



# 04/23/25 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: (Yaz@minheredia) Case Discussants: (Dr. Rich Snyder)

**Scribing (SEEME)**  
**CC:** 50 year old female with lower extremity edema and nausea

**HPI:** worsening SOB and lower extremity edema over the last 2 weeks ,previously could walk 2 miles without issue, now dyspnea walking 2 blocks, also has nausea and metallic taste in her mouth

**ROS:** Denies fever, chills, diarrhea, orthopnea, chest pain, and joint pain.

**PMH:**  
 SLE  
 HTN

**Meds:**  
 Couldn't take medications

**Fam Hx:** not significant

**Soc Hx:**not significant

**Health-Related Behaviors:** not significant

**Allergies:** NKDA

**Vitals:** T: afebrile BP:159/ 91 RR:18 HR: 61 Sat: 100  
**Exam:** Gen: normal  
**HEENT:** moist mucous membranes, oropharynx clear, no oral ulcerations  
**Neck:** no JVD  
**CV:** normal rate and rhythm, no murmurs, rubs or gallops, no JVD  
**Pulm:** clear lungs bilaterally  
**Abd:** non-tender, non-distended, no organomegaly  
**Neuro:** normal, no focal deficits  
**MSK:**2+ pitting edema of BLE to the knee  
**Skin:** No rashes, no petechiae, no jaundice, no bruises.

**Notable Labs & Imaging:**  
**Hematology:**  
 WBC: 11.6 Hgb: 8.5 Plt:120 Hct: MCV:78  
**Chemistry**  
 Na:140 K:5.3 Cr:5.3 BUN:133 Ca:8.4 Glu:96 Cl: 110 Co2: 17  
 AST:12 ALT: 12 ALP:62 Bili:0.3 albumin:2.7  
 Protein:5.4  
 UA: specific gravity: 1.013, protein 3+, blood 2+ rbcs 6  
 Urine protein/ creatinine: 8.2  
 SPEP, UPEP without monoclonal spike.  
 HIV and Hepatitis panel negative  
**Imaging:**  
 Renal US: bilateral kidneys 11.6cm, increased echogenicity , no hydronephrosis or stones  
 ANA: 1:1280, anti-sm:8, C3: 55 (low) and C4: 15.5 (low), smear: rare schistocytes, Anti-dsDNA: negative  
 ADAMTS13 35%  
 Kidney biopsy: glomerulus with evidence of membranous nephropathy with subepithelial spike formation combined with endocapillary and mesangial hypercellularity, early crescent formation.  
**Dx Lupus nephritis**

**Problem Representation:**  
**50 year old FM with history of SLE presented with lower extremity edema, nausea and SOB.**

**Teaching Points (Eugene):**  
 Edema: defined as fluid in interstitial space. Lower extremity edema:, thinking (cardiac , renal, liver). Important to know baseline of patient before current presenting symptoms.  
 Metallic taste in mouth points to uremia. Other causes: zinc deficiency (can cause non-cirrhotic hepatic encephalopathy)  
 Refractory hiccups not getting better think about uremia in advanced kidney disease.  
 Indications for dialysis: On exams-uremic pericarditis. Acute indications: AEIOU (refractory Acidosis, Electrolytes imbalance (hyperkalemia), Intoxication, Fluid Overload, Uremia)  
 Asterixis is non-specific and can present for any type of metabolic encephalopathy  
 -Labs are important but the patient is the most important. Other things to look out for is the volume status of the patient, hemodynamic status, and whether the patient is making urine.  
 -11.6cm diameter of kidneys on USG is a decent size, increased echogenicity indicates chronicity. There is loss of corticomedullary differentiation.  
 -High protein creatinine ratio, hypoalbuminemia, and 3+ proteinuria indicates nephrotic syndrome  
 -Thrombotic microangiopathy: TTP, Anemia (MAHA),  
 Typical HUS: shiga toxin, atypical: complement mediated, other causes  
 -Lack of anti dsdna does not mean patient doesn't have lupus. Level elevation though correlates with disease  
 -On biopsy, Seeing endocapillary hypercellularity and subepithelial spike formation ( classic for membranous class v) points to lupus-  
 -Goal is to see if patient is treatable to get them off dialysis.  
 -Lupus nephritis can recur after transplant  
 -Take Home: For lupus nephritis, remember your serologies: ANA and anti smith.  
 Complements are low, anti dsdna 9/10 is going to be elevated, but not always. Overlap with TMA. Can coexist with sjogren syndrome.  
 Lupus podocytopathy: glomerular disease. MMF for indication therapy and maintenance.