6/5/20 Morning Report with @CPSolvers

***Case Presenter**: Brian Rosenberg **Case Discussants**: Reza Manesh (@DxRxEdu) and Rabih Geha (@rabihmgeha)*

CC: Itchy red rash on both legs

HPI: 68F p/w itchy red rash in both legs. Rash started 4 d ago around her ankles and went up. Similar rash in upper extremities forearm, palm and wrists. No difficulty of breath, no fever, no night sweats, no dysuria, no exposure to new cleaning products, no exposure to outdoors. Joint pain in knees and wrists (long standing history of OA). The pain is worse in the morning less intense as she went through the day.

12 hours after admission: Severe abdominal pain

PMH:
OA longstanding
Hypertension

Meds:
Losartan
Chlorothiazide
Metoprolol
Naproxen

Fam Hx:
Non contributory

Soc Hx:
No outdoor exposure
Born and raise Dominican Republic

Health-Related Behaviors:
Nonsmoker, no drugs

Allergies:

Vitals: **T**: af **HR**: 99 **BP**:130/89 **RR**:20 **SpO_2**: 98

Exam:
Gen: Well appearance, no distress
HEENT, CV, Pulm: wnl
Abd: Skin over abdomen periumbilical bruising
Neuro: nl
Extremities/Skin: UPPER Ext: scattered palm lesions, non tender, dusky center
LOWER Ext: 1+ pitting edema mild calf both legs.
Large palpable purpura with bullae and ulcerative lesions, negative nikolsky sign bullae ashang? sign negative. No mucosal involvement

Notable Labs & Imaging:
Hematology:
WBC: 12.3 (75% neutrophils, 20% lymphocytes, 10% monocytes, no eosinophils) Hgb: 10.2 MCV: 78 Plt: 304
Chemistry:
Na: 139 K: 3.9 Cl:94 CO2:22 BUN:81 (base line: 30) Cr:2.63 (baseline: 1.27 glucose: 127 Ca:8 Phos: 3.9 Mag: 1.7 Anion gap: 23
AST:51 ALT: 44 Alk-P:232 T. Bili: 0.5 Albumin: 2.5; total protein: 5.4
Coagulation panel: wnl
UA: gravity 1.74, 2+ protein, no ketones, 48 WC, 51 RBC
Imaging:
CT: Diffuse pericolonic inflammation and thickening of ascending colon concerning for colitis
Blood cultures, HIV, Hepat B, Hep C,Cryoglobulinemia: Negative
PR neg ESR: 43, ANA 1:4, Serum Ig A negative, ANCA ELISA: neg, RF: 49 C3,C4: wnl
Renal biopsy: immunofluorescence positive staining for IgG focal endocaílar necrotizing tissue consistent with Henoch Schonlein purpura

Problem Representation:
68F p/w itchy red rash on both legs, abdominal pain with periumbilical bruising and palpable purpura in the lower extremities, bilateral arthralgias, colitis, GN, with renal biopsy consistent with Henoch Schonlein Purpura

Teaching Points (Elena Vasti):
Approach to Rash: (1) Time course (2) Associated symptoms (ex: itchiness, pain) (3) distribution (ex: diffuse vs localized, centripetal, top-down, palms/soles) Inside job (multisystemic) vs outside job? (4) Epidemiology
Purpura: maps onto blood vessels; ask if **palpable** vs **nonpalpable**. **Palpable** tells you this could be a small vessel vasculitis like leukocytoclastic vasculitis. **Necrosis** ("dusky" center) suggestive of rapidly progressive cell death. **Bullae** is secondary to another process - will track that in parallel
Blanchable rash: vasodilatory process. **Nonblanchable**: extravasated blood cells.
4 itis's in GI tract: infection, inflammation (IBD), ischemia, infiltrative disease. Ischemic dz least likely to cause diarrhea.
Intrarenal schema: Glomerulus, tubule, interstitium, surrounding vascular. **GN**: ANCA (GPA, MPA, EGPA, drug), Anti-GBM, immune complex (SLE, IE). Infection-associated GN is no-miss diagnosis. HSP can be genetic, LCCV on derm bx.