



11/15/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Allegheny IM Residency (IG: @AHNIMres) Case Discussants: Jeffrey (@) & Zakariyya G (@)
<https://clinicalproblemsolving.com/present-a-case/>



Scribing (Eyron)
CC: 89/F with dementia presenting with **worsening fatigue and SOB** for the last few months after a **mechanical fall** at home
HPI: Pt lives on the 2nd story and fell down 12 stairs, no LOC, **+head strike and scraped elbows** -> presented to ED as trauma, **A&Ox0**. Pt more fatigued over the last few months, breathing trouble may be related to movement. With movement, **O2 drops to 70s-80s** though improves with 1-2L oxygen. Pt is able to ambulate but needs help with ADLs (finances, cleaning).
In the ED: Eval by neurosurg -> no intervention, stable for floor admission. Trauma surg -> s/p lac repair, while in ED, **desatt on 15L O2** -> HFNC and admitted to medicine. **More SOB when sitting up and agitated, improved when lying down**
ROS: No recent fevers, chills, dizziness, lightheadedness, chest pain.

PMH:
 -Dementia
 -Low grade B cell lymphoma (no tx)
 -PFO w R-L intracardiac shunt
 -HTN
Meds:
 No recent changes
 -Vit D
 -Vit B12
 -Donepezil
 -Lisinopril

Fam Hx:
 NC
Social Hx:
 Social etoh
 Lives w daughter
Health-Related Behaviors: —
Allergies: —

Vitals: T: afebrile HR: 85 BP: 200/100 RR: 16 Sat: well on RA
Exam: Gen: NAD HEENT: (+) L scalp laceration
CV, Pulm, Abd: wnl
Neuro: A&Ox1, responds fluidly, CNs intact, full strength and sensation throughout **Extremities/skin:** bruising on b/l elbows, no LE edema

Notable Labs & Imaging:
Hematology: WBC: Hgb: 11.3 Plt: MCV: 95.4

Chemistry:
 Na: nl K: nl Cl: nl HCO3: nl Cr: 0.83 BUN: 24 Glucose: 102 Ca: 8.3
 ProBNP: 275 Troponins flat at 11
UA: trace blood, 6-10 RBCs, no WBCs, no leuk esterase, bacteria, protein
 Procal 0.05
Imaging:
EKG: NSR, no ST changes
CXR: increased R basal patchy opacity c/f pneumonitis vs aspiration PNA
Repeat CXR [after desaturation]: no changes
CT Head: (+) large L parietal scalp lesion, trace L intraventricular horn hemorrhage. No acute fx
CT A/P: diffuse LAD in abdomen and pelvis (c/w lymphoma hx), no PE

Dx: Acute hypoxic respiratory failure with R->L shunting, platypnea-orthodeoxia syndrome 2/2 flash pulmonary edema + aspiration PNA

Problem Representation: Elderly female with PMHx of PFO w/ R->L intracardiac shunt with worsening hypoxia with movement improved when laying flat requiring supplemental O2

Teaching Points (Evan)
 -Hypoxia at rest = lungs. Hypoxia elsewhere = CV.
 -Elderly patients often have multiple diagnoses which can present with multiple overlapping symptoms which can lead to these pts having multiple diagnoses.
 -common (HTN, DM) vs life threatening - get CT head to rule out -signal vs noise. O2 is an objective measure
 -hypoxia with normal A-a gradient = hypoventilation = causes -lungs need to work, intact neuromuscular anatomy, CNS issues, outside substances
 -diffuse lymphadenopathy - is it a consequence of low grade B cell lymphoma
 -baseline severe dementia makes it hard to assess mental status change
 -platypnea-orthodeoxia syndrome - SOB and low blood O2 when sitting/standing that improves when lying down.