9/27/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: (@)* ***Case Discussants****: Kirtan (@) & (@)Glen*

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

Scribing (Noah):

CC: 68 y/o M p/w burning urination 2 days

HPI: Reports 1 week of fever with chills and rigor, followed by 2 days of dysuria. No hesitancy. Seen by doctor outpatient, return precautions. Maybe OTC antibiotics.

ROS:
No hematuria, nausea, vomiting, loose stools, abdominal pain, skin lesions.

PMH: T2DM

Meds:
Insulin
Vitamins

Fam Hx:

Social Hx:
Post-office worker
Recent travel to Ooty (hill station/forestry)

Health-Related Behaviors:

Allergies:

Vitals: T: Afebrile **HR**: 80 **BP**: 110/80
Exam: Gen: Alert and oriented
HEENT: wnl **CV**: wnl
Pulm: wnl **Abd**: wnl

Notable Labs & Imaging:

Hematology:
WBC: 7000 (neutrophil predominant) Hgb: 13.6 Plt: 119 MCV:

Chemistry:
Na: 129 K: 3.8 Cl: 103 Ca: 1.15 Mg: BUN: 43 Cr: 1.1 Glu: 302
Total bili 0.8 ALP 93 AST 52 ALT 72 Alb 3.4
UA: No evidence of RBC, casts, glucose
Urine culture negative
HIV negative

Imaging and course:
Echo: Normal LVEF.
Admitted, acute worsening dyspnea.
CT chest with bilateral pleural effusions.
Thoracentesis with MTB negative, cytology with diverse lineages of WBC with reactive mesothelial cells in a background of hemorrhage
Sputum MTB negative
USG mild prostatomegaly, bladder wall thickening, thickening of bilateral perirenal fat pat, mild splenomegaly, liver coarsened echos
CTAP: Chronic inflammation of both kidneys, bilateral pleural fluids, consolidation with fibrosis, collapse lower lobes.
Patient elected to be discharged.

Final Dx: Suspected diabetes, tuberculosis, pyelonephritis

Problem Representation: 68 yr old M p/w acute inflammatory urinary sx,fever with pleural effusions,chronic inflammatory changes in the urinary tract on imaging with negative MTB diagnosed as disseminated TB.

Teaching Points (Siva)

Chills & rigors-always get B/C,NBGP,Malignancy.
AKI-fluid challenge,foley will resolve most cases.
Pleural involvement without parenchymal changes(not classic) - Lag,TB pleurisy,abdominal infections>pleura(parasitic ,GI-GN.
Bladder wall thickening- chronic obs, acute inflammatory edema.
Acute sx presentation with chronic changes-indolent org.

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"One life, so many dreams" **Case Presenter**: *Jeffrey (@)* **Case Discussants**: *Ram (@)*

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Scribing (CPS Fan):
CC: 66M with **black fingertips**
HPI: Finger pain for 2-3 weeks, now dusky and necrotic fingertips on both hands.

Came back from California. Walking barefoot on beach, ate oysters, new tattoo, hike in desert, THC exposure.

ROS: myalgia

PMH: —

Meds: —
Creatine supplements
Doxy course

Fam Hx: none

Social Hx: long time smoker 40 p/y, active. Socially EtOH

Allergies: amoxicillin

Vitals: nl **T**: 99.6 F **BP**: 150/80
Exam: **Gen**: looks well
ER -> exam: fingertips look dark, eschars on tips, tender to palpation, no drainage / erythema. Palms and proximal fingers warm. Palpable pulses bl. Dopplers: nl. No motor / sensory deficits.

Otherwise normal. No arthritis / synovitis / rashes / sclerodactyly.

Notable Labs & Imaging:
US with Duplex: all major arteries normal
CTA UE: nl **Photoplethysmography:** finger pressures slightly low
BCx: neg **CXR**: nl **UA**: nl **UCx**: neg **TTE:** nl

ANA: (+) 1:80

CBC: **WBC**: 13.8 [N predominant] **Hgb**: 10.9 Plt: 240 MCV: nl
Chemistry: **Cr**: 1.4 -> 2.8 [no bl], otherwise nl
ESR: 90 **CRP**: 12 (nl 1)

Repeat UA: 3+ blood, 3+ protein **UPCR**: 1600 g
ENA panel: neg **C3**: borderline low **C4**: nl
HIV, hepatitis screen, TB, Histo / Blasto / Cocci serologies: neg
c-ANCA +, **PR3 +**, MPO neg. **RF +**, CCP neg **CK**: 558

-> pulse dose steroids

CT chest: emphysema **Delayed UDS:** neg
Renal Bx: IC mediated GN **BCx:** MRSA **TEE**: vegetation

Final Dx: subacute MRSA IE

Problem Representation: A 66 y/o gentleman with rich exposure Hx presented with subacute acral ischemia syndrome, neutrophilia and GN with nl C3/C4. Initial BCx and TTE neg. c-ANCA +, PR3 +. Renal Bx showed IC mediated GN. Repeat BCx -> MRSA, TEE -> vegetation. Final Dx: subacute MRSA IE mimicking AAV.

Teaching Points (Renzo)

- **Time Frame** guides us. 2 weeks (acute) of vascular compromise to rule out limb threatening etiologies.
- Long standing smoking history in a elderly patient → Peripheral artery disease.
- Macrovascular disease is spared. Next step to rule out is microvascular disease, **small vessels vasculitis** can explain abnormalities. Other consideration would be Raynaud phenomenon.
- **Bilateral upper extremity compromise** make us think about a systemic process. Endocarditis, despite less likely, would be worth it to rule it out.
- **AKI dilemma without a baseline creatinine.** Contrast and creatine supplementation can mask the cause of AKI.
- **AKI work up** → UPCR and UA. This can guide us if there is a GN process. Look for infections and other autoimmune panels. Serologies for ANCA and infections (HIV, HB, HC, TB, Blasto)
- **ANA positive or other autoimmune serologies. How can it change our diagnostic process? Do not ancho**r on autoimmune diagnosis if something does not fit.
- I**f history suggest endocarditis. Pursue a TEE if TTE is negative,**
- **Endocarditis is a big mimicker** of autoimmune diseases and vice versa