



8/9/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter:** Sarah Blaine **Case Discussants:** Kirtan Patolia & Manaswini Keshav
<https://clinicalproblemsolving.com/present-a-case/>



Scribing (Sam B): CC: 49 M, 6 months of progressive anemia and fatigue HPI: Was at normal state of health PCP workup ongoing: CBC with progressive anemia, otherwise unremarkable 3 days ago worsening SOB at rest and dizziness, went to ER ROS: Fatigue, myalgias, sweats, joint pain, spots in vision Denies meleneas, diarrhea, nausea, abd pain, edema, exertional dyspnea		Vitals: T: 100 F HR: 97 BP: 130/80 RR: 12 Sat: 100% BMI: 23 Exam: Gen: exam is noncontributory CV: mild tachycardia, systolic murmur	Problem Representation: 49yo M patient with 6 months progressive anemia and fatigue, otherwise healthy, found to have abnormal inflammatory and iron studies, mitral valve vegetation
PMH: N/a Meds: Noncontributory Supplements	Fam Hx: n/a Social Hx: n/a No farm exposure No pets Health-Related Behaviors: 1 EtOH drink/week Nonsmoker Allergies: None	Notable Labs & Imaging: Hematology: WBC: 6 Hgb: 7.6 Plt: nl MCV: 85 RBC: 2.91 (L) Chemistry: CMP normal ESR elevated, CRP 10 (H) Iron studies: Iron 16 (L), %sat 10 (L), TIBC 157 (L), retics 2.6% (H) Ferritin 1281 (H), LDH 228 (H), aldolase nl, Low C4, +RF Negative: ANA 12+ profile, RADx6 profile, ANCA, cryoglobulins, Hep C qQuant, Lupus anticoag, B2 glycoprotein, Brucella, Q fever, Bartonella, HIV, HBV, HCV, cryoglobulin, ANCA, ANA Imaging: Echo: atrial leaflet echodensity on posterior mitral leaflet, moderate mitral regurgitation, EF 60-65% CTA abd/pelvis: splenomegaly w/new splenic infarct, patent vasculature, no vasculitis, no abdominal masses, pleural effusions CT head: small hemorrhage 1x1cm in L superior parietal lobe Dx: Gemella burgeri endocarditis Mitral valve replacement, did well and was d/c	Teaching Points (CPS Fan = RAM <3) Anemia as CC: -Proximal / part of the Dx -> get full picture [get ROS, check other labs, understand the COG -> anemia ☹️] & specify CC -Quick Dx scan -> What's lethal? What's likely? Acute on chronic tempo: Progression? Complication? Unrelated? [chronic tempo is tricky as triggers adaptation -> minimal contribution]; Sx = tempo x severity Keep it broad -> approach the Sx, then narrow it down Spots in the retina: Cotton wool spots -> Anemia - focal retinal ischemia ; DM, HTN Approach to normocytic anemia: Iron and TSAT low does not imply IDA. -Ferritin>30 -> IDA less likely; 30-100 -> gray zone;>100 -IDA unlikely (except ESRD, HF) - TSAT -> Iron/ TIBC; Even Anemia of chronic dz -> low Iron -After Iron studies, worth getting hemolytic anemia workup -> Haptoglobin, LDH; Reticulocyte count vs reticulocyte proliferation index -> absolute count >100,000 you can assume it is elevated but cannot trust %. RPI >2 = appropriate bone marrow response and here % > 6%. -Multiple myeloma - when iron studies, hemolysis workup(-). Approach to cardiac mass: In the context of systemic symptoms + cardiac mass -> vegetations vs thrombi vs cardiac mass -> get more exposure h/o => infectious vs non infectious - Non infectious - RA, SLE, IgG4 ; malignancy - Benign - myxoma, lipoma, rhabdomyoma; Malignant - angiosarcoma ; TEE >> than TTE for Dx -Myxoma symptoms - Embolic - stroke, visual changes, ischemia; obstruction - HF (due to flow through mitral valve); constitutional - releases IL-6