4/29/20 Morning Report with @CPSolvers

***Case Presenter**: Patrick Fadden (@ptfaddenMD) **Case Discussants**: Rachel Tenney & Mike Rose (@MikeRoseMDMPH)*

CC: chest pain

HPI: 35M p/w 3hr constant, severe, pleuritic chest pain
-Central chest pain without radiation that is non-exertional and non-positional
-Started when at work

ROS: no fevers, chils, diaphoresis, night sweats, abdominal pain, back pain, +b/l ascending ankle and knee pain and days of wrist pain

PMH:
Non-fistualizing ileocolonic chron's disease

LTBI s/p rifampin

Meds:
Mesalamine
Infliximab

Fam Hx:
Osteoarthritis
CAD
HTN

Soc Hx:
Mechanic

Health-Related Behaviors:
1.5packs of tobacco/day
Occasional EtOH
Monogamous, no STI

Allergies: NKDA

Vitals: **T**: afeb **HR**:110 **BP**:127/80 **RR**: 28 **SpO_2** >95%
Exam:
Gen: Mild distress, tachypneic
HEENT: no JVD
CV: tachycardic, 3/6 systolic episodic murmur
Pulm: CLAB
Abd: soft, non-tender
Neuro: wnl
Skin: no rashes
Ext: b/l **fingers** +eff w reduced ROM, b/l **wrist** ttp +eff, b/l **knees** ttp, -effusion, b/l **ankles** ttp, mild eff

Notable Labs & Imaging:
Hematology: WBC 13.3 Hgb 13.1 Plt 376

Chemistry: Na 138 K 3.6 Cl 105 CO2 26 BUN 15 Cr 0.8 Glu 131 Albumin 2.9

UA: 100mg/dL protein, 1RBC, no blood, -leuks, -nitrite
CRP: 6.89, LDH: 165
EKG: diffuse STE, PR depression
BCx: negative
STI panel: negative
Rheum panel: ANA+ 1:640, C3/C4 wnl, RF/anti-CCP wnl, +anti-histone, +dsDNA 9IU/mL

Imaging:
TTE: normal EF, small pericardial effusion

Problem Representation: Young man w/ IBD on Infliximab p/w subacute polyarthralgia/arthritis followed by sudden onset pleuritic chest pain found to have diffuse STE & PR depressions on EKG and positive anti-histone Ab diagnosed with drug-induced lupus

Teaching Points (Moses):

Chest pain: laterality can help localize.
- Initial approach: 4+2+2 = emergent etiologies
- Pleuritic: PE/PTX = morbid causes. Think: pathology in the chest wall, mediastinum, abdomen

Length-dependent neuropathies: Exp: DM, EtOH, Thyroid, paraproteins. Pattern can be helpful: sensory, motor, autonomic

Painful Neuropathy: vasculitis (exp: mononeuritis multiplex). Note: **GBS:** can be painful! Think demyelination as the underlying mechanism

Clearly articulated sx onset: think obstruction, perforation, electrical discharge + others

Tenosynovitis: common = staph, strep, disseminated gonococcal disease. Dactylitis can also be caused by TB, sarcoid, SSD + others

TNF alpha blockers: risk of granulomatous disease: mycobacteria, fungi. Also risk of lymphoma, autoimmune processes (like drug-induced lupus, most common cause!). Development of autoantibodies is common, often without symptoms. ~72% dsDNA positive in TNF-alpha mediated TNFa induced lupus