6/28/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Daniel Lim(@)* ***Case Discussants****: Lourenco (@) & Sarah Blaine(@sarahkblaine)*

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

Scribing (Varsha)

CC: 35Y/F presents with 2 months of fatigue worsened by exertion

HPI: associated with palpitation, chest tightness, lightheadedness, worsened by exertion. Exertional SOB x 2 weeks. Chest tightness occurs mainly at night (burning sensation)

2 weeks ago → yellowing of eyes and skin. Occasional nausea and no vomiting, unintentional weight loss, dark urine, generalised pruritus without rash. 4 months ago, she was bitten by an insect → swelling and redness. She then developed generalised body ache and nausea, which resolved over time.

ROS: Negative Cough, sputum, fever, edema, abdominal pain/ swelling

PMH:
Alcohol fatty liver disease
Obesity
IDA

Meds:
Cyclobenzaprine
Naproxen

Social Hx: 5- 6 drinks of alcohol per day x 6 years

Health-Related Behaviors: lives in california, no travel history

Allergies:

Surgical H/o: cholecystectomy (2012) LSCS

Vitals: T: 98 **HR**: 93 **BP**: 99/54 **RR**: 22 **Sat**: 99 **BMI**:

Exam: Gen: scleral icterus +

HEENT: - **CV**: unremarkable **Pulm**: unremarkable

Abd: tenderness + periumbilical and suprapubic region, no abdominal swelling

Neuro: - **Extremities/skin**: jaundiced skin

Notable Labs & Imaging:

Hematology:

WBC:2.8 Hgb: 4.8 Hct 16 Plt:141 MCV:140

Chemistry:

Na: K: Cl: HCO3: Cr: wnl BUN: wnl Glucose: Ca: Mg:

AST:wnl ALT: wnl Alk-P: wnl wnl Bili: 8.7, direct 3.3 Albumin: 4.4 Total Protein:

ESR: CRP: PT 15.2, INR 1.28

Vit B12 and Folate normal, , Iron 169, TIBC, TST and ferritin wnl

UA: red color, Leukocyte 2+, nitrate +, bilirubin +, no bacteria or cast

US abdomen: hepatomegaly with fatty infiltration, no evidence of biliary dilation

Transfused with 3U of PRBC and started on IV ciprofloxacin for UTI

Blood smear: macrocytes and dacryocytes +

LDH 339**, haptoglobin** < 10**, retic % 24.8, Retc Hg 33.5**

CT chest/ abdomen/ pelvis: hepatomegaly and massive splenomegaly, no enlarged lymph nodes

DAT COOMBS IgG +, C3 +, warm Ab +

BM biopsy: hypercellular marrow, erythroid hyperplasia

Infectious: Negative HIv, HBV, HCV and syphilis

ANA 1: 40, speckled nuclear pattern (no rheumatological symptoms)

Dx: Primary warm autoimmune hemolytic anemia

She was started on corticosteroids, f/u a week ago with similar symptoms (medication non compliance)

Problem Representation: 35Y/F presented with % of fatigue, weight loss, and jaundice. Exam was + for jaundice and abdominal tenderness. Labs revealed pancytopenia with elevated bilirubin, and a UTI. Imaging + for hepatosplenomegaly. Hemolysis workup revealed elevated LDH, low haptoglobin, DAT COOMBS +, and warm antibodies . She was then diagnosed with Primary warm autoimmune hemolytic anemia.

Teaching Points (Ramaswamy)

Approach to fatigue: Hard to localize, easier to focus on other symptoms -> can be associated with dyspnea

Approach to palpitations chest pain: Cardiac vs pulmonary, infection vs autoimmune, anemia; chest tightness + burning sensation -> GERD -> chemical injury to the lungs vs larynx

Age - always consider potential genetic predispositions

Female - Potential predisposition for heart failure post pregnancy

SOB + chest tightness + fatigue + jaundice => ? hemolytic anemia, intracellular infections; in the context of cholecystectomy -> ? serositis is worth considering; h/o chole in the parents

Approach to pancytopenia - *direct destruction vs splenic sequestration vs improper production; also consider inflammatory or immune causes of marrow destruction*

Elevated MCV - Macrocytic anemia -> megalo vs non megaloblastic anemia; if this is pancytopenia -> B12 vs folic acid deficiency;

Hemolytic anemia - haptoglobin, retic count reqd., LDH, peripheral smear (esp for Babesiosis vs other intracellular parasites vs schistocytes) ; Coombs test necessary

Massive splenomegaly *-> malaria vs schistosomiasis vs autoimmune hemolytic anemia; lymphomas is also worth considering; this may be due to extramedullary hematopoiesis*

Dacryocytes *-> May not need marrow -> RBCs being damaged in transit -> can have this from spleen also*