07/29/21 WDx Morning Report with @CPSolvers

***#BossLadies Case Presenter**: Promise Lee (@promiseflee) **Case Discussants**: Anika Nair & Andrea Anampa-Guzman (@andreaanampag)*

CC: Frequent falls and SOB

HPI: 63yF p after a fall at a neighboring hospital. Fell on R foot and couldn't bear any weight. At arrival had AMS, limited history. Family: "has had multiple recent falls and hasn't been able to take care of herself."

Chronic pain and multiple deformities due to RA. At ED she's dyspneic and hypoxemic. She's had SOB for some time. Unsure if she's had fever.

PMH:
RA, Depression

Meds:
Prednisone (5mg/day)
No biologics in the past. Has been unable to see a rheumatologist
Oxycodone
Amitriptyline
Cyclo-benzaprine
Dulcolax
Citalopram

Fam Hx: None
Soc Hx: Lives alone. Started relying more on neighbors. No sick contacts, travels, or sexual activity.

Health-Related Behaviors: Smoking 2packs/day for 40y. No alcohol, drugs.

Vitals: **T**: 36.4 **HR**: 117 - 101 **BP**:120/56 **RR**:20 **SpO_2**: 80%, 95ish% w/4L
Exam: **Gen**: Thin. Older than stated age. Looks disheveled.
HEENT: Wound over R eyebrow. Atraumatic head. Anicteric sclera.
CV: RR, tachycardic. Normal S1,S2, no murmurs.
Pulm: Mildly increased work of breathing. Diminished breath sounds. Diffuse expiratory wheezes.
Abd: Normal **Neuro**: Alert, oriented only to person.
Extremities/Skin: Warm and well perfused. Swan neck deformity, swollen MCPs and DIPS. 2+ bilateral lower extremity edema R>L. Ulcer in abdomen w/surrounding erythema and ulcer in L distal arm jacked borders . Multiple ecchymosis in R side of body + face consistent with fall.

Notable Labs & Imaging:
Hematology: WBC:0.8 (ANC 0.1, ALC 0.6) RBC 2.7g Hgb: 7 HCT 22.4 MCV normal. MCH 25.3 RDW 18.7 Plt: 186. Peripheral smear: decreased platelets, normocytic anemia, w/out anisopoikilocytosis. Neutropenia and lymphopenia. Negative for blasts, morphological normal cells.

Chemistry: Na:133 Cl: 96 BUN:26 Cr:0.8 BUN/CR: 30 AST:330 T. Bili: 1.4 Albumin: 1.3 Lactate: 2 ProBNP 5300. B12, folic acid, nutrients: normal. LDH: normal. HIV neg. Quantiferon gold: neg. Fungal antibodies, crypto and histo: neg.*Unable to get sputum for TB test. Declined bronchoscopy + skin biopsy.
RF: >1200 CCP >340 ANA 1:160 Speckled pattern. DsDNA neg. ENA neg. C3 65, C4 9.7, SPEP normal. Cryoglobulins negative. CRP 272. ESR 106.

Imaging: CT Chest: R upper lobe consolidation w/ cavitary lesions and bronchograms. Air fluid in pleural space. No PE. Emphysematous changes. CT Leg: tibial plateau fracture. TTE: normal. CT Abdomen: Splenomegaly -15.6cms Bone Marrow Biopsy: hypercellular marrow w/ trilineage hematopoiesis and 8% T large granular lymphocytes in cytometric analysis. T cell receptor gamma rearrangement positive, cytology normal.
Final Dx: Felty syndrome w/ possible RA vasculitis complicated by necrotizing cavitary pneumonia secondary to aspiration.

Problem Representation: 67yF w/PMHx of RA w/chronic use of prednisone and chronic smoking p/w frequent falls and SOB. PE notable for respiratory distress, fluid overload and multiple skin ulcers. Labs and imaging revealed bicytopenia, splenomegaly, lung consolidation and cavitary lesions.

Teaching Points (Sukriti):
Investigating the Sx:
Falls: What do we need to walk?
Input: Vision, Proprioception; Output: Coordination, Neuromuscular, Osteoarticular
Hypoxemia: Why is oxygen in the atm not reaching the lung?
Airway, Alveoli, Interstitial space, Vascular
Layering on the foreground onto the background, look beyond the dz process at play, consider severity, clinical course it has taken and Tx.
> Disease association, appropriate therapy, medication adverse effects

Collecting Clues:
Pitting edema = Volume overload (elevated proBNP) - RA associated w/ pulm HTN
Expiratory wheeze = Cardiac pathology vs COPD (smoking history)
Clinical Reasoning Pearl: Thinking about pathology in different sites = **Inside job (blood, blood vessel)** > Outside job
> Ex. Ulcer in abdomen + ulcer in arm = RA w/ vasculitis > DAH
Bicytopenia: Increased destruction, Bone marrow suppression > sequestration
> **Neutropenia + pulmonary inf:** Organising pneumonia, Nocardia, aspergillus

Framing a hypothesis: Cavitary lung lesion + splenomegaly + bicytopenia + Rheumatoid arthritis = > Felty's syndrome
Thinking ahead, Felty's, at risk for lymphoma, infection (neutropenia)