11/12/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: (Manaswini@)* ***Case Discussants****: (Dr.Leverenz@)*

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

Scribing (Seeme & Mohammed)

CC: 37YO Female presents with loss of consciousness

HPI: Sudden onset SOB 5 days before w/ pleuritic chest pain was worse on lying down. 1 day before admission, she had heavy menses, lightheadedness. Patient also noticed red spots scattered in her legs.

ROS: Lightheadedness. 10lb wt loss. Symmetrical arthralgia 6 months (wrist/knees/ankle). Progressive ankle swelling. 1hr morning stiffness. Myalgia. Hair thinning in the past 6 months.

PMH:
Hypothyroidism (anti TPO positive)
Carpal tunnel syndrome

Meds:
Azithromycin
Levothyroxine

Fam Hx: nil

Social Hx:
From China moved to US 1 year ago, moved to US 4 months ago
Works with lab mice as a researcher

Vitals: T: 97 **HR**: **BP**: 85/65 **RR**: 114 **Sat**: 94% on 4L NS **BMI**:
Exam: Gen: appears critically ill, waxing and waning mentation
HEENT: bilateral cervical, submandibular and axillary lymphadenopathy
CV: weak peripheral pulses diffusely. **JVD**
Pulm: **Diffuse crackles and rhonchi.**
Abd: soft, nontender, **Neuro**: wnl
Extremities/skin: multiple scattered flat, non-blanching red spots under the skin of b/l lower extremities. Swelling in dorsum of hands bilaterally

Course: Patient admitted to ICU and started on dobutamine and antibiotics. 5 days after tx, she had worsening AKI

Hematology:
WBC: 2.4 (lymphopenia/neutropenia) ANC: 1300 Hgb: 8.7 Plt: 47k MCV:80

Chemistry:
Na: 132 K: 5.8 **Cr: 3.8 BUN: 56** Glucose: 105
AST: 82 ALT: 33 Alk-P: 87 Albumin: 2.0 Total Protein: 5.4
ESR: 30 CRP: 5.6 **LDH: 400 CK: 384** Ferritin: 140
Urinalysis: +3 proteinuria, +2 blood, many WBC and RBC urine protein/creatinine: 4.2 Blood smear: schistocytes, undetectable haptoglobin and IB, SPEP/UPEP: polyclonal hypergammaglobulinemia

Imaging:
Echo: no vegetations, normal valves EF<15%, no vegetations
CT chest/abdomen: b/l basilar consolidations and GGO, b/l pleural and pericardial effusion, scattered mediastinal and axillary LN, mild mesenteric and inguinal lymph nodes with reactive appearance
ADAMTS13: slightly low (not concerning for TTP)
ANA +, high dsDNA, SSA, RNP. Low C3 and C4. p-ANCA 1:40. RF+, CCP -
Renal Biopsy: ATN, TMA, **class IV lupus nephritis**.
Lymph node biopsy: Reactive hyperplasia

Dx: SLE (Systemic Lupus Erythematosus) with TMA(thrombotic microangiopathy)

Problem Representation: 37YO F presents with acute AMS w/ HMB, SOB Pleuritic chest pain. She was hemodynamically unstable, and critically ill. Workup is concerning for systemic illness (hematologic (pancytopenia, hemolytic anemia) and rheumatologic fingerprint (lupus nephritis). Diagnosed w/ **SLE**

Teaching Points () hans

Symptom summary look broad; [loc heavy menses, petechial-bleeding diathesis, orthopnea-cardiogenic most serious, pleuritic chest pain) signal/noise distinction
Morning stiffness, symmetrical arthralgia, wt loss fingertips in the cold; inflammatory processes [ra, sle, mCTD]

Severe multisystem illness; slE, CPS, macrophage activation syndrome(MAS) [HLH] vasculitis, MDA5 dermatomyositis
Castleman (TAFRO)
Pulmonary renal syndrome: DAH (ANCA, SLE, Infections coagulopathies)
Pancytopenia: eg SLE, macrophage activation syndrome(normal ferritin attention heavy menses, causes underlying inflammatory dz)
HF (SLE: Libman Sacks,, myositis, RA)
Serology suggestive of SLE w/ CAPS overlapping vasculitis and multisystem involvement; further corroborated by renal biopsy

TX Pulse dose steroids consider plasma exchange (in context w/ CAPS),

Dx: SLE (multiple manifestations)