Points (Lukas):

- **Dysprovement of dyspnoea is difficult and very subjective → hypoxia isn't! → Dyspnea Pyramid!**
  Hypoxemia as an objective anchor that cannot be masked by gut pathology
  → imaging lacks behind!
- **What can you Think of vs what should you think of**
  → generative exhaustive differential diagnosis lists upfront leads to cognitive overload; triage like in ED
- **Problem framing over premature closure: signal vs noise, rare syndromic combinations doesn't need direct pattern recognition - characterize the disease tempo, inflammatory state, organ specific localisation, host (e.g. TNF-alpha inhibitor as immunosuppression changes the whole DDx!)**
- **Always think about IBD mimics, don't always copy/paste prior diagnosis**
  → histopathology is king e.g. viral inclusion bodies (owls eye)
  → confirm with prior imaging to find the delta
  → e.g. honeycombing takes normally months to years to develop so think about rapid progressive diseases
- **CTPE is not enough to rule out lungs/vascular as the culprit. Bronchoscopy is needed in IBD patients because e.g. necrotizing tracheobronchitis is a rare complication**
- **Treatment failure: wrong bug, wrong drug, wrong diagnosis, dual pathology, pharmakokinetic/resistance failure**
- **Don't forget drug toxicity especially in ILD e.g. 5-ASA (mesalamine) induced pneumonitis/eosinophilic pneumonia**