8/26/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Masah Mardini (@MardiniMasah) Case Discussants: Ravi Singh (@rav7ks) and John Black (@)

https://clinicalproblemsolving.com/present-a-case/

Scribing (Saketh)

CC: 44 y/o M p/w coughing up blood x 1 day

HPI: Has been coughing up greenish sputum for 5 months and then started to occasionally cough up some blood. Woke up this morning with chest tightness, coughed up a large amount of bright red blood. In past 2 hours had 4-5 episodes ,noticed clots. He also felt short of breath. Previously treated for PNA (Staph Aureus) twice in past year (once in OP and once in IP).

ROS: No weight loss, No loss of appetite, no fever or chills, no night sweats.

PMH:
- Hospitalised for epistaxis 2x in last 5 years (requiring transfusions)
- COPD
- Gastritis
- Eczema
- Asthma
- R sided Pneumothorax
- DVT (provoked - Hip Rep Surgery)

Meds:
Omeprazole
Apixaban
Vit D
LABA + !CS
SABA

Fam Hx:
1) Father -?sinus problems
2) Mother - Asthma

Social Hx: Ex Smoker (30 PY - stopped 1 year ago) 18 Units of Alcohol weekly

Health-Related Behaviors:
Engineer in factory

Allergies: NKA

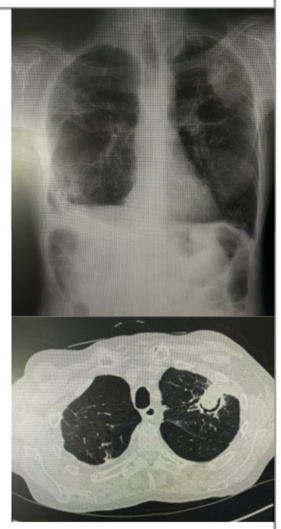
Vitals: T: 36.3 **HR:** 103 **BP:** 108/86 **RR: 20 Sat: 97% RA**

Exam: Gen: Speaking full sentences, sitting upright, coughing blood while talking, AO x 3
CV: normal heart sounds
Pulm: generalized wheeze on expiration
Abd: Soft, NT, Non distended
Neuro: No FND
Extremities/skin: No Leg swelling, no calf tenderness

Notable Labs & Imaging:

Hematology:
WBC: 13.7 (N 9.0 L 1.5 E 1.9) Hgb: 8.8 (baseline 10.3))
Plt: 384 MCV: 89.7

Chemistry:
Na: 139 K: 3.8 Cr: 36 (64 -104) Urea: 1.8 (nl 2.5-7.8)
AST: ALT: 13 Alk-P: 85 Bili: 8 Albumin: 26
CRP: 132 (nl 0-10), PT 13.3, aPTT 30.4, D-dimer 0.43
UA: WBC < 50, RBC > 10, Epithelial cells +
Blood Cx: Negative
Atypical viral screen: Negative
ANA & anca -ve, HIV -ve, alpha trypsin -ve
Sputum culture: Mycobacterium Chimaera



Imaging:
CTPA; WNL
CT Chest: Centrilobular & Paraseptal Emphysema with extensive bullous disease. Thick walled cavity with intracavitary material in the LUL, R Pleural Thickening
CXR: B/L upper zone scarring, opacification in LUL & RUL, Rt Pleural effusion
Serum IgE > 5000, Aspergillus IgG 139, Aspergillus IgE 28.9
Dx: Aspergilloma on a background of ABPA complicated by DOAC
- -> DOAC held, started on voriconazole for 4 weeks

Problem Representation: 44 y/o M with PMHx of COPD, asthma, provoked DVT on anticoagulation p/w acute hemoptysis on 5 months history of productive cough. Labs show eosinophilia and elevated Serum IgE. Imaging shows cavitary lung disease with aspergilloma.

Teaching Points (Seeme):

Approach to coughing up blood (hemoptysis):
-We can think about infections or autoimmune diseases or malignancies.Protecting the airway, stabilising the patient and imaging is important.
- It is important to quantify the quantity as mild hemoptysis can be seen in pneumonia or certain types of vasculitis. Bronchiectasis is also worth considering.

Approach to epistaxis:
-Epistaxis can be due to platelet (qualitative or quantitative defect) or coagulation cascade issue.Uremia can contribute to bleeding.
-Substances can also affect integrity of nasal mucosa

Approach to past medical history and exam findings :
-Smoking and alcohol can affect immune system and contribute to lung diseases.
- We can think who is this host- has a lot of risk factors for oropharyngeal and pulmonary malignancies.
- Patient seems to have recurrent sinopulmonary infections and apixaban can make the bleed worse. Aspergillosis and mucormycosis and other fungal infections can cause bleeding by invading vascular system.

Approach to labs and imaging:
- Shifting of trachea can be seen with effusions or mediastinal masses. Hyperinflated lungs can be seen in COPD which can be related to smoking.
-Asthma+eosinophilia can be seen in vasculitis (EGPA) but we should rule out infections (parasites) or autoimmune diseases. We can see if kidney is involved. Goodpasture's disease is also worth considering.
-Rasmussen aneurysm- can cause TB and hemoptysis