6/2/20 Morning Report with @CPSolvers

***Case Presenter**: Robert Centor (@medrants) **Case Discussants**: Elkana Onsarigo (@onsarigo93), Kaitlyn Rogers (@kaitlyn_Rogers9)*

CC: Diffuse pain

HPI: 65M p/w diffuse pain

-Reports he was in his USOH until 3 months ago when he first developed bilateral hand pain with difficulty completing his job as a construction worker (unable to carry cinder blocks)
-He was treated with NSAIDs without improvement
-Then developed hip and shoulder pain, low grade fevers, profound fatigue
-Arrives to appt with nurse walking slowly with difficulty sitting down. Upon meeting MD, he cannot squeeze the hand in the handshake due to pain.
-ROS negative for jaw/temporal pain, vision changes, rashes, oral ulcers, night sweats, or other symptoms

PMH:
None known

Meds:
NSAIDs

Fam Hx:
No hx of AI disease

Soc Hx: Construction worker. Lived south of Birmingham, AL

Health-Related Behaviors:
None

Allergies: None

Vitals: **T**: 98 **HR**: 75 **BP**: 130/90 **RR**: 14 **SpO_2**: 99%
Exam:
Gen: Looks younger than actual age, +appears to be in distress 2/2 to pain
HEENT: MMM, no LAD, no oral ulcers, no temporal tenderness
CV: RRR, normal S1/S2, no murmurs
Pulm: CTA bilaterally
Abd: Soft, ND, ND
Neuro: CN intact, **5/5 strength throughout but limited 2/2 to pain with difficulty rising from seated position**, no sensory changes
MSK: +Puffy hands, spongy tender symmetrical MCP/ PIP bilaterally
Skin/Extremities: No rashes or lesions, +no edema

Notable Labs & Imaging:
Hematology:
WBC: 7.6 (normal differential) Hgb: 14.3 Plt: 222

Chemistry:
Na: 136 K:4.2 Cl: 105 CO2:25 BUN:9 Cr:0.8 Glucose: 98 Ca: wnl Phos: wnl
AST/ALT/Alk Phos/Total bili wnl, no gamma gap
RF: negative
ESR>80

Imaging:
Hand film: no erosions

Problem Representation:
65 y/o M with no PMHx presents with ~ 3 months of symmetric polyarthralgias associated with fevers and fatigue, found to have synovitis of bilateral hands with markedly elevated ESR and negative rheumatologic workup, treated with steroids with complete response and diagnosed with presumptive RS3PE.

Teaching Points (Alex Horne):
-If a chronic pain syndrome, try to identify if the pain is **nociceptive vs neuropathic vs centralized**
-Nociceptive: caused by stimuli that threatens or results in tissue damage -> structural cause (eg,degenerative joint disease), inflammatory (eg, RA), other (eg, sickle cell and vaso-occlusion)
-Neuropathic: central or peripheral nervous system
- "Centralization" of pain can occur as a result of persistent noxious stimulation from either nociceptive or neuropathic pain with alteration pain sensory process + impaired central pain modulation
- **Inflammatory joint pain** characterized by morning stiffness and improvement with exercise/movement; associated with other s/s of systemic inflammation (eg, ESR/CRP elevation, hypoalbuminemia, leukocytosis, anemia, weight loss, etc)
- **Ddx inflammatory polyarthritis**: systemic rheumatic illnesses (RA, SLE, systemic vasculitis, polymyositis/dermatomyositis, Still's disease), seronegative spondyloarthritis (Ankylosing spondylitis, IBD, psoriatic), post-infectious (reactive arthritis, rheumatic fever), inflammatory OA, infectious (Lyme, endocarditis), other systemic illnesses (sarcoid, familial mediterranean fever, etc), crystal induced
- **Pearl on seronegative RA**: 30% of RA with negative RF! This is more more common in older men and can see lack of destructive changes
- **RS3PE syndrome**= **R**emitting **S**eronegative **S**ymmetrical **S**ynovitis with **P**itting **E**dema: acute inflammatory polyarthritis that is more common in elderly adults, seronegative, swelling which is typically pitting over wrist to MCPs ("boxing glove") is characteristic, high ESR/CRP, limited hand/wrist ROM