



# 3/5/26 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Rahul (@RahulPottabath1) Case Discussants: Rabih (@rabihmgeha) & Mohammed (@ZubaidiK20713)  
<https://clinicalproblemsolving.com/present-a-case/>



Scribing (Eyron)

CC: 85 y/o male p/w acute epistaxis

HPI:

"He's okay" - hx obtained from granddaughter  
Epistaxis started this morning - noted entire floor to be covered in blood, prompted neighbors to call EMS  
Denies trauma, prior hx of epistaxis  
(+) Generalized weakness, fatigue, loss of appetite  
(+) Hx of recent admission at OSH for b/l pleural effusions and pitting edema requiring chest tube causing pneumothorax

ROS:

Denies chest pain, SOB

PMH:

HTN, ruptured AAA s/p EAVR (2013), aortoiliac stent graft with femorofemoral bypass, endovascular embolization, anemia, skin ca, hematuria, CKD 3, AFib, Gout

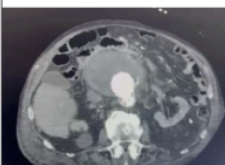
Meds:

Labetalol 100 mg BID  
Eliquis 2.5 mg BID  
Allopurinol 100 mg  
Furosemide 120 mg  
ASA 81 mg  
Atorvastatin 80 mg

Social Hx:  
lives alone

Health-Related Behaviors:  
Non-smoker, drinks wine, no illicit drug use

Allergies: NKDA



Vitals: T: 36.5 HR: 101 BP: 100/55 Sat: 97% on RA BMI: 25-26  
Exam: Gen: A&Ox4, cachectic | HEENT: no JVD, rhino rocket in L nostril  
CV: S1-S2, no murmurs | Pulm: Clear | Abd: Non-tender, (+) voluntary guarding, no rigidity | Extremities/skin: dried blood over face, hands, and scalp, ulcerated skin lesion over the vertex, mild bilateral pitting edema

Notable Labs & Imaging:

Hematology:

WBC: 6.8 Hgb: 6.6 (baseline 10) Plt: 191k Hct 20.1 MCV: 84 RDW 19.9

Chemistry:

Na: 144 K: 4.5 Cl: 101 AG: 13 Cr: 2.82 (baseline 2.5) BUN: 76 Glucose: 116  
Ca: 8 Mg: 2.5 | AST/ALT: nI Alk-P: 133 TBil: 1 Direct: 0.5 Albumin: 2.5 Total Protein: 5.5  
NT proBNP 17k | Trop: 21 (nI)  
UA pH 5.5 WBC 11-20, RBC 3-5, negative protein  
Iron 19 TIBC 126 Tst 12 Ferritin 522 | PT 12.6 INR 1.24 PTT 32.3 Fibrinogen 336

Imaging:

EKG: AFib

Non-con CT A/P: moderate bl pleural effusions, severely displaced aortic stent anteriorly from spine, surrounding mid and distal portion of stent - large aneurysm with large surrounding hematoma possibly due to leak or rupture (14 cm superior to inferior x 16.5 cm transverse, x 13.8 AP dimension) possibly ruptured aneurysm and large hematoma  
CT A/P w/ Contrast: Active contrast extravasation representing endoleak

Dx: Ruptured AAA

Problem Representation:

85 y/o M with PMHx of ruptured AAA s/p EAVR, aortoiliac stent graft with femorofemoral bypass, and endovascular embolization (2013), AFib on Eliquis and ASA p/w epistaxis. PE notable for voluntary guarding. Workup revealed anemia with hemoglobin of 6 and CT of the abdomen revealed abdominal aneurysm with surrounding hematoma and active contrast extravasation.

Teaching Points (Eugene)

Epistaxis :

- local vs systemic causes. Anterior (most common) vs posterior
- Important to know patient's background
- Attempt to stop bleed by pinching soft lower part of nose (cartilaginous part) to occlude the kiesselbach's plexus.

Background:

- Anticoagulants/antiplatelets could be contributory
- Hypertension -: in severe form-> shearing forces in confluence of small arteries forming kiesselbach's.
- skin cancer hx?

Labs:

- Acute anemia sec to bleeding: Hb 6.6 may be disproportionate to acute bleeding. Other sites: skin, abdomen, reduced production in background of ckd, systemic inflammatory disease?
- Low albumin: enhanced anticoagulation from apixaban.
- Transfuse RBCs to improve quality of blood in the context of hypoxia or ischemia

CT abdomen: Reach out for this tool to investigate retroperitoneal bleed in this case where there is a background of repaired ruptured triple A.