



4/1/20 Morning Report with @CPSolvers



<p>CC: 70 F p/w fatigue & new anemia HPI: 3-4 weeks ago, admitted for acute abdominal pain found to have cholecystitis & choledocolithiasis, ERCP: papillary stenosis, sphincter of Oddi dysfunction, no e/o gallstones, sphincterotomy. D/C → SNF</p> <p>2 week ago: melena, 2U pRBCs, ERCP: clot & bleeding</p> <p>1 week ago: Denies melena</p>	<p>Vitals: all normal Exam: GEN: no acute distress HEENT: conjunctival pallor Cards: RRR Lungs: CTAB, no wheezes/crackles Skin: normal Abd: soft, NTND, no BRBPR, no melena Neuro: 5/5 strength throughout. Followed commands</p>	<p>Problem Representation: Older woman w/ hx of APLS, nephrotic syndrome, p/w fatigue, acute on chronic anemia & melena s/p 2U pRBC transfusion found to have hemolysis c/w delayed transfusion reaction.</p> <p>Differential Diagnosis: In a pt w/ recent procedure on AC - concern for bleed Hemolysis Complication of transfusion</p>	
<p>PMH: Nephrotic syndrome (MCD), HTN, APLS, stroke, peritoneal carcinomatosis 2/2 Gyn Ca (remission) Meds: pred, cyclosporine, warfarin, labetalol, hydral, alendronate, letrozole + a few others</p>	<p>Fam Hx: Sister - breast cancer Brother - pancreatic ca</p> <p>Soc Hx: Burma → US (remote) Dependent on IADL</p>	<p>Notable Labs & Imaging: CBC: WBC 9.5, Hg 10 (1 mo ago) → 7.8 (1 wk ago) → 6.1 (now), Plts 242, MCV 103 INR: 2.3 Iron studies: Fe 62, ferritin 811, %sat 42 BMP: 143/3.7/115/21/25/1.17(0.84) glu 114 AST 25, ALT 50, AlkP 91, Tbili 2.0, Dbili 0.6</p> <p>CK 95, LDH 956, haptoglobin low, retic 195 UA: large hgb, 3-10 RBC Type & screen: anti little C - Ab DAT: IgG (+), C3 (+) Smear - polychromasia</p>	<p>Teaching Points: Anemia - bleed, hypo-production, destruction. Acuity affects your differential, is it acute vs chronic anemia? Check prior hgb, reticulocytes, smear, VS Acute anemia - usually symptomatic, +orthostatic Chronic anemia - normal vital signs Melena - upper GI bleed above ligament of Treitz or slower lower GIB, DRE for tarry stool! Ferritin >150 and not on iron = not iron deficiency, unless CKD Background - when the pt's history is rich, it comes to the foreground and can expand the differential Haptoglobin binds Hgb, preserved in extravascular hemolysis, so low haptoglobin suggests massive intravascular hemolysis TRALI, TACO - more acute reaction Delayed transfusion reaction - stable patient</p>