10/30/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Lourenco (@) **Case Discussants**: Rabih (@) & Reza (@)

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

Scribing (CPS Fam <3):

CC: 74 yo women w/ 2 weeks of fever, malaise, fatigue, shortness of breath, face and leg swelling, and orthopnea.

ROS:
Endorses slight cough and diarrhea
Denies chest pain, urinary pain, night sweats

PMH: htn, t2dm, obesity, ckd 3 w/ baseline cr 1.3 2/2 diabetic nephropathy, hld

Meds: atorvastatin, dapagliflozin, bisoprolol, spironolactone, ozempic 4 months ago (lost 5 kg),

Fam Hx:
Not relevant
Social Hx:
w/ husband, retired newspaper boutique, no pets, recently scratched by a cat, no travels

Vitals: T: 37.2 **HR**: 95 **BP**: 160/100 **RR**: 22 **Sat**: 97% ra **BMI:** >35
Exam: Gen: pale, nl mm, elastic non-tender LAD in posterior cervical chains
HEENT: jvp hard to evaluate **CV**: pitting edema bl LE, normal rrr, no m/r
Pulm: no accessory muscle, diminished breath sounds, rales bl bases
Abd: palpable non tender hepatomegaly **Neuro**: nl **MSK/skin**: no rash synovitis

Notable Labs & Imaging:
Hematology: WBC: 15k (10k neutrophils) Hgb: 10 Plt: 360k MCV: 87
Smear: nl, RPI: 1.2% (low)
Chemistry: Na: nl K: nl Cl: nl HCO3: 19 Ca: Mg: BUN: 78 Cr: 2.8
AST: 30 ALT: 29 GGT: 82 ALP: 174 T. Bili: 0.4 Alb: 3.1
ESR: 67 CRP: 2 LDH: 283 ferritin: 96 NT-proBNP: nl Folate: 4 B12: 500
ABG: nl except bicarb 19 **Coags:** wnl

Infection & Autoimmune:
HIV, Hep B, Hep C: nl | COVID: pos, flu: negative | Blood cultures x2 neg, bartonella pcr: negative
Negative ANA, anti-dsDNA, APL, ANCA; RF, anti-CCP, and cryos;x2 Negative ASO, anti-DNAse antibodies
Low C3, C4; Normal IgA, IgM, low IgG; elevated kappa and lambda free light chaises with normal ratio, SPEP w/o monoclonal spike

EKG: signs LVH | CXR: normal | Kidney us: loss of corticomedullary differentiation, nl size and shape
UA: neg nitrites, 154 leuc, 1043 RBCs, UACR: 1.2 g, UPCR: 1.8 g, urine sediment: dysmorphic RBC and casts
Echo: grade II diastolic, LVEF: 64%, LVH, mild pericardial effusion 5 mm, no valvular vegetation or thrombus
CT C/A/P: periaortic, mediastinal, paratracheal, inguinal LAD, hepatomegaly, nl spleen
Kidney Bx: MPGN, 4 glomeruli w/ pseudo thrombi, immune fixation w/ immune complexes of IgM, kappa, C3
Immunofixation: monoclonal component of IgM Kappa type, negative bence jones in the urine, urine immunofixation w/ polyclonal free light chains
Course: fluctuating lymphocyte count >3000 and <5000
Flow of peripheral blood: Monoclonal Kappa+, population B cell c/w with non hodgkin lymphoma marginal zone or lymphoplasmacytic type 3.6%
Flow cytometry of bone marrow: monoclonal, Kappa+, pop. of B lymphocytes c/w non-Hodgkin lymphoma, of the marginal zone or lymphoplasmacytic type.

Assumed waldenstrom's due to systemic feature, rituximab started and patient improved
FINAL DIAGNOSIS: MPGN secondary to Lymphoplasmacytic lymphoma or MPN:

Problem Representation:

Teaching Points ()

Rare condition are so much rare than common conditions with a twist.

New onset HF usually have sub clinical HF in the past. Majority of patients with diabetic nephropathy never develop nephrotic syndrome. Facial swelling unusual for HF and point more towards a renal pathology.

Myocarditis,endocarditis,pericarditis .How to reconcile the low BNP.Since it has a high negative predictive value. But obesity with its extra adipose tissue can break down BNP.BNP is released when there is a stretch of chambers.if she has constrictive pericarditis then there wouldn't be much stretching.
Disseminated process involving multiple processes including heart etc.

Inflammation of kidney is the glomerulonephritis and that where Urine analysis is very important.Glomerulus,tubules ,intestituism

Dysmorphic red cells high specificity for glomerulonephritis which explains the urine protein and hypertension. IgA nephropathy doesnt have low complaints.Sle,Infective endocarditis can have hypocomplementemia Normocomplelent GN,IGAare GBM,ANCA.

Membranoproliferative is most likely a consequence.
Cll 30 % risk of monoclonal gammopathy.