



8/28/25 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Carter() Case Discussants: Rabih (@rabihmgeha) and Julia Z (@juliazanco - IG)
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Vijay)
CC: 29 y male w/ Nausea, vomiting, abdominal pain x 2 days
HPI:
 H/O car ride(Denver → Colorado) 5000ft elevation change
 After camping noticed episode of **LUQ pain** radiating to back, worsening with **movement, breathing.**

ROS: Denies chest pain, URT symptoms
 No diarrhea, urinary symptoms, skin rash, joint pain, newmeds.
 No prior episodes. No exposure/B symptoms

Vitals: T: afebrile **HR:** 85 **BP:**150/80mmHg **RR:** 16 **Sat:** Normal **BMI:**
Exam: **Gen:** In pain
HEENT: Normal
CV: Tachycardia but RRR
Pulm: Clear
Abd: Non-distended abdomen. Tenderness, guarding LUQ

Notable Labs & Imaging:
Hematology:
WBC: 38k(PMN 84%) → NI Hgb:14.8 Hct 41 Plt: 343
Chemistry:
HCO3: 27(AG 10) Cr: NI. AST/ALT/ALP: NI Bili:2.1/1.0
Glucose: 407, BHB- 18.8. NO acidosis on VBG
UA: trace protein, 2+ketone, 1+ blood, 2+ glucose. Lipase, lactate, TSH - NI
Monospot: negative, **CRP 273**, ESR 2, **A1c 6.5%**, LDH 1161, Retic: High.
Haptoglobin: Low. DAT, Osmotic, G6PD: negative
HPLC: 54% HbA, HbA2, HbS 39% - SCT
BCR-ABL, JAK2 negative
PT/INR/apTT: Mildly elevated. HHH: negative. CMV IgM, EBV IgM, ANA - Negative.
Sickle cell screen: Positive(Caveat: False +ve in leucocytosis)
Blood c/s: Sterile.

Imaging:
ECG: NSR **CXR:** Normal
CT(TAP): Splenomegaly 15cm. Vague areas of hyperattenuation in spleen(?Hemorrhage). No abscess/collection. Consistent subcapsular hemorrhagic infarct. Abnormal **bony involvement(?AIHA/SCD/Thalassemia)**
USG GB: Normal with no ductal dilation

Dx: Sickle Cell Trait

PMH:
 DM(Dx @19yr - Not sure of type/Not on Meds)
 HTN
Meds:
 Used Insulin
 Metformin
 BP medications

Fam Hx: Nil
Social Hx: Denver
 Moved from New Mexico
Health-Related Behaviors:
 Marijuana, Vaping, Alcohol
Allergies:

Problem Representation:

Teaching Points (Magnus):
Approach to LUQ pain and N/V
 -Anatomical approach: skin, stomach, spleen, pancreas, colon + referred
 -> remember EKG and chest-x-ray
 -Worsening with breathing -> diaphragm -> abd or thoracic side (PE)
 -Worsening with movement-> superficial vs visceral (ischemia, peritonitis)
 -PMH of DM -> consider DKA/HHS (consequence) or pancreatitis (reason)
Approach to leukocytosis and splenomegaly
 -splenomegaly -> context! (ie lymphocytosis -> EBV) -> here WBC 38K
 ->infection (blood/endocarditis), ischemia (splenic vein thrombosis)
 -> obtain blood cultures and examine splenic vasculature, if negative consider autoimmune
 -sickle cell screen positive, normal hgb and high retic count -> hemolysis, and abnormal bone on CT-scan
 -splenomegaly takes time + acute event (-> leukocytosis) such as osteomyelitis (severe complication of sickle cell disease) or ischemia (splenic infarct)
 -Hemoglobin electrophoresis -> sickle cell traits (baseline leukocytosis + sickle cell occlusion -> leukocytosis)

Sickle Cell Type	Hemoglobin Composition
HbAS - Sickle Cell Trait	60% Hemoglobin A ("normal") 40% Hemoglobin S ("sickle")
HbSβ- Thalassemia	40% Hemoglobin A 60% Hemoglobin S
HbSC Disease	50% Hemoglobin C (other variant) 50% Hemoglobin S
HbSS Disease	80-90% Hemoglobin S 10% other hemoglobin types e.g. F, A2
HbSβ- (Sickle - Beta Null Thalassemia)	Mostly Hemoglobin S Small amount of hemoglobin F