11/11/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Eyron(@)* ***Case Discussants****: Ravi (@) & Zak G(@)*

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

Scribing (Vini)

CC: 72 year old female coming in for generalized weakness

HPI: 3 hours prior to arrival, patient complained of generalized weakness accompanied by lightheadedness, dull right frontal headache graded 8/10, nausea, and diaphoresis, no associated extremity numbness/weakness blurring of vision, chest pain, dyspnea or other subjective complaints.

2 hours prior, patient stated she felt warm and relatives noted onset of fever of 38 C (100.4 F) associated with onset of non-radiating epigastric abdominal pain, rated at 8/10 in severity associated with nausea. No associated vomiting, chills, dysuria, hematuria, bowel changes. Patient was given Tylenol 500mg with slight relief of symptoms. Interim, relatives noted patient would not answer appropriately to questions. Patient would be asked how she was feeling and patient would respond with moans which is not usual. Given these symptoms, patient was brought to the ED for further evaluation.

ROS: No unintentional weight loss, night sweats, colds, chest pain, palpitations, vomiting, dysuria or hematuria

PMH: HTN, T2DM, CKD, Post surgical Hypothyr., DLP, Pulm. TB, Vascular Dem., Diverticulosis

Meds:
Losartan, Amlodipine, Rosuvastatin, Sitagliptin + Metformin, Insulin Glargine, Ketoanalogue, Levothyroxine, HRZE, Memantine, Senokot.

Fam Hx: DM2 siblings

Health-Related Behaviors: No alcohol, smoke or drug use.

Surg. Hx: Total Thyroidectomy, TAHBSO, C-section.

Allergies: None

Vitals: T:38.1 (100.5) F **HR**: 115 **BP**: 180/80 **RR**: 23 **Sat**: 99 **BMI**: 20.4

Exam: Gen: awake, not in distress. Anicteric sclerae. Dry lips and oral mucosa

CV: no JVD, Tachycardic, regular rhythm, no murmurs

Pulm: clear bilaterally

Abd: no distended, direct tenderness in the L lower quadrant.

Neuro: unrevealing.

Extremities/skin: pulses full and equal, no lower extremity edema

Notable Labs & Imaging:

Hematology:
Hgb: 14.8 WBC: 22000 - N 96% L 3% Plt:265

Chemistry:
Cr: 1 BUN: 15 Na: 140 K: 4 Cl: 100 Ca: 1.3 Mg: 2.1 AST: 24 ALT: 25 Uric Acid: 12.1 Glucose: 208 HsTrop: 17.4 (<25) wnl TSH : 14.4 A1C: 9.4%

Imaging:
EKG: sinus tachy. UA: wnl
CXR: BILATERAL UPPER LUNG DENSITIES.
Abd. XR: non obstructive bowel gas, fecal stasis.
CT A/P:**Non inflamed colonic diverticulosis. Circumferential bowel wall thickening with associated narrowing and minimal perilesional fat stranding densities along the sigmoid colon. Left adrenal mass.**
BC neg. **TB PCR neg**. Pt responded well to Tx - ATBs.
Adrenal Mass/incidentaloma to be investigated Outpat.

Dx: Infectious Sigmoid Colitis

Problem Representation: 72 yo F p w/ generalized weakness for 3h w/ fever and abd. Pain. Recently diagn. w/ pulm. TB and Hx of diverticulosis. On PE, tenderness in the LLQ. Labs: WBC of 22k - N pred. CTAP revealed colonic diverticulosis and the Pt finally had Inf. Sig. Colitis.

Teaching Points (Shriya)

Approach to weakness
-associated with systemic symptoms or focal like limited to limbs
-could be metabolic,medications,systemic syndromes,autonomic or neurodegenerative dz(like MS,vasculitis)

Headache
-weakness with headache and n/v localizes to brain d/t raised ICP(infection,mass,stroke)
-Imaging to rule out bleed/ischemia is crucial
-Epigastric pain makes suspicious of aortic patho or myo ischemia
-Age itself is immunocompromised state d/t Immunosenescence

Past hx
- TB and its t/t complications (meningitis,peritonitis)to be considered
-With hypothyroidism,consider possibility of thyroid ca in long course and levothyroxine intake hx needed to inquired
-**Sympathetic toxicity** could be d/t adrenal(pheochromocytoma),thyrotoxicosis
-**LLQ pain** think of descending colon,sigmoid,skin,muscle or referred pain,also adrenal mass with symp surge
-Always think of constipation in elderly with GI sx
-High UA either inc intake,inc resorption or dec excretion
-Adrenal TB is most commonly adrenal insufficiency
-TB could present like pseudoGI tumor
-**Infectious sigmoid colitis** could be presentation of extrapulmonary TB