8/5/20 Morning Report with @CPSolvers

Case Presenter: *Karl Saardi* ***Case Discussants***: *Adam Burke and Patricia Pleta*

CC: rash

HPI:
70 yo M with "dermatitis" that started 4 years ago. Redness, itchy, scaly. Progressed to involve the entire body 4 months ago
Seen 4 dermatologists: No new medications, or changes in skin care. Small LN in left axilla -> biopsy: dermatopathic changes (increased immune trafficking of normal cells)
Dx: Hives -> bx spongiotic and interface dermatitis, IF negative
Dx: erythrodermic dermatitis, AI w/u negative; bx -> psoriatic dermatitis; LN repeat biopsy -> dermatopathic changes
Dx: erythrodermic dermatitis possibly due to BB
Tried: antihistamines, psoriasis medication
2 years into disease course developed MPGN. Started on 50mg pred (few months, then taper) with some initial improvement, symptoms persisted with Azathioprine 50 mg BID
Skin biopsy in clinic: spongiotic dermatitis and psoriasis dermatitis

PMH:
HTN
CKD 3
Meds:
Pred 10mg daily, AZA 50mg BID, Bumex 2mg BID, Coreg 3.125 BID, Certitizine BID
Clonazapam 0.5 qHS
Losartan 25mg daily
1000u Vit D daily

Fam Hx:
Son - early stage colon cancer
Health-Related Behaviors:
20 pack year history smoking
No ETOH or drug use
Computer programmer

Allergies:
NKDA

Vitals: **T**: 37.1 **HR**: 80 **BP**: 131/81 **RR**: 15 **SpO_2**: 99 on RA
Exam:
Gen: well appearing, NAD
HEENT: no oral lesions, conjunctival injection, scleral icterus or cervical lymphadenopathy
CV: RRR no murmurs
Pulm: CTAB
Abd: nontender, no palpable HSM
Neuro: intact
Extremities/Skin: diffuse erythroderma

Notable Labs & Imaging:
Hematology:
WBC: 12.9 (57N, 4Mono, 3 Eos) Hgb: 15 Plt: 158

Chemistry:
Na: 138 K: 4.8 Cl: 101 CO2: 21 BUN: 13 Cr: 1.5
Glucose: 85
Albumin: 4.1 Total Protein: 6.4

HBV, HCV, HIV, RPR, HTLV negative

Flow cytometry: CD4/CD8 32; 92% CD4 + CD7-
T cell rearrangement studies - clonal for beta chain

Dx: Sezary syndrome

Tx with alemtuzumab with rapid improvement in rash and renal disease

Problem Representation:
Elderly male presenting with 4 years of progressive erythroderma and 2 year history of MPGN with multiple non-specific skin/LN biopsies found to have Sezary syndrome.

Teaching Points (Andrea):
- Precipitating factor: Malignancy (adenoca),exposure (like vietnam veterans), medication
- Primary skin condition vs secondary (autoimmune, exposition)
- Spongiotic dermatitis: Dermatitis that involves fluid buildup in your skin. Typically seen as red, itchy areas. It can occur anywhere on the body, in one spot or widespread. Common causes: allergic reactions, contact dermatitis, fungal infection, stress, changes in hormone levels or in temperature
- Infection, paraneoplastic
- MPGN: Glomerular injury due to deposition of immune complexes and/or complement factors in mesangium and capillary walls results in mesangial proliferation and capillary wall remodeling. Typically affects children and young adults. It may be idiopathic or caused by a systemic immune diseases, chronic infections (such as hepatitis C), syphilis, and cancer
- Erythroderma with mildly eosinofilia: psoriasis, cutaneous lymphoma, drug, lupus
- Mycosis Fungoides/Sezary Syndrome: common and indolent variant of a cutaneous T-cell lymphoma (CTCL) that initially manifests itself in the skin. It is caused by chronic antigenic stimulation that leads to neoplastic transformation of memory T cells and their subsequent accumulation in the skin