3/18/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter**: Varuni (@)* ***Case Discussants**: Sharmin (@) & Ravi (@rav7ks)*

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

Scribing (Sam B)

CC: 25F primigravid with fever, cough, palpitations x4 days

HPI:

13w gestation with high grade fever, chills, rigors, cough, palpitations x4 days

No similar episodes in the past

Normal menses in the past, normal bleeding

Primigravid

ROS:

Negative for dysuria, urinary frequency, chest pain, weight loss, rashes, joint pain, hair changes, oral ulcers, alopecia, bleeding disorder, seizure, appetite changes, bowel changes

PMH:

Hypothyroidism

Autoimmune hemolytic anemia dx 6 months ago

Meds:

Levothyroxine

Steroids

Azathioprine

Fam Hx:

n/a

Social Hx:

Health-Related Behaviors:

No addiction

Allergies:

Vitals: T: 38.9 **HR:** 102 **BP:** 112/70 **RR:** 14 **Sat:** **BMI:**

Exam: Gen: moderately built, well nourished, conscious, oriented

HEENT: Pallor noted, no icterus, cyanosis, LAD

CV: Normal S1 and S2, no murmur

Pulm: normal breath sounds

Abd: distended, linea nigra and stria gravidarum

Neuro: No focal deficit

Extremities/skin: No clubbing

Notable Labs & Imaging:

Hematology: WBC: 9300 Hgb: 3.5 → 8.9 retic: 16.43 MCHC: 68.7 (high)

Chemistry:

Cr: 1.06 → 1.14 Urine protein/Cr ratio 1.55 ST, ALT, Alk-P, Bili: all nl ESR: 150

Very low serum albumin

Anticardiolipin antibodies: 23.24 (H), anti histone, anti dsDNA, anti nucleosome AMA antibodies all positive C4: 6.13 (L) urine protein: 3+ Urine micro: RBC with granular casts

ANA IIF positive with homogeneous pattern, antiphospholipid panel negative

CSF: protein 57 (H), oligoclonal bands and IgG negative

Brain auditory evoked potential and visual evoked potential study normal

Anti NMO CSF panel negative, serum aquaporin negative

Imaging:

MRI: T2 weighted demyelinating hyperintense lesions bilaterally around corpus callosum, juxtacortical white matter of bilateral frontoparietal and occipital lobes, corpus callosum and calloso-septal interface. Do not resemble MS, does not satisfy McDonald criteria for MS

Course:

Treated with transfusion after which cough and palpitations improved

Underwent MTP given risk of preeclampsia and immunosuppression

Later in stay developed a headache without mental status changes

Received high dose IV steroids, discharged on prednisolone and hydroxychloroquine with improvement

1 week later returned with swelling in both legs, decreased urine output, and vulval edema for last 4 days

Renal biopsy: lupus nephritis class III, focal proliferative GN, endocapillary hypercellularity with wire loop lesions

Dx: SLE with MS-like lesions, lupus nephritis, AIHA, and hypothyroidism

Problem Representation: Young pregnant female with fever, pmhx of AIHA, severe anemia, elevated inflammatory markers and multifocal demyelinating brain lesions.

Teaching Points (Eugene)

Fever in a primigravid

- -Infections; with cough; consider pulmonary etiology.
- -Other inflammatory processes.
- -Immunosuppressed state in cyesis

PMHX/vitals/labs

- -AIHA: flare?- high ESR, pregnancy state
- -Infection precipitating hemolysis?
- -investigate other sources of blood loss
- -High retic count: marrow responsive.
- -confirm hemolysis with ldh, indirect bil, haptoglobin

ANA panel

- -+ve ANA, anti dsdna; consider sle.
- -+ve antihistone: consider drug-induced lupus

Multifocal demyelinating brain lesions

- -In the context of lupus, don't jump to MS.
- -consider disseminated infection causing encephalomyelitis
- -could be lupus related
- -hypercoagulable state

Anasarca post delivery

- -consider lupus nephritis
- -pre-eclampsia related with her pregnancy could lead to this