



# 2/27/26 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: **Lorenço Case Discussants:** Rabih (@rabihmgeha) & Prof Rez (@RxDxEdu)

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

Scribing (Kevin)  
CC: 47 y/o F with 4 days of N/V,  
non bloody diarrhea and  
subjective fevers

ROS: no urinary Sx, rashes, weight  
loss, night sweats, chest or  
abdominal pain

PMH:  
- HTN  
- MGUS [IgA  
lambda on  
surveillance]  
- CKD  
- Transplanted  
kidney in 2021  
and reaction  
treated with  
plasmapheresis  
and rituximab  
- Possible neo  
proliferative  
lesion in  
ascending colon  
in 02/25,  
colonoscopy  
with negative  
biopsies

Fam Hx: none

Meds: MMF,  
Tacrolimus,  
prednisolone,  
carvedilol,  
prophylactic  
valganciclovir,  
darbepoetin  
50mcg/week,  
Insulin 20+12  
UI

Social Hx:  
From Uganda,  
now in  
Portugal.  
No travel,  
pets.  
Unemployed.

Allergies:  
NKDA

Vitals: T: 35.5 HR: 92 BP: 97/65 Sat: 97% on RA  
Exam: Gen: ill and uncomfortable Neuro: nl Extremities/skin: nl  
HEENT: pale mucosa, no JVD CV: nl Pulm: nl  
Abd: soft and generalized tenderness on palpation, no masses, no organomegaly, or signs of  
peritonitis, negative Murphy sign

Notable Labs & Imaging:  
Hematology: WBC: 2390 (1700 Neutrophils) Hgb: 9.2 (bl 12.6) Plt: 139K  
Chemistry: Na: 118 K: 4.9+6 Cl: 83 Cr: 14.9 (bl 4) BUN: 240 Ca: 1.29  
AST: 34 ALT:7 GGT: 132 Alk-P: 1600 Bilir: 2.9 Direct Bilir: 0.38  
Glucose: 329 CRP: 219 LDH: 2418 (prv 281)  
ABG: pH 7.35 / CO2 19.4 / O2 84 / HCO3 10.9 Lactate: 0.8 AG: 24  
CT scan: hepato- and splenomegaly, discrete terminal ileal distension, distended appendix in  
continuity with extensive heterogeneous colic wall thickening, with contrast enhancement  
and surrounding fat stranding, worsened in comparison to a scan from 05/25 (possible  
neoplastic origin)  
UA: nl UCx: neg BCx: + E.coli  
-> started on HD, empirical Zosyn, increased dose of prednisone  
Repeat labs: pancytopenia (Hb 6, Leuc 15.13, Plaq 84k) Retics: low Fibrinogen: nl  
Ferritin: 6K B12: > 2K PBS: pancytopenia Coombs: weakly positive for Cd3, iGRA negative  
> patient improved with fluids, prednisone and Abx, CRP improved  
> inflammatory markers increasing again, no signs of improving kidney function  
BCx: + Enterococcus faecium  
Bone marrow smear and biopsy: nl smear Flow: neg Cx: neg [fungal + MB]  
PET: hepatomegaly with homogenous uptake, nonspecific diffuse osteo medullary activity - in  
the axial skeleton of tenuous/mild intensity  
Bone scan: no lesions ALP isoforms: severely increased bone ALP  
Right hemicolectomy by general surgery: large inflammatory mass of the ascending colon,  
adherent to the right Toldt's fascia with duodenum tightening, no secondary lesions or  
peritoneal effusion  
> after resection: patient overall improving, decreasing inflammatory markers, no new fevers or bacteremia  
> dialysis for approx. another month: kidney function recovered to baseline Cr, dialysis suspended

Bx: Michaelis Guttman bodies Dx: intestinal malakoplakia

Problem Representation:  
A 47 year-old woman presents herself with ongoing nausea, vomiting, non-sanguinolent diarrhea and  
subjective fevers for 4 days - with a medical history of hypertension, LVH, hypertensive retino- and  
nephropathy, MGUS IgA lambda, kidney transplantation in 2021 with several complications and a  
possible neoproliferative lesion in the ascending colon in 02/25.

Teaching Points (Manaswini)  
Approach to diarrhea in Immunosuppressed Patient: Immunosuppression might skew our approach  
but the **HIST rarely influences the calculus of a common problem like diarrhea!**  
- Acute diarrhoea in 100% in immunocompetent host and 98% of immunocompromised host → Routine bugs or  
meds (Virus or bacteria? Self resolving or is it more sinister?)  
- Calculus changes in 2% of patients → patient who are critically ill OR we suspect an evolving problem  
Key aspects to focus on here: Acidosis, Hypovolemia (LR-NS)  
- Hypothermic, decreased WBC → Pt meets the SIRS criteria (S<>Sp)  
- Start the pt on Vancomycin (Gram+ve) + Cefepime/Ertapenem (Gram-ve) to cover GI bugs  
- Is she meeting the Dialysis criteria? → AEIOU: **Acidosis** (here), electrolytes, Ingestion, volume Overload, Uremia  
Diagnostic Reasoning for raised LDH & ALP:  
- Drop in Hb can be explained by Kidney dysfunction, but is it hemolytic? (raised LDH: i.e increased cell turnover after  
the transplant—causing a hemolytic process)  
- Raised LDH → Bypassing infarction, think malignancy → PTLD [Causing raised ALP by infiltrating the hepatobiliary  
system (due to disproportionate ALP/GGT) OR bone marrow]  
- Get imaging to prove the hypothesis but intrahepatic biliary canalicular infiltration can still be missed on MRCP →  
Prudent to get PET (which was +ve here) Fact: You Cannot do hemato-pathology without radiology :)  
Source localisation: Involving RE system beyond the GI:  
- Your job is Never done once you Dx E.Coli!!! → E. coli bacteremia will not cause LDH of 2000! This patient has a  
hyperacute complication of a rapidly progressive condition.  
- Bacteremia from infectious gastroenteritis is **extremely rare** unless it is a **food borne organism** (implies a structural GI  
defect >> systemic immunosuppression). There is a nidus of vulnerability in her GI system  
- Rate of Gram-ve rods bacteremia in pt with AIDS in low → High prevalence of **Non typhoidal salmonella** (an  
exogenous food borne organism) in AIDS illustrates the foodborne vs endogenous distinction  
- Microscopic breach present (E.coli to seep through GI breach → and spread into the RE system) → So what is causing  
the intestinal breach?? → What is invading the canalicular without damaging the hepatocytes! (Raised ALP,  
Normal-AST/ALT)  
- Friction point here → Tremendous Blastic activity → Increased ALP → But Radionuclide uptake is still not present!

Michaelis Guttman bodies → Characteristic of Malakoplakia  
Defence mechanism against infection → In immunocompromised → macrophages digest bugs but cannot destroy them  
here → tries to form a granuloma/ pseudotumor lesions → → Surgery+ Use Ab like TMP-SMX to treat it → →  
penetrate granulomas → ALP of int/colon origin OR Liver origin. COURSE here → Surgery (right colon resection) cured  
the pancytopenia! + Clinical improvement, normalisation of LDH and ALP, resolution & dialysis cessation seen

Fun fact - 1st EVER RLR interaction → RLR's excerpt Release ahead of the book release! E.Coli is the  
first clue to Strongy hyperinfection! that leads to the a breach in the mucosa.