07/23/25 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: *Maryam (@)* **Case Discussants**: *Jeffrey Shen (@) and Emma (@)*

Scribing (Vijay)

CC: 76 yr male, generalised weakness, LE swelling over 3 months

HPI: Generalised weakness - 3 months at rest.
Difficulty in standing and walking
Denies any paresthesia, numbness
LE swelling - Worsening with pain around ankles(Right>left), a/w cramping worsening with exertion
Poor appetite. 10 pound weight loss over 1 month
Denies palpitation, chest pain, night sweats, cough, fever, chills, urinary symptoms, GI symptoms
Declined dialysis - K binders, diuretic challenge

PMH: not known

Meds: not known

Fam Hx nl
Social Hx: Lived in car
Stayed with cousin 1 month ago.
Northern california, Mexico once
H/O existential experience

Health-Related Behaviors: Denies smoking, alcohol use. Marijuana everyday

Allergies:

Vitals: T: 98.4 BP: 140/88 **HR**: 96 **Sat:** 95 RA
Exam: Gen: Chronically ill appearing not in distress **HEENT:** WNL.
CV: Tachycardia with no murmurs/gallops **Pulm:** Bibasilar crackles. NI work of breathing **Abd:** WNL **MSK:** Well perfused. 2+ DP, 3+ pitting edema(B/L). Right LE extremity erythema. Calf tenderness; **Skin** : no rash
Neuro: Normal **Psychological assessment:** Magical, Grandiose thinking.

Notable Labs & Imaging:

Hematology: WBC: 9.4(nl diff) **Hgb: 7.4** Plt: 363 MCV: 83

Chemistry Na: 137 K: 7.3 Cl 105: BUN: 111 Cr: 10.36 HCO3: 25 AG:19 ca 7.3 PO4 7.4 CRP: ESR: LDH: AST: 25 ALT:21 ALP:114 Bili: 0.3 Alb:2.1
INR: 1.2, CK- 35, Ferritin 618 TSAT 27% B12 388 FA 5.72 Retic 1.1% ARC 33000.
Hemolysis, DIC labs negative, LDH 191
Trop - 46, Nt proBNP >70k
pH 7.33, pCO2 31.2, pO2 22(VBG), HCO3 16.4
UA: 1+ glucose, 2+ blood, 2+ protein, 1+ Leukocyte esterase, 11-20 RBC, 6-10 WBC, 3-5 cast. UPCR 2.6g/day
Glucose, HbA1c, lipid profile - Normal
C4 13, C3 114 -Normal, Cryoglobulin - negative
GBM, ANA, ds-DNA, HIV, hep panel, RPR,RA negative. Quant-Gold - Intermediate
MTB PCR negative. 3AFB smear negative. Mycobacterial culture awaited.
c-ANCA negative,PR3 -0.5, pANCA positive, MPO >8(positive)

Imaging: CT Chest: Motion artifacts. Areas of bronchiectasis, calcification RUL(old infective sequelae), smooth interlobular septal thickening -p.edema, Mild pleural effusion
LL US: Occlusive Proximal DVT(Right femoral, popliteal, calf)
TTE: LVEF - 39%, Global HK. No vegetation/effusion
USG: Inc Echogenicity of kidney
Cardiac Stress MRI: No vasculitic involvement

Dx : Renal limited - MPO vasculitis [Microscopic Polyangiitis(MPA)]

Problem Representation:76M with chronic marijuana use presents with 3 months of weakness, LE swelling, exertional cramps, and 10-lb weight loss. Exam notable for bibasilar crackles, right proximal DVT, and 3+ LE edema. Labs show normocytic anemia, severe AKI with nephritic UA, and positive p-ANCA/MPO

Teaching Points (Anmolpreet):

I] **Lower extremity edema: Heart x kidney x liver, meds, thyroid**
II] **Chronicity** of the symptoms helps us in narrow down differentials:
Acute-ADHF, chronic-nutritional deficiencies, hypoalbuminemia,
III] **Generalised weakness** in itself is not specific/specific; could represent anything from asthenia to myopathy
IV] **Rheumatology take on weakness/myopathy** :
proximal vs distal and Symmetric vs asymmetric
Weakness on standing up- proximal weakness
Autoimmune myopathies - weight loss (paraneoplastic/otherwise)
Statin induced myopathy: proximal muscle weakness
DDx also includes *inclusion body myositis, immune mediated myopathy*
V] **Asymmetric pain on ankles with pain worsening on exertion :** claudication, autoimmune myopathy (inflamed+hypercoagulable), inflammatory arthritis/synovitis
VI] **Inflammatory myopathies:** dermatomyositis can be ruled out, - rash
VII] **Edema, crackles, kidney injury: volume overload 2/2 kidney dysfunction : AKI vs CKD** : possible decline in 3 months - rapidly progressive glomerulonephritis → PAN (*HepB neg)*, ANCA vasculitis (small>medium>>>large), cryoglobulinemic vasculitis, urticarial vasculitis (-rash,- arthritis); Lupus (renal dysfunction-lupus nephritis + psychiatric manifestations- look for painful bleeding ulcers in mouth, raynauds) - get complement*(ANA, dsDNA neg)*, serum sickness, cholesterol emboli, endocarditis; get a CT chest (r/o DAH- sign of ANCA vasculitis); need to know if true or drug-induced ANCA vasculitis; need ANCA, need TEE (to r/o endocarditis which is a mimic)
VIII] **DVT:** Behcet (arterial+venous), antiphospholipid, ANCA vasculitis is not known to cause DVT that much (venous vasculitis)
IX] **RPGN with normal complement:** ANCA Vasculitis (GPA>=MPA>>>>EGPA), IgA vasculitis (HSP) possible in the absence of other sx - adult onset (classic rash +-)
CNS involvement is seen in ANCA vasculitis; negative imaging (CTA/MRA) - small vessel vasculitis; diagnosis: brain biopsy