1/26/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Lourenço Garcia (@lourenco_garcia)* ***Case Discussants****: Austin (@RezidentMD) & Alec (@ABRezMed)*

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

Scribing (Magnus)

CC: 69M found collapsed on the ground

HPI:

Was alone and it was unwitnessed. On initial assessment, found to be obtunded and unable to provide hx. Opened his eyes to verbal stimuli, moved all four extremities in response to pain, had intact pupillary reflexes. He produced speech, although disorganized and bizarre.

Last seen the morning before he went to the ED. Had been taking his meds, and no new meds.

PMH:
HTN
HLD
Obesity

Meds:
Bisoprolol
Losartan
Amitriptyline
Sertraline
Trazodone
Oxazepam

Fam Hx:
Not contributory

Social Hx:
Lives in Lisbon in a rented room, with daily support for meals and med administration

Health-Related Behaviors:
Former smoker
Former alcoholic

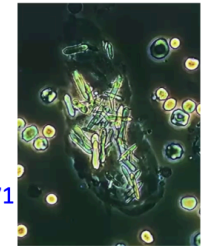
Vitals: T: 36.5 **HR**: 78 **BP**: 135/80 **RR**: 26 **Sat**: 85 -> 97 on 3L NC

Exam: Gen: looked hydrated, tachypneic, using accessory muscles

CV: nl **Pulm**: nl **Abd**: nl

Neuro: poor speech, isocoric and reactive pupils, spontaneous movement of all four limbs, no pathological reflexes **Extremities/skin**: nl

Notable Labs & Imaging:



Hematology:

WBC: 22 (neutro 90%) Hgb: 14.3 Plt: 171

Chemistry:

Na:141 K: 5.3 Cr: 1.30 BUN: 59 Glucose: 180 Ca: 1.22

Liver panel: nl CRP: 7.3 (nl) LDH: 561 Trope 28.1 CK 665 Myoglobin 871

ABG [on O2]: pH 6.77 CO2 18 O2 114 HCO3 2.6 BE -32 Lactate high

-> intubated, arterial line placed, urinary cath placed (1.3L output)

Started on IV fluids with sodium bicarb, with marginal improvement in pH, lactate and bicarb -> started dialysis

Neuro re-evaluation: AxO x3, no focality

After suspension of dialysis, creatinine started to trend upward (3 -> 5.7 -> 9.2) and the patient became anuric -> dialysis restarted

UA: 40 RBCs **HIV, hep B and C:** negative **Tox:** neg for benzos and EtOH

Head CT: chronic vascular lesions, no acute findings

CTA C/A/P: obstruction RL bronchus with atelectasis, gallbladder fundus wall thickening suspicious of malignancy. Hilar LAD of the liver and infiltration of omentum. No signs of organ ischemia.

Started on ceftriaxone and azithromycin

Repeat labs: Normal protein, albumin, SPEP, Ig, C3, C4 and ANCA

UA: Hgb 3+ hyaline casts, isomorphic RBCs, calcium oxalate monohydrate crystals with needle or cigar-shaped morphology

Gallbladder biopsy: Moderately differentiated adenocarcinoma

Dx: Ethylene glycol intoxication w/ severe lactic acidosis + disseminated gallbladder adenocarcinoma

Problem Representation: 69 y/o male with PMH of HTN & dyslipidemia presented with LOC, found to be severely acidemic, temporary improvement with dialysis f/b worsening AKI post dialysis suspension. CTA suspicious of GB malignancy and UA showed cigar shaped calcium oxalate crystals.

Teaching Points (Sana)

Approach to CC: cause vs consequence (clues- PMH, tempo, associated symptoms)

Approach to history: 1. Assistance: indicative of cognitive impairment? 2. Meds- usage or withdrawal- cause for encephalopathy? Past psychiatric illness?

Approach to Exam:

-In ptns with dyspnea the resp exam may be falsely negative

-Poor speech; baseline deficit? Resurgence of sx from past CVA due to acidemia? (Consequential isolated deficit > causal)

Approach to Labs: Stabilize first

-Elevated blood glucose - d/t underlying DM or cortisol response to inflammation?

-HAGMA: check for lactate, ketones, serum osmolality [MUDPILES]

-LDH: from ischemia or hemolysis? Trend hemoglobin

- Resp failure + acidemia in the setting of neutrophilic leukocytosis -> empiric ABx f/b imaging

-Worsening AKI post dialysis- from an intrinsic issue masked by dialysis or d/t iatrogenic causes (hemodynamic changes/meds/toxins)

-GB wall thickening: incidental? Causal- malignancy - unlikely to present acutely.

-Ethylene glycol- initial osmolar gap f/b anion gap

- Lactate gap (ABG >> VBG)
- Rx- Fomepizole