02/26/21 Morning Report with @CPSolvers

Case Presenter*: Paul Kunnath (@PaulKunnath)* ***Case Discussants****: Rabih Geha (@rabihmgeha) and Reza Manesh (@DxRxEdu)*

CC: Difficulty swallowing

HPI: 42F p/w difficulty swallowing and fullness in the neck, as well as worsening diffuse pain in the extremities over the last month.

- She complains of solid food getting stuck in the back of throat and reports pins and needles like sensation in arms → legs

She was seen in ED earlier where she was Dx w/ Strep throat and treated w/ oral penicillin

Revisits Clinic for new Chest pain

PMH: Uterine fibroids Iron deficiency anemia, CTS C-section, CT release surgery

Meds: Gabapentin, ferrous sulphate, Penicillin (completed)

Fam Hx:
Father - throat cancer
Sibling - Lupus

Soc Hx:
Unemployed, lives w/ children

Health-Related Behaviors:
Alcohol - socially, smokes mariujana, not sexually active, does not smoke

Allergies:
No known allergies

Vitals: **T**: 98.5 **HR**: 113 **BP**: 104/68 **RR**: 18 **SpO_2**: 97% RA **BMI** : 20

Exam:

Gen: Appeared uncomfortable

HEENT: No oral lesions, exudates; no obvious macroglossia; fullness submandibular region, no thyromegaly, no bruits

CV: Tachycardic, no JVD

Pulm: Clear

Abd: Normal

Neuro: CN intact, 5/5 Strength U & L; sensation intact

Extremities/Skin: Edema 1+ just below knees, no obvious rashes

Notable Labs & Imaging:

Hematology:
Hgb:9.6

Chemistry:
Na: 140 K: 3.9 Cl: 105 CO2: 26 BUN: 8 Cr: 0.6 glucose: 92 Ca: 9.1
AST: 12 ALT: 17 Alk-P: 108 T. Bili: 0.3 Protein 5.9 Albumin: 3.2
BNP 228 Trop 0.095 TSH: 5.8 T4 0.6 (free)

Imaging:
EKG: NSR, HR 100, no ST changes, intervals N, P wave indicative LA enlargement
CXR: Unremarkable ; CT pulmonary angiogram - no clots ; CT soft tissue neck w/ contrast: unremarkable
Rheumatologic panel, ESR, CRP N;
L. Cath LVDP 10; EF 65% Grade 3 diastolic dysfunction, concentric hypertrophy of LV w/ apical sparing
SPEP: Monoclonal IgG k/l > 100
BM biopsy: 60% plasma cell Bone survey: Lytic lesions -- iliac bones; Congo red stain +

Dx: Multiple Myeloma w/ AL amyloidosis

Problem Representation: 42 y/o F w/ pmh of CTS p/w difficulty swallowing, neck fullness, pain in UE x 1 month, recent onset CP, found to have submandibular fullness, mild LE edema, elevated BNP, trop, and echo with DD and apical sparing.

Teaching Points (Travis @RosenelliEM):

- What distinguishes the chest/abdomen and extremities are the visceral causes you can't see in the chest/abdomen..
- Rule out emergency causes of CP= 4+2+2 then go from there.
- The life threatening causes in extremities is harder to hide from you: skin, venous, arterial, muscular, osteoarticular (what you see)
- If you don't see something in the extremity, think neuro/bone
- For Dysphagia, think of a tunnel. Is there an obstruction, think motility and structural. For dx: EGD (structural) or barium swallow (motility)
- Oropharyngeal dysphagia comes immediately after swallowing, structural or motility. Solids favor structural like a mass. Through a paraneoplastic process can cause a neuropathy. Don't forget about structural cervical osteophytes.
- Zenker's diverticulum can also exist in the esophagus also esophageal webs.
- Pins and Needles= neuropathy = where in nervous system is it occur. Polyneuropathy bc of all ext affected. Also mononeuritis multiplex. Guillain Barre, B12 def, and toxins
- Iron def anemia & Esoph. Webs= Plummer Vinson syndrome; 15% develop upper airway malignancy, so make sure to monitor them.
- Carpal Tunnel: Mononeuropathy to the median nerve from overuse (95%), don't forget infiltrative diseases <5%. Narrowing vs compression. Non dominant arm, young age, bilateral. + macroglossia = acromegaly, hypothyroidism, amyloidosis.
- 5 common causes of submandibular swelling, lipoma, goiter, lymph nodes, salivary glands, branchial cleft cyst. Also think metabolic with bilateral enlargement.
- Sjogrens is the most common autoimmune dz overlapping with neuropathy
- Myelopathy can mimic polyneuropathy but no bladder/bowel dxn less likely
- Edema in legs: base rate is venous insufficiency (bad valves). Look for other pathology or stigmata of disease from cirrhosis, CHF etc.
- Amyloidosis (although isoteric) is never the leading diagnosis until its the diagnosis