03/12/21 Morning Report with @CPSolvers

Case Presenter: *Ann Marie Kumfer(@AnnKumfer)* ***Case Discussants***: *Prof Rez (@DxRxEdu) and Rabih Geha (@rabihmgeha) R&R <3*

CC: Facial droop and leg weakness

HPI: A 45M PMHx RA, COVID 5 months prior, renal infarct 4 mo prior, + untreated strongyloides antibody test transferred from a nearby hospital p/ w Left facial droop, Right leg weakness and dizziness.
2 wks of difficulty speaking + swallowing, sore throat, blurry vision (ongoing for a few months) → several weeks of generalised weakness; pain in elbows, knees shoulders
No fevers, NS
Hospital course: Elevated white count, tachycardia (130), CT head showed no abnormalities, CT abd pelvis chronic renal scarring, CXR and urinalysis no sign of inf, started on Abx, blood cultures drawn
MRI brain showed multiple infarcts in L and R corona radiata

PMH:
RF and CCP +, care intermittent - multiple barriers, no Tx -- in the past on steroids and TNF-a (not in 6 mo)
Renal infarct - Antiphospholipid panel + -- Tx apixaban (not started yet), ANCA +

Meds:
Tylenol

Fam Hx:
Mother - RA

Soc Hx:
Lives in the States

Health-Related Behaviors:
No current tobacco, alcohol, substance use

Allergies: No known allergies

Vitals: **T**: 35.8 C **HR**: 97 **BP**: 130-150/80 **RR**: 16 **SpO_2**: 97% RA
Exam:
Gen: Uncomfortable due to pain
HEENT: White coating on mouth, scraped off; decreased range of motion jaw; dental caries no obvious abscess, no cervical LAD
CV: Tachycardic, no murmurs, no CW tenderness
Pulm: Clear, no accessory muscle use
Abd: Not remarkable
Neuro: Alert and oriented, CN intact, L facial droop resolved, Strength 5/5 Left upper and lower extremities, % in R lower extremities, decreased sensation; R sided dysmetria, dysdiadokinesia
Extremities/Skin: Hypopigmented lesions, scattered nodules palpable b/l hands and forearms; B/L upper extremities reticular erythema; Pulses intact

Notable Labs & Imaging:
Hematology:
WBC: 10.9 (N predominant 8.3, L 1.3) Hgb: 10.9 MCV: 96 Plt:571
Chemistry:
Na: 133 K: 4.7 Cl: 106 CO2:19 BUN: 11 Cr:1.31 (Baseline: 0.9) glucose: 66 Ca: 9.1 Phos: N Mag: N
AST:N ALT:N Alk-P:N T. Bili: 1.2 Albumin: 2.6 T. P 5.9 Blood cultures: -ve
Urinalysis: sp G 1.018; Protein 30; UPCR 1; UACR 0.23; Microscopy: granular cells, no other abnormalities
ANA -ve complement N dsDNA -ve Hep C -ve Hep B immune; HIV -ve Elevated Kappa; K/L N RF: 1200 CCP: 345 Cardiolipin IgG 28
Cryoglobulin -ve CRP 200; ANCA panel MPO titres 163 (high); LP: non sp inflammation, no growth
Imaging:
EKG: Sinus tachycardia
Renal USG w/ doppler: no RA stenosis-- Cr improved w/ IV fluids
TEE: No abnormal valvular lesions
MRA brain: Decreased caliber MCA R>> suggestive of CNS vasculitis
PET scan full body: No systemic large or medium vessel wall uptake
Dx: CNS ANCA-vasculitis

Problem Representation: Middle-age men with untreated RA presents with CNS multiple infarcts and chronic renal scarring.

Teaching Points (Kiara):

- **L FACIAL DROOP:**
  - Plus something else: Sinister causes → Central (brainstem) vs Peripheral (VII cn) VS Isolated: LMN bell's palsy
- **Renal infarct**: Hypercoagulable state (Covid), vascular risk factors
- **RA + neuro:** Happens if uncontrolled → atlantoaxial instability. Rheumatoid vasculitis
- Recognize systemic sd: Ask if something is disseminating.
- **Multi Inflammatory vascular disease:** Occlusion → Ask **what** (thrombi as only cause?) an **where** (origin: cardiac, renal or hypercoagulable state can cause clots everywhere).
- **Hypercoagulable state:** Cancer, APLS, vasculitis.
- **Immune status:** Skin lesions and increased platelet count → Immune compromise, antibiotics, immune cell impairment.
- **Dismetria and dysdiadokinesia:** R lateral cerebral hemisphere
- **Likelihood for extra articular arthritis:** HIgh in men, smoke, RA very high, and untreated pts.
  - Complications: Soft tissue (rheumatoid nodules), lung disease, skin, cardiac. Les common and sinister Felty sd (RA + destructive joint involvement + splenomegaly and neutropenia), risk of lymphoma. No miss dx: Rheumatoid vasculitis.
- **Glomerulopathy:** Check on albuminuria, HTN, hematuria. The absence of red-blood cast don't rule out glomerulopathy.
- **CNS vasculitis:** infection (TBC, syphilis), autoimmune (variable vessel: RA, relapsing polychondritis, cohen's- eye and ear), LES, BEchet. Before high dose immunosuppression, make sure not missing atypical infx: Syphilis, RPR, TB, fungi.