9/25/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: David (@davserantes) Case Discussants: Rabih (@rabihmgeha) and Hee Mun (@)

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

Scribing (Gillian)

CC: 52 yo F admitted to nephrology with AKI

HPI:

Initial labs: Cr: 1.46, Urea: 35, Urine: >200 wbc/ul, >200 RBCs/ul, dysmorphic RBCs (30%), protein/creatinine ratio: 2mg/mg

Seen by rheumatologist, checked labs, saw AKI, neutropenia (2500), anemia (11.5) + leukopenia, thrombocytopenia (80k)

Malaise and asthenia for 3 mo, postprandial epigastric pain, intermittent vomiting, brown urine.

Last month episodes of fever (night) 2-3x per week with sweating.

ROS: no chest pain, dizziness. Endorses oral ulcer, Weight loss of 5 kg past 2 months

PMH:
Asthma (well controlled), IDA, Rheumatoid arthritis (methotrexate)

Meds:
Methotrexate (withheld one month ago due to neutropenia)

Fam Hx:
nc

Social Hx:
Spain w/ no recent travel, poultry industry, 2 dogs and 3 birds

Health-Related Behaviors: non smoker, no alcohol or other drugs

Allergies:

Vitals: T: 37 **HR:** 80 **BP:** 150/85 **RR:** nl **Sat:** 96% on RA **BMI:**

Exam: Gen: no acute distress, A&O **CV & Pulm:** normal

Abd: mass in epigastric and in LUQ and left flank (Deep, non-painful mass)

Neuro: normal **Extremities/skin:** normal w/o edema or skin lesions

Notable Labs & Imaging:

Hematology: WBC: 2k (normal diff) Hgb: 11 Plt: 63k MCV: 88

Chemistry: Na: nl K: nl Cl: nl HCO3: nl Cr: 1.5 BUN: 40 Glucose: 107 Ca: 9.2 (corrected, 8.4 non corrected)

AST: nl ALT:nl Alk-P: nl Bili: nl Albumin: 3 Total Protein: 8.7

ESR: >140 CRP: 3 (mild elevation) LDH: 208 CK: nl TSH: nl

Complements: nl C3: 137 C4: 11 Rheumatoid factor: + (40) CCP: - IgA: nl IgG: high (4000) IgM: low (30)

Urine: >200 RBC/uL, 100-200 WBC/uL, urine culture negative, no dysmorphic RBC Urine protein/creatinine ratio: 1.8 mg/mg, albumin/creatinine 1 mg/mg

SPEP w/ IFE: Increased polyclonal gamma globulins, Kappa and lambda increased, ration normal

ANA: 1:160 , anti dsDNA: strongly positive, anti- myositis: negative, ANCA positive w/ atypical pattern, MPO: negative, PR3: positive

Coombs IgG positive, C3 negative

HIV, HCV, HBV, CMV, EBV, Syphilis negative, cocci negative

Bone marrow biopsy: leishmania positive, leishmania antibody positive

Imaging:

CXR: nl

CT Abd: splenomegaly 22 cm, focal liver lesions (hemangiomas)

No hydronephrosis, small lymphadenopathy in right axillary and inguinal area

Dx: Disseminated Leishmaniasis

Problem Representation: Middle aged woman with a history of presumed RA and asthma, presenting with tubulointerstitial nephritis, pancytopenia, splenomegaly, and autoantibody craze found to have disseminated leishmaniasis.

Teaching Points (Magnus):

Approach to AKI

-Use baseline creatinine, component of CKD?

-Common: Prerenal (dehydration/infection), meds

-Pyuria + AKI: interstitial nephritis vs. UTI + dehydration

-Hematuria + AKI: GN vs. trauma/stones + dehydration

-Dysmorphic RBCs + proteinuria + AKI -> think GN

Pancytopenia + RA

-RA can be a presumed diagnosis -> emergence of visceral findings should make us question the Dx

-Methotrexate -> bone marrow suppression, toxicity can emerge from AKI or accumulation in effusions

Splenomegaly + inflammatory symptoms

-Febrile + pancytopenia + immunosuppression + splenomegaly + AKI -> rule out infections (granulomatous, HIV/EBV/CMV)

-Nefritis (HIV, HBV) or interstitial nephritis (granulomatous)

-GN usually no pyuria and 70-80% albumin (selectively), whereas interstitial nephritis cause pyuria and proteinuria (non-selective)and can cause hematuria

-Unusual to have extreme splenomegaly and negative complements in SLE