07/16/25 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Jomer Polanes (@) **Case Discussants**: Sharmin (@sharminzi) and Kirtan (@KirtanPatolia)*

Scribing (Bayan)
CC: 65M presenting with vomiting
HPI: 1 day ago, developed multiple episodes of non-bloody, non-bilious vomiting associated with nausea and abdominal cramping. He had homemade soup before the attacks began.

ROS: no fever, chills, syncope, chest pain, diarrhea, melena, hematochezia, hematuria or dysuria.

PMH: HTN, T2DM, hyperlipidemia, TIA

Meds: aspirin, semaglutide, amlodipine, lisinopril, pioglitazone, rosuvastatin, dapagliflozin

Fam Hx: -

Social Hx:

Health-Related Behaviors: denies smoking, alcohol use, and illicit drug use

Allergies:

Vitals: T: 36.4C **BP:** 143/81 **HR**: 94 **RR:** 22 **Sat:** 99
Exam: Gen: dry mucous membranes
HEENT: nl **CV:** nl **Pulm:** nl **Neuro:** nl **MSK:** nl
Abd: tenderness in the right and left lower quadrants. No guarding or rebound.

Notable Labs & Imaging:

Hematology:
WBC: 12.24 (neutrophil predominant) Hgb: 11.3 MCV: 87

Chemistry
Na: 120 K: 5.6 Cr: 10 BUN: 77 Ca: 8.2 Glu: nl Cl: 82 HCO3: 15 AG: 23 LDH: 371 AST: 1602 ALT: 2520 ALP: nl Bili: nl CK 3000+ Lactate 3.6 ESR nl CRP nl C3 and C4 nl
UA +ve blood. No RBC seen.
ABG pH 7.42 pCO2 24 pO2 75
Serology for HIV, HBV, HCV -ve
SPEP nl. ANCA -ve, Anti-GDM -ve

Imaging:
US Ab: b/l echogenic kidneys. no hydronephrosis.
CTAP: no significant abnormalities.

Nephrology d/c statins and recommended hemodialysis.
Kidney biopsy: mesangial hypercellularity w/ matrix expansion, interstitial fibrosis, tubular atrophy, intimal fibrosis of arteries suggestive of diabetic glomerulosclerosis. Tubular casts positive for myoglobin

Dx : myoglobin cast nephropathy superimposed on diabetic nephropathy

Problem Representation: 65M w/ 1 day hx nausea, multiple episodes of vomiting, & abdominal cramping found to have elevated levels of AST, ALP & CK.

Teaching Points (Anmolpreet):

I] Recall bias: is important while taking history of present illness
II] Causes of vomiting:

1. Metabolic (DKA- electrolytes),
2. Toxic (food poisoning - Staph, bacillus),
3. Drug-induced side-effects (look for new meds/ others)
4. Any obstruction in GI tract (acute esophagitis, gastritis, small bowel obstruction),
5. Vestibular system (ask for associated symptoms),
6. Brainstem issues (mass/stroke),
7. Cerebral cortex issues (intracranial catastrophe raising ICP),
8. Cardiac issues (vasovagal symptoms)

III] Always rule out VIPO in abdominal pain: *if they are able to pass flatus?*
IV] Semaglutide (GLP-1 agonists) - gastroparesis (mechanism)
Dapagliflozin - euglycemic diabetic ketoacidosis
V] Patients with diverticulitis & appendicitis can have a non-classical bilateral abdominal pain
VI] Severe acute liver injury (>1000): - ischemic, viral hepatitis (HepA, Hep B, Hep C, Hep E, HSV, VZV) , toxin (DILI - acetaminophen (bili elevation as well), statin, mushrooms (Amanita), autoimmune
VII] Elevated CK: Rhabdomyolysis, exertion, toxins [statin (combined with ezetimibe and fibrates increases the risk of myopathy significantly), mushroom-Amanita], infections (Leptospira, Legionella, EBV, CMV), prolonged seizures, inflammatory myopathies, genetic
VIII] Severe kidney injury : baseline creat? - look for indications of dialysis?? Can be 2/2 rhabdo, DM, dehydration - multifactorial
IX] Diabetic patients can have renal papillary necrosis as well along with DKD/ESRD as a microvascular complication of long-standing DM