



# 9/30/24 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Dr. Andrew Song Case Discussants: Dr. Arielle Langer

**CC:** 37 yo F Hx of ITP, presents to ED w malaise, chest pain and reticular rash

**HPI:** four days ago, she was in hematology clinic for ITP. Baseline plat 125, now is 60, adherence to eltrombopag. Received a rituximab infusion, and two days later, she presents to ED w those symptoms. Two years ago-> rheumatology evaluated SLE based on fatigue, myalgias, arthralgias, and the ITP, by this time, antibodies were revealed.

**Hospital day 1:** appears unwell, progressive chest discomf., SOB, rash is spreading over leg. Heparin started.

**Hospital day 3:** deteriorating clinically. BP drop 130 to 80-90.

**Later on:** Hematology consulted: started steroids methylprednisolone 1g /day. Labs continued to worsen. Derm consulted. Started antiplatelets + IVIG. Eculizumab was deferred

**Vitals:** T:afebrile **BP:** systolic - initially 130, dropped to 80-90.

**Exam:**  
Notable:  
**SKIN:** Examination of L leg shows deep erythematous macules, papules, nodules w/ reticular pattern, some superficial ulcers

**Notable Labs & Imaging:**  
**Lupus anticoagulant +, Anticardiolipin + IgG, anti beta glycoprotein + IgG. Later -> antiphospholipid antibodies**

**Hematology:**  
**Hospital day 1:** Cr baseline 0,9 -> 3,2 UA proteinuria and hematuria.  
WBC 8,4, Hb 9,8, plat 60, LDH 1100, low hapto, neg coombs test, INR nl, PTT 44, fibrinogen 720, D-dimer 812, troponin 540

**Imaging:**  
EKG: Global t wave inversion  
Cardiac catheterization - angiographically normal vessels  
VQ Scan to evaluate DVT and PE  
Echocardiogram: diffusion wall motion abnormalities.

**Later on:** Trop 3000, D-dimer above assay, plat 53.  
PE: abd pain.  
**CT abd.:** splenic infarcts bilaterally, multifocal cardiac hypodensities.  
**Cardiac MRI:** Microvascular ischemia - not consistent w myocarditis.  
**Triple therapy:** plasma exchange or IVIG, anticoagulation, steroids  
Heparin to warfarin. Continued aspirin. Additional rituximab infusion.  
**Dx: Catastrophic Antiphospholipid Syndrome**

**Problem Representation:** 37 F p/w malaise; chest pain; hx ITP drop PLT from 125k to 60K despite medical adherence, previously suspected SLE, on admission deteriorated with a drop in BP & renal impairment.

**Teaching Points (Parisa):**  
**ITP** → dx of exclusion r/o TTP; leukemia; clues are (isolated low Plt 30K) the lower the narrow; the chronicity; the isolation.  
Abrupt onset is typically associated with infections and drug reactions versus autoimmunity.  
**Antiphospholipid antibody:** co- association of lupus and ITP  
The assay might not capture antibodies just antigens.  
The more this test are positive the more reliable they are.  
**Catastrophic APLS:** Involvement of 3 end organs damage are diagnostic → most common organs skin; kidneys.  
**Presence of arterial venous thrombosis is not necessary.**  
**Management:** smear looking for schistocytes hemolysis microvascular damage; steroids; One of these (plx; IVIg); Rituximab; anticoagulation heparin IV; Eculizumab (anti C5)  
Affects both small (microcirculation) large vessels  
Caps triggers: viral infection; pregnancy  
**APLS:** Obstetric(recurrent fetal loss, pregnancy challenges) ; CAPS; Non criteria; Primary vs Secondary  
In ITP when PLT<50 there may not be an adequate response to transfusion.  
**Triple therapy** → anticoagulation; steroid; plasma exchange IVIg  
**Warfarin:** is choice in this setting by knocking down factor 7 and thrombin, slowing the rest of the cascade; two other clinical trials has been halted d/t safety reasons.  
Repeat testing for antiphospholipid Ab is necessary after 12 week  
The efficacy of aspirin for primary prevention of thrombotic events in patients with antiphospholipid antibodies but no thrombosis is poorly supported by current data.

**PMH:**ITP  
Lupus  
Antiphospholipid antibody  
**Meds:**  
eltrombopag

**Fam Hx:** no notable  
**Soc Hx:** no notable  
**Allergies:** no notable