5/23/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Sarah Park (@) Case Discussants: Rabih (@) and Maddy (@)

Scribing (Zakariyya G.)
Chief Concern: 81 yo Male with an *acute painful left leg*
HPI:
2 days ago: mechanical fall. Initially: moderate pain 6/10 with subsequent bruising and swelling
Following day: Bullae and skin discoloration
Continued Aspirin and Apixaban
Worsening Pain sensitive to touch
No improvement
No constitutional symptoms, chest pain, abdominal pain or rashes elsewhere

PMH:
HFrEF 40%
Afib on apixaban
CAD on aspirin
HPT
Dyslipidemia
CKD baseline creat 2
BPH
Anemia (baseline Hb 11.3)
Meds:
Atorvastatin
Empagliflozin
Finasteride
Lokelma
Torsemide
Metoprolol
Entresto. Tamsulosin

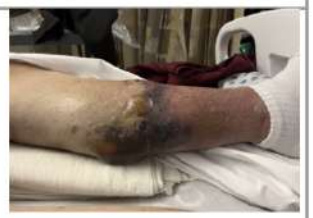
Fam Hx:

Social Hx: lives at home

Health-Related Behaviors:
Nil
Allergies:

Vitals: Temp 96.4 **Pulse** 67 **BP** 110/17 **RR** 17 **O2** 97% on RA
Exam: Gen: No acute distress
CVS: JVP elevated, otherwise normal **Pulmonary:** Normal
Neuro: Normal including *normal sensation and motor exam of left leg*
MSK: Bipedal edema. No crepitus. Normal capillary refill. Normal DP pulses bilaterally on doppler

Notable Labs & Imaging:



Hematology:
WCC 8.5 **Hb** 8.5 **Plat** 206
Na 140 K 4.9 Bicarb 30
BUN 76. **Creat** 3.43. Glucose 105
Iron 41 Ferritin 26 TIBC 230 TSAT 18
Ca 8.9 **Mg** 2.6 **PO4** 5.5 GFR 20
CK 241 **Urinalysis**: Unremarkable **BNP** 2000 (baseline 400)
CT: 20cm left extremity hematoma. *Vascular surgery decided against acute intervention due to soft compartments and stable Hb.*
Cardio Consult: Apixaban and ASA withheld. Hb stabilized. Pain manageable. **KUB: CKD - no hydronephrosis**
Further history: POCUS: *Dilated IVC, low collapsibility.* Diuretic trial with worsening renal function. Fluid challenge then tried, but renal function continued BUN 112 to worsen with new evidence of pulmonary edema .
Overnight: New AMS - Hallucinating - then agitated and delusional.
ECG: AFib otherwise Normal. **Troponin** normal. **Echo:** EF 40%
Patient underwent dialysis. BUN and creatinine dropped to 87 /2.42. Still confused post dialysis. **Repeat UA:** Still normal. **Abdominal U/S**: Query Cirrhosis like appearance **Dermatology then called:** *Invasive melanoma + Basal Cell Ca from prior biopsies!*
Eventually discharged. Melanoma excised. Followed up with GI. Continued to undergo dialysis. Eventually passed away.

Final Diagnosis: Age-related chronic illness with superimposed Cancer

Problem Representation: 81y M w extensive PMHx p w painful L leg, sec a fall, CT revealed to have stable hematoma. POCUS revealed dil. IVC. Hospitalization complicated by decomp. HF + worsening renal function + AMS. -> Dialysis. Derm involved. revealed. melanoma.

Teaching Points (Vini):
- Do not miss: Ischemia, rapidly progressive deep infection, gas gangrene.
- Use score for necrotizing soft tissue infection.
- Bullae represents separation of dermal and epidermal layer. Internal - DVT, compartimental sd., limb ischemia, pseudoaneurysm or external issue - invasive infection, necrotizing fasciitis, drugs, burns.
- Preceded by trauma: involved fracture?/ phlegmasia cerulea dolens? + Risk factors: LE edema sec. to HF, bacteria inf. sec. trauma.
- Eval. rapidly for compartment syndrome + life threatening sepsis, consult vasc. surg. ER triage: feel the pulse, elevate the leg, pain control, labs, USG, XRay for eval. fracture - ortho eval, CT for possible necr. Fasciitis + comp. sd.
- Labs: nl WBC and CBC talks against infect. + IDA present. - maybe sec. to iron loss in GI tract or AV Malformations + h BNP supports decompensated HF - correlate w possible etiologies. Acute blood loss - Low Hb can indicates blood going to hematoma.
- Where is the hematoma come from? Artery, capillary vs vein? Pt previously on anticoag. Soft tissue hematoma?
- Hematomas can separate the skin from its blood supply.
- Stop apixaban, no need to reverse - no severe bleeding. Acute bleed rarely cause iron def. anemia.
- AMS/delirium: Cardiogenic shock? Kidney etiology? - impaired perfusion to the brain? Consider inotropes. Stroke? Proceed w CT.
- Circulatory dysfunction - Heart or kidney dis. progressed? Cardiorenal sd.?
- SPIKES protocol to deliver bad news. Show respect for the situation. How much want to know, literacy level, experience w training, not a checklist, personalize the delivery of news, sociocultural value, adaptation to patient's reality. Bring the patient and the family alongside you. Deliver in a gentle way. Patient vs Our problem list.