6/26/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Hira (Sinai Chief Resident) (@)* ***Case Discussants****: Rabih Geha (@) & Glen Mpotsang (@glen13_thabiso)*

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

Scribing (Lukas)

CC: 51 yo male p/w increased SOB on exertion from his baseline with upper abdominal pain and left sided chest pain

HPI: walking 10 feet already causes SOB and dizziness. resolving on rest; occasionally nausea without vomiting; weight loss of a few pounds over a few weeks while eating normally; developed vesicular, itchy rash and darkened skin on the back of the hands (scratching led to darker, hyperpigmented lesions)

ROS (+): dark urine, low grade fevers, bitter taste in his mouth, weight loss, decreased thirst, constipation

PMH:
CHF Hefref (EF 21-25% last echo 1 year ago)
Hypertension
Hyperlipidemia
PE in the past
On anticoagulation
CVA (left sided upper extremity weakness)
NSTEMI 5/2024 (cause of ischemic Hefref)
LHC with a stent in the L MCA (12/23)
11 mm right middle lung lobe nodule

Meds: reduced (!) compliance with
Losartan
Aspirin
Entresto
Lasix
Eliquis

Fam Hx: -

Social Hx:
Desk job
Lives in New jersey in apartment

Health-Related Behaviors:
No smoking
No recreational drugs
Drinking for 10-15 years, quit 3 years ago

Allergies:
No meds, environmental or food allergies

Vitals: T: 99.2 **HR**: 83 **BP**: 128/83 **RR**: 18 **Sat**: 97% RA **BMI**: 24.09
Exam: Gen: not in acute distress
HEENT: no conjunctival pallor, no icterus, no cervical LAD, moist membranes // **CV**, **Pulm and Abd**: wnl
Neuro: left hand atrophy with left sided hemiparesis unchanged from baseline
Extremities/skin: generalized hyperpigmented lesions in forearms. Vesicular rash >> scratches lead to hyperpigmented round lesions

Notable Labs & Imaging:

Hematology:
WBC: 7,5 Hgb: 11,2 (base 3) Plt: 71 (base is normal) MCV: 94.1 HK: 33,2 RBC: 3,53
Chemistry:
Na: 130 K: 3.9 Cl: 105 anion gap: 5 HCO3: 20 Cr: 1.11 BUN:16 Glucose: 95 Ca: 8.8
Mg: AST: 39 ALT: 19 Albumin: 3.3 LDH: Total bili: 3 / Direct bili: 1,2 pCO2: 20 TSH: wnl
Lactate: 0,9 BNP: 429 Troponin: 35 Ferritin: 1325, TIBC: 179 Iron: 14 Transferrin: 129

Imaging:
EKG: no ischemic changes (similar to previous EKG)
CXR: no acute pulmonary findings
CTC/A/P: lung nodule seems stable, aorta wnl, bilateral renal scarring with non obstructing right renal stone, some cholelithiasis
Doppler: no evidence of DVT bilaterally
UA: wnl, no casts
LDH: 509 **Hapto**: < 10 **HIV**: neg **RPR**: neg
Serology: Lyme: neg; blood cultures/bloodsmear: positive for babesia
Hx: Patient reveals regular wandering in the nature in the summer

Dx: Babesiosis

Course: Rx with Azithromycin + later Doxycyclin (for Ehrlichiosis coverage), echo was ≈ to previous echo, discharged after 6 days with stabilization of his symptoms

Problem Representation: 51 yo male p/w progressive SOB and dizziness on exertion, abdominal and left-sided chest pain and a vesicular rash with secondary darkening after scratching with image negative focus. Targeted patient history reveals possible tick exposure with blood cultures came back positive for Babesia

Teaching Points (Lourenço)

- **SOB + chest and abdominal pain**: when a patient has > 1 CC, pursue the symptom that's more severe or has a narrower DDx. Since SOB points to loss of function, it's the most relevant to clarify.
- **Chest + abdominal pain**: think of structures that go through the diaphragm (e.g., aorta, esophagus). Lesions of these structures can lead to pain that radiates to both the chest and abdomen.
- **Symmetry**: drugs and AID cause symmetric diseases (*blood-based problems*), while **infections and cancers** are very asymmetric. Since the patient has **LEFT sided chest pain**, search for these etiologies, especially in the context of weight loss (i.e., systemic disease).
- **Nodular rashes**: when a rash goes deep in the skin, like nodules do, always think of systemic diseases (VS local diseases, that stay on the surface of the skin).
- **History VS exam:** the patient is untrained, therefore the history can be flawed, especially when paired with an unremarkable exam or test results. In these situations, trust the physical exam (when done by an experienced physician) over the history.
- **Localize thrombocytopenia**: marrow problems or peripheral causes (immune destruction or splenic sequestration). The marrow usually affects the RBCs and WBCs. The lack of signs of portal hypertension should point us towards peripheral destruction, such as ITP. Always exclude HIV, Hep C and liquid cancers.
- **Anemia + thrombocytopenia:** always look for hemolysis. If positive, the DDx is narrow, and we must always exclude TMA.