12/30/20 Morning Report with @CPSolvers

Case Presenter: *John Woller* ***Case Discussants***: *Anusha Chidharla (@mdanusha) and Ali Azeem (@Ali_Azeem01)*

CC: Fever and b/l thigh pain

HPI: 66M p/w fever chills and fatigue.
May 10th '20 - first noticed something was wrong-- fatigue, weakness --Dx subacute infarct precentral gyrus no tPA/ intra-vascular intervention
June-July '20 - b/l thigh pain, NS, chills, 20 pound wt loss
No numbness, tingling, chest pain, dyspnea or LE edema
Course: Malaise, fatigue, decreased exercise tolerance + ABI: B/l low (0.5cm)
CTA chest abd: multiple arterial occlusions-- ileum, jejunum , mesenteric soft tissue mass
ECHO normal, blood culture -ve
BM Bx, PET CT -ve malignancy
Suspected Vasculitis Tx steroids and tocilizumab -- Sx improved ---> worsening back and leg pain, general malaise

PMH:
Bicuspid aortic valve-- 2010 bioprosthetic not on anticoagulants - non convulsive seizures
Meds:
Atorvastatin, Zolpidem, Lamotrigine, Prednisone 60 mg daily

Fam Hx:
Mom -Hamman Rich Syndrome
Mom, sister - PV
2 brothers and dad healthy
Soc Hx:
Lives with wife; 5 pack year smoking history; active, retired firefighter, sexually monogamous, no animal exposure
Health-Related Behaviors:
Up to date on colonoscopy
Allergies: No known allergies

Vitals: **T**: 36.5 **HR**: Normal **BP**: 140/80 **RR**: Normal **SpO$_2$**: Normal
Exam: **HEENT**: Petechiae palate lip, L buccal mucosa 4mm purpuric lesion, no LAD, JVP normal
CV: Regular rate & rhythm, 3/6 harsh crescendo-decrescendo murmur radiating to carotids, no pedal edema
Pulm: CTAB & **Abd:** obese, soft, NT/ND
Neuro: Coordination intact, B/l intention tremor, motor and sensory exam normal
Extremities/Skin: femoral pulses 2+, post. tibialis +1 (R>L), no joint swelling or erythema, small ecchymosis and scattered purpuric lesions

Notable Labs & Imaging:
Hematology:
WBC: 14 Hgb: 13 Plt: 43
Chemistry:
Normal CMP, T. Bili: 0.2; Trop I 0.86 (1.78-1.26 at 48HRS), Lipid panel normal ;INR 1.3 aPTT 25 D-dimer 10.3 (0.5) Fibrinogen 136, Hapta <3 dRVVT: normal; HIV -ve; U/A 18 RBC; PS - thrombocytopenia; reticulocytes 89, reticulocyte index normal; ESR 8
Imaging:
EKG: lateral non sp T wave flattening, sinus rhythm
CTA abdomen: splenic, renal, super mesenteric, celiac arterial occlusions with ill defined soft tissue nodule mesentery
TTE: EF 75%, septal hypertrophy, moderate aortic stenosis + regurgitation of bioprosthetic valve no vegetation
Aortic CTA normal
Blood cultures: (5 days) -ve fungal and mycobacteria; Hep viruses -ve; lyme, coxiella, brucella,bartonella -ve; whipple PCR -ve
ANA, APLA, ANCA -ve, RF 31 (mildly elevated), JAK2 -ve
SPEP- chronic antigenic stimulation
PET- focal avidity posterior aspect of aortic valve
Blood cultures: C acnes after 10 days
Prosthetic Valve Endocarditis/Abscess from Cutibacterium acnes

Problem Representation: 66 year old M w/ h/o history of bicuspid aortic valve s/p replacement (10 yrs ago), recent subacute brain infarction, multiple arterial thrombi is now presenting w/ subacute inflammatory sxms after being on 60 mg of prednisone for a few months along w/ thigh pain and was found to have a sys EJ murmur, palatal petechiae and skin ecchymosis with thrombocytopenia, leukocytosis, an elevated dimer, low haptoglobin/ fibrinogen & a PET scan showing abnormal uptake w/ TEE showing a prosthetic valve abscess

Teaching Points (Travis):
- The presence of bilateral thigh pain that is worse with exertion lead one to think about PAD.
- With proximal weakness or pain also think about vasculitides
- With such diffuse blockages buckets, think of: accelerated atherosclerosis (eg SLE), prothrombotic state (malignancy, APLS, other clotting disorders as AMK just said!), vessel obliteration (vasculitis, prob medium vessel like polyarteritis nodosa given GI vessels described) (@Andrew)
- Thrombosis of multiple different vascular territories and an interesting family history makes us shift our differential
- The story should be told in the "CBC," looking for genetic markers in some of the different proliferative diseases
- The Ying/Yang bias of a case that has been worked up the "", dig into those hospital records. Was tissue obtained looking for granulomatis changes etc.
- Is the weight loss, fatigue, fevers new or secondary to something from his prior presentation or something completely separate.
- Petechiae are little bleeds possibly from issues with VWF or Plts but the other way you can bleed is if the small vessel integrity is disrupted or through micro thrombosis
- TTP is a devastating condition affecting kidneys and CNS that should get ruled out, does it fit the time course
- Why all the clots? - Phospholipid, ? malignancy, cult - endocarditis