11/1/25 Morning Report with UMKC@CPSolvers

***"One life, so many dreams" Case Presenter**: UMKC IM Residency (IG: @umkc_im) **Case Discussants**: Rabih (X: @rabihmgeha) and Parisa*

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

Scribing (Seeme)

CC: 71 y old FM presented with fever, generalized weakness, weight loss and decreased oral intake for 5 to 6 weeks.

HPI:

Over the last 6 weeks has been having fever, had a recent UTI treated with amoxicillin without improvement , weight loss of 25 pounds in 6 weeks

PMH:
HTN
prediabetes
Cholecystectomy

Meds:
Gabapentin
Desvenlafaxine-irb
esartan
HCTZ

Fam Hx:
-

Social Hx:
Born and raised in Honduras , moved to US in August

Health-Related Behaviors:
Use of unpasteurized milk
Has dogs and cats
Mosquito exposure

Allergies: NKDA

Vitals: T: 101.4 **HR:118 BP:** 131/60 **RR:** 18 **Sat: BMI:**
Exam: Gen: no acute distress, no lymphadenopathy
HEENT: nl, CV: no murmur, Pulm: no wheeze or crackles
Abd: soft non-tender non distended ,Neuro: alert, able to move extremities, Extremities/skin: nl

Notable Labs & Imaging:

Hematology:
WBC: 15 (N 86.7) Hgb: 11.1 Plt: 508 ferritin: 236

Chemistry:
Na: 132 K: 3.7 Cl: 101 HCO3: Cr: 0.8 BUN: Glucose:156 Ca:8.6 Mg:1.7
AST: 31 ALT: 52 Alk-P: 107 Bili: Albumin: 2.8 Total Protein:
ESR: 78 CRP:141 LDH: Co2: 25
Negative blood cultures, peripheral smear: negative for malaria, HIV: -ve

Imaging:
CXR: nl, CT abdomen and pelvis: unremarkable
Started on doxycycline and gentamicin, ID consultation obtained
CT chest : 3 bilateral pulmonary nodules prominent subpleural fibrosis, prominent biapical, 5mm in size, mostly peripheral
Bacterial- brucella, francisella, tularensis: -ve
Viral: dengue, chikungunya, adenovirus, coronavirus, RSV, pertussis:-ve
TB: Negative. Fungal - nocardia, pneumocystis, cocci, aspergillus - neg.
Brucella, frans, bartonella, leptospira, coxiella - negative.
Mycoplasma and chlamydia - neg.
TEE: negative, EF more than 70%
Proteinase 3 antibody, ANA, SSA,SSB, SCL 70: negative
p-ANCA: 1:80, MPO:184
Bronchoscopy: mixed oral flora
Cr : 0.8 → 1.5 proteinuria: 443 mg/24hr
Biopsy: focal crescentic glomerulonephritis, pauci immune type with necrotizing arteritis
Received IV methylprednisolone, transitioned to PO prednisone and rituximab

Dx: Microscopic Polyangiitis (MPA)

Problem Representation: 71 y old FM presented with fever, generalized weakness, weight loss and decreased oral intake. Prominent bilateral pulmonary nodules were found on imaging and p-ANCA titers were positive

Teaching Points (Saketh)

1) **Approach to Fever**: IMADE (Infections, Malignancies, Autoimmune, Drugs & Everything Else)
Time course of Fever (6 weeks): Inquire about previous healthcare visits
2) **Weight Loss**:
-Surface manifestations: Look for LAD and signs of poor immune status (e.g oral thrush)
-Radiographic fingerprint of the underlying disease
-Labs: Cytopenias (Marrow), LFTs
3) Dense Neutrophilia & Thrombocytosis with no radiographic imprint : Think about Infections (e.g. culture negative endocarditis), Hyperinflammatory cancers (Hodgkin's Lymphoma), autoimmune disease (e.g. vasculitis, inflammatory myositis)
4) **Pulmonary nodules** (Signal or Noise ?): Look at the number and distribution of the nodules
- MPA (pulmonary manifestations): bronchiectasis, ILD pattern
-**Sub radiological disease**: cardiovascular system (TEE), vasculitis - think about GCA, anca associated vasculitis in elderly population (autoimmune labs)
5) Decision regarding immunosuppression:- **DO NOT** miss malignancy and subacute endocarditis (Bartonella - can cause anca positivity)