08/02/23 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Maddy (@MadellenaC) **Case Discussants**: Steph and Zaven(@sargsyanz)*

CC: Patient A: 87F presented w/ **bilateral** lower extremity swelling & redness
Patient B: 47F presented w/ **unilateral** lower extremity swelling & redness

HPI: **Pt A:** noted worsening swelling & pain in the last several days with more pain; mainly sitting on the couch fo rlast 4 days due to difficulty walking; no fever, chills night sweats, SOB, & abdo pain
Pt B: woke up with fever (Tmax 104˚F) & chills; noticed her left leg was swelling; 10/10 pain; also endorsed night sweats and chills a day before

PMH:
Pt A: chronic lymphedema 2/2 obesity with recurrent cellulitis, AF, HTN
Pt B: chronic lymphedema secondary to obesity, HTN, lupus erythematous tumidus

Meds:
Pt A: Amlodipine, Furosemide, Eliquis
Pt B: prednisone, metoprolol, furosemide

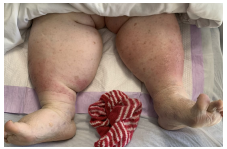
Allergies:
N/A

Fam Hx:
N/A

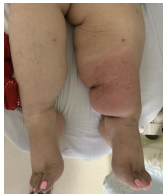
Soc Hx:
Pt A: smoker, a pack a day. Retired, liver alone at home. Walks with a walker, independent, hasn't moved a lot in past.
Pt B: noncontributory

Health-Related Behaviors:
Non-contributory

Pt A: Vitals: T: afebrile HR:62 BP:138/45 RR:19 SpO2 100% RA
Exam: Abd: no abdominal pain



Pt B: Vitals: T: 102.4 **HR:** 100-120s **BP: RR: SpO2 95% RA**



Notable Labs & Imaging:
PATIENT A:Hematology: WBC: 9 Hgb: 10.9Plt: 182
Chemistry: unremarkable
Imaging: Duplex US: negative, no DVT,
Patient A: BNP 4800, Echo with EF 73%, no regional wall motion abnormalities or valvular disease

PATIENT B: Hematology: WBC: 20 with neutrophil dominant Hgb: Plt: 2.7
Chemistry: wnl
Duplex US: negative, no DVT,

Pt A: working dx - chronic lymphedema with venous stasis dermatitis

Pt B: dx - unilateral cellulitis

Both treated with Ancef -> Keflex

Problem Representation: A 87F w/ a hx of chronic lymphedema 2/2 obesity presented with worsening **bilateral** lower extremity swelling & redness; she was also afebrile. On the contrary, a 47F w/ a similar background presented with **unilateral** lower extremity swelling & redness with severe pain, fever, and night sweats.

Teaching Points (Bea):
Definition of **lymphedema**: *problem in lymphatic drainage from an insult* (sth compressing => tumors themselves/answer to drugs/radiation therapy…) **primary/secondary** (99%)
Lymphedema does increase chance of cellulitis!
Swelling => **unilateral**: local process (i.e. cellulitis, especially with erythema) vs **bilateral**: systemic process more likely
Immobility => chronic venous stasis should be considered
Chronic swelling in lower extremities: venous insufficiency from obesity
Fever: systemic involvement; **night sweats:** sepsis
HTN, fibrillation, hypothyroidism in PMH, amlodipine: ***HF concern***
Infectious inflammation vs stretch/injury damage inflammation
Steroid inflammation: DVT, HTN, fever
Patient A: high BNP; Left ventricular HF: SOB and edema
Cellulitis Management: elevation and removing venous pressure improve clinical picture even before antibiotics
In a patient with a history of chronic lymphedema, it may be challenging to assess whether **dermatitis is from venous stasis or cellulitis => bilateral cellulitis is rare!**
Cellulitis: Staph(purulent) Strept (non purulent)more common

All edema is lymphedema: extravasation happens all the time, what clears is the lymphatic system; in HF developing edema (pulmonary, ascites…), extravasation outpaced the drainage!
8lt of daily liquid extravasation and soaking up! Everything is multifactorial: how much drugs/venous/lymphatic is contributing to the liquid excess

Lymphangioscintigraphy: assess how lymphatic is functioning