11/22/23 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Sawsan Sweilmeen **Case Discussants**: Jack Penner (@jackpenner) and Sharmin Shekarchian (@Sharminzi)*

CC: Left calf pain and swelling for 3 days

HPI: 51 yo female in the ER with left calf pain and swelling gradually starting and progressive. Also right palm swelling over her thenar area.

PMH: Type 2 diabetes well controlled, sickle cell trait (25% HbS on electrophoresis)

Meds: metformin, glipizide

Fam Hx: no family history of coagulopathy

Health-Related Behaviors: no smoking, no hormonal replacement tx

Vitals: hemodynamically stable, **SpO2:** % basal
Exam:
Extremities/skin: calf tense, tender and swollen. No erythema. Peripheral pulses intact.

Notable Labs & Imaging:
Hematology:
WBC: 5.900 (60% N, 26% L) Hgb: 5.5, MVC 62, RDW high, Plt: 246k
Smear: microcytic hypochromic anemia, retics: normal, ferritin 19.6

Chemistry:
D-dimer: 0.9
Positive stool occult blood

Evolution: Due to logistics, unable to undergo doppler US, so was started on therapeutic enoxaparin and given 3 units of blood.
US doppler: ruled out DVT. Vascular recommended CT-angio, which was unremarkable.
Pt developed ecchymoses and calf pain increased -> concern for compartimental syndrome. Heme recommended stopping anticoagulant.
Coags: INR 1.21, fibrinogen 430, PTT 80.3 (after stopping the anticoagulant: PTT 76). She referred heavy menstrual bleeding.
Calf US: hematoma.
Platelet function assay: 85 sec (wnl).
Coombs direct and indirect negative. ANA negative.
Upper gi endoscopy: no active bleeding, mild superficial gastritis.
Mixing study 50:50 → 61.5 (non-correcting).
Factor VIII inhibitor: positive

Dx: acquired hemophilia A
Pt was started prednisone and rituximab.

Problem Representation: 51 y/o F w/ PMH of DM, Sickle cell trait, history of 6-month-long menorrhagia, and no family hx of coagulopathy presented with L-calf and R-palm swelling. Labs were significant for microcytic hypochromic anemia, physical exam was positive for stool occult blood, ecchymosis.

Teaching Points (Tansu):
Unilateral causes: Irritation, inflammation of skin+soft tissue & deeper structures → panniculitis; local obstruction of vasc. (DVT).
Systemic causes → Fluid +edema 2/2 hypervolemia.
- Inflammation present? Superficial inflammation comes with erythema. // Coagulopathies → systemic clotting.

Separated areas of focal swelling- mechanism? Is there systemic issue, or are these separate processes?
- Swelling w/o pain → more worrying.
- Edema first, pain might come later. Pay attention to the progression.

51 y/o woman,PMH: SS-trait→Dactylitis, acute chest syndrome… DM → immune dysfn, polymicrobial skin+soft tissue infs.
FHx: Absence of family hx is ok. Acquired coagulopathy with adult population.
Exam + lab evidence of clotting + bleeding. (Hgb low → check vitals → stable?; if acute → would see it on vitals. Monitor closely) Vitals stable here → subacute-chronic process. Rtc normal → check the BM? Get PBS, hemolysis labs, coags beyond D-dimer, PT, PTT. LDH, haptoglobin. → Bleeding problem. → Check coags → PTT elevated despite stopping heparin. → Factor 8,9, vWF disorders, vit K deficiency, APLS, acquired hemophilias? → Mixing study → deficiency/presence of an inhibitor. **If there is deficiency, mixing study corrects it. If there is an inhibitor, mixing study would not correct it**). Mixing study → Non-correcting. → 1) Which inhibitor? 2) What is driving the presence? → SPEP, LAP, SS-trait increased risk? Also think of treatment w/ immunosuppression.