5/15/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Samy (@samymady12)* ***Case Discussants****: Rabih (@rabihmgeha) & Zaven*

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

Scribing (Eyron)

CC: 20/F p/w crampy epigastric pain x 8 hours

HPI:
Pain radiates into lower abdomen, 4/10 -> 7/10, slowly progressive, never had this pain before. Usual state of health before, had breakfast 1 hour earlier (acai bowl), associated with nausea, non-bloody vomiting x 3

ROS:
(-) diarrhea, constipation, blood per rectum, rigors, B-symptoms, cough, dyspnea, dysuria, vaginal discharge, rash, MSK pain
No prior abdominal surgeries
LMP 2 weeks ago

PMH:
Constipation since childhood
URI 4 weeks ago (no Ab needed)
Jaundice at 9 y/o (spontaneously resolved)

Meds:
None

Allergies:
none

Fam Hx:
Follicular thyroid CA (father)

Social Hx:
Non-smoker, no etoh or drugs,
From Israel, lives in Austria, goes to university,
No animal contact
No insect/tick bites

Health-Related Behaviors:
Sexually active (protection used)

Vitals: T: 36.8 **HR**: 76 **BP**: 135/77 **RR**: 16 **Sat**: 99% RA **BMI**: 29
Exam: Gen: marked distress 2/2 pain, oriented x 4
CV/Pulm/Skin/Neuro: wnl
Abd: Soft, (+) mild epigastric and RUQ TTP, Murphy's (+), (+) mild b/l flank TTP, no distension, NBS

Notable Labs & Imaging:
Hematology:
WBC: 19 (neutrophil predominant) Hgb: 13,5 Plt: 340 MCV: 83
Chemistry:
Electrolytes (+Ca), AST, ALT, ALP, Bili, CK, LDH, troponin, PTT, INR, TSH, pregnancy test, vBG, Covid/influenza/RSV PCR wnl Cr: 1.1 Glucose: 126 Albumin: 3.5 Total Protein: 7.5 CRP: 12 (<5)
Lipase 9251 UA SG 1.025 1+ protein 2+ketone neg leukocytes, nitrites
Imaging:
CXR: wnl | **TTE:** no vegetations
US: Liver and Kidney wnl, portal and hepatic vein wnl, spleen normal sized, gb w/o sludge or gallstones, no extra/intrahepatic cholestasis, free fluid in the morrison and koller pouch, no hydronephrosis, pancreas not visualized
CT: peripancreatic fluid collection extending into right paracolic gutter and pelvis w edematous pancreas predominantly involving tail (exudative pancreatitis).. No evidence of pancreatic necrosis or pseudocyst. No signs of cholestasis, thin walled gallbladder w/o gallstones
MRCP: no choledocholithiasis or -cystolithiasis, no new pancreatic findings
Repeat labs in 3 days:
Hgb 5.7, adequate retics, Plt 28k, CRP 280, PCT wnl, Cr 1.5, Bili 6, Direct 2, LDH 2500, Haptoglobin undetectable, D-dimer 14, INR 1.5, aPTT wnl, decreased UOP, mentated normally, SBP 150mmHg -> admitted to ICU
PBS 1% schistocytes, anemia, thrombocytopenia, no blasts or erythroblastic changes, ADAMTS13 80%, coombs negative
Normal: TGs, IgG4, PETH, HIT-Ab, Folic, b12/MMA, immunoglobulins, SFLC, urinary porphyrins wnl, Ferritin 1100 C3 low, C4 wnl | G6PD nl |UACR 17, no casts or dysmorphic RBCs, PLA2R Ab, THSD7A Ab, (-), ANA, ENA, APLS ab (-) |Negative: HIV, Hep, Tox, Strongy, BCx, flow cytometry neg, leptospira/hanta, stool cx/PCR, blood herpesvirus/parvob19, adenovirus PCR, Hb-electrophoresis, G6PD-activity, legionella/pneumococcal UAg Genetic analysis for hereditary pancreatitis (-) |**EUS**: microlithiasis in the gallbladder

Dx: Biliary pancreatitis c/b atypical HUS

Problem Representation: 20/F p/w epigastric pain found to have elevated lipase and CT revealing a peripancreatic fluid collection and edematous pancreas c/w pancreatitis. 3 days later noted with dark urine and labs revealing hemolytic anemia, thrombocytopenia, schistocytes, AKI, low C3 levels, and normal ADAMTS13 activity. EUS was done revealing microlithiasis ultimately suggesting biliary pancreatitis complicated by atypical HUS.

Teaching Points (Varsha)

EPIGASTRIC PAIN:
- Epigastric pain radiating down - probable Hepatobiliary pancreatic pathology/ pelvic pathology
- Common causes of Epigastric pain - very common type - functional dyspepsia, PUD, etc
- Time course: self presenting < 8 hrs - likely morbid, Less possibility of spontaneous resolution

PANCREATITIS: (clues in our patient: - Epi pain radiating to back/ bridging flank pain +, elevated lipase +, imagining findings +)
- Most common casese: Alcohol and Gallstones
  - Approach : Structural or substance
    - Structural: gallstone causing critical obstruction, annular pancreas, Ca
    - Substance - Most morbid - elevated TG (Xanthomas), medications
  - Time course: Acute presentation → points towards probable structural cause vs slower progression with substance
- Imaging, MRCP
- Rx: Fluids, early enteral feeding

HEMOGRAM:
Acute drop in Hg + Elevated indirect bili, low haptoglobin, elevated LDH → hemolysis +; with low platelets: microangiopathic hemolysis (intravascular); with renal damage → think MAHA/ TMA/ TTP
- Solid organ ca - Ca cells can trigger TTP - extravascular clue to intravascular process
- Stem cell transplant/ organ transplant - medication can cause TTP (tacrolimus)

How to interconnect hemolysis with pancreatitis:
- Baseline : Pigment gallstones
- If thrombocytopenia is + - something common to both RBC and PLT is affecting/destroying them
  - Infection (malaria)
  - Ab (usually not hyperacute in onset)
  - Shared environment of both (MAHA)
- 3 main causes of pure intravascular MAHA - APS, TTP, atypical HUS
  - Atypical HUS: low complement, pancreatic edema (C5a+ → increased vascular leak)
  - Rx: Eculizumab