10/27/26 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Gillian (@) Case Discussants: Ravi (@rav7ks) & Sam (@samkeenanbarry)

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

Scribing (Meghna):

CC: 62 y/o F with 4 days of diarrhea, nausea, LLQ pain and weakness that became worse the previous day

HPI: Five episodes of worsening diarrhea, blood streaked, daily, associated with sharp LLQ abdominal pain, which radiates to the back. She has also noticed dark urine without clots, frank hematuria or dysuria. Over the past several days, she has developed weakness in her arms and legs, progressing to inability to stand/walk. Also reports B/L numbness and paresthesias in upper and lower limbs.

ROS: Denies fever, vomiting, recent falls, trauma, bowel/bladder incontinence or saddle anesthesia. Reports chronic B/L hand/finger numbness and chronic paraspinal back pain. No chest pain, dyspnea, dizziness.

PMH: Chronic back pain
Chronic finger nose numbness
UC treated with Adalimumab (dose increased recently)
CKD
Asthma
Scabies - treated w Ivermectin
Dx: Severe rhabdomyolysis with biopsy confirmed necrotizing myopathy (uncertain etiology)

Meds: Adalimumab, buspirone, empagliflozin, mesalamine, albuterol, atorvastatin (intermittently)

Fam Hx: Nil

Social Hx: Daily cigarette use 0.5 PPD 25 yrs, no alcohol/drugs/recent travel

Allergies: Denied

Vitals: T: **HR**: 58 **BP**: 128/56 **RR**: 18 **Sat**: 100% on RA **BMI**:

Exam: Gen: no acute distress

CV: nl **Pulm**: nl **Abd**: diffusely tender, soft, no rebound

Neuro: UE 4 / 5, proximal LE 2-3 / 5 -> 5/5, distal LE 4-5 / 5 -> 5/5. Sensation nl. Reflexes 2+, symmetric.

Notable Labs & Imaging:

Hematology: WBC: 7.1 Hgb: 10.9 Plt: 246 MCV: 85

Chemistry: Na: 140 K: 3.5 HCO3: 14.6 BUN: 83 **Cr**: 15.84 (2019 -1) Glu: 68 Phos: 7.4 Mg: 2.6 **AST**: 2997->28 **ALT**: 1478-> <8 ALP: 281 T. Bili: 0.5 ESR: 120 CRP: 3.7 LDH: INR: 1.1 Lipase 226

VBG: pH 7.16 pCO2 45 Bicarb 15 Lactate: 0.9 B12 > 2K

UA: Brown, cloudy Blood: large Protein: 200 Glucose: 200 RBC: numerous WBC 11-25 Leuk est/nitrates: negative UPCR 1.65 UACR: 189 CMV: neg

CK>80,000 -> 29,000 -> 84

Imaging:

CT A/P (w/o con): No hydronephrosis, no urinary calculus, no definite abdominal inflammatory process, mild rectosigmoid thickening

Renal USG: B/L echogenic kidneys compatible w renal parenchymal disease, no hydronephrosis

Abdominal doppler: Normal liver appearance with patent hepatic vessels

MRI cervical, thoracic, lumbar: normal

MRI femers: B/L symmetric muscle edema involving thigh and pelvic muscles, sparing or vastus

IV fluids, bicarbonate - progressive oliguria, anuria, worsening azotemia, persistent metabolic acidosis -> hemodialysis

Persistence of weakness - methylprednisolone, IVIG x 5 days; Adalimumab, atorvastatin held

Utox - negative ANA +ve (1:160, 1:640), RF -ve, dsDNA, smith, RNP, SSA, SSB, mitochondrial: -ve, ANCA -ve cryoglobulins -ve Anti-RNA polymerase III -ve, Anti-CCP: 55 HAV IgM, HCV Ab, HIV -ve HBV positive total core Ab, negative surface Ab and core IgM -> *Entecavir, TMP-SMX;* Renal Biopsy - deferred

Muscle biopsy: necrotizing myopathy pattern; Anti-HMGC, Anti-SRP, Extended myositis: Negative; CT Chest: No suspicious mass or adenopathy

Problem Representation: 62 y/o woman with PMH of UC treated with Adalimumab presented with diarrhea, nausea, LL weakness, labs showed transaminitis, metabolic acidosis, elevated CK, positive ANA & Anti CCP and muscle biopsy showing necrotizing myopathy

Teaching Points (Varsha)

Approach to Multiple problems (Diarrhea + abdominal pain + urine changes + neurological features + weakness) → **is it a unifying diagnosis or unrelated**
Metabolic Vs inflammatory Vs Infectious
Inciting factors/ triggers?

Blood in stools → 1st step → ensure pt is stable (vitals), Hg and Hct (to triage severity of bleed)

Dark urine → concentration of urine (low volume - dehydrated) Vs pigments - hemoglobin(RBC +) / myoglobin(no urine RBC, CPK ++) Vs porphyria (recurrent episodes/Family history?)

+Neurological symptoms - severe weakness → due to severe anemia? Vs GBS Vs Gut malabsorption (Vit B12/Vit C deficiency)

Diarrhea → Acid base abnormalities Vs Ketosis → Electrolytes

Relevant history:

Drugs (Adalimumab, Ivermectin, statins) → is there a nephrological impact Vs muscle related complication Vs neurological complication

Immunocompromised status → Scabies

Exam: lower extremity weakness >> than upper → ascending neuropathy? → B12 deficiency Vs Vit C, Zinc, Electrolyte (++ due to CKD) VS GBS Vs Peripheral neuropathy

Labs:

Liver enzyme → elevated AST ALT >> ALP → hepatocellular injury
Alcohol → toxic alcohol, HIV, hepatitis, Cu (wilsons), Tylenol and Aspirin toxicity, medications (Viral panel VS ANA/Ab Vs Wilsons Vs toxins Vs Medications)
Worsening of CKD → leading to worsening liver?

CKD → renal US → rule out post renal obstruction
Abnormal urine → Glomerulonephritis? → ANA, Hep C, hep B, Pauci immune Ab, MPO, ANCA

Medication induced injury → direct side effect Vs autoimmune flare (statins induced muscle injury) → 1st step → Stop drug, if we suspect an autoimmune provocation → Pt improves with immunosuppression

Myositis - elevated CPK, ++ Weakness → Primary or secondary (meds) → drugs → adalimumab increases severity of statin induced muscle injury due to liver enzyme suppression
Myositis panel: Anti HMG CoA Ab, Anti SRP ab