7/18/22 Morning Report with @CPSolvers

***Case Presenter**: Lakshmi Jayaram **Case Discussants**: Dr. Anisha Dua (@anisha_dua) & Josh Waytz*

CC: 58yM w/ 1 week of joint pain + confusion

HPI:

- Shoulder pain 1 week prior, spread to R shoulder, difficulty abducting shoulder
- Weakness in R arm
- Couldn't lift things+ spread to b/l wrist → red, swollen
- More confused than usual, fell down, landed on R hand due to weakness → came to ED
- Pain in both passive / active ROM
- h/o memory deficit due to prior aneurysm, but seems more altered
- no rash, no GI sx, febrile at ED
- Patient has a dog (no recent bites).

PMH:
HIV (well controlled)
Regular HAART
Type 1 DM
Posterior intraceb. Aneurysm w/ coil

Meds:
Aspirin
Statine
PPI
HAART

Fam Hx:
none

Soc Hx:
Desk job, husband (sex. Active w/ multiple partners)

Health-Related Behaviors:
No tobacco, substance or illicit substance abuse

Vitals: **T**:39°C **HR**: 108 **BP**:110/74 **RR**:14 **SpO_2**: 99% on RA
Exam:
Gen: pleasant, no acute distress
HEENT: no facial trauma, no rash
CV: no murmurs; **Pulm**: wnl ; **Abd:** soft, non-tender
Neuro: ⅗ elbow flexion and ROM shoulder abduction;
Extremities/Skin: wrist swollen over flexor tendon; tender to palpation, erythematous swollen;, full ROM of wrist and fingers, R wrist swollen, tender to palpation, unable to make a fist on R side;
shoulder: L shoulder unremarkable, R shoulder w/ frank synovitis, active & passive ROM impaired , hands: no swelling or synovitis

Notable Labs & Imaging:
Hematology:
WBC: 14.2 Hgb:11.3 Plt:216
Chemistry:
Na: 130 K: Cl:95 CO2: 29 BUN: Cr:1.8 glucose: 307 Ca:wnl
LFTs normal, ESR 131, CRP 228
Joint aspiration: 14k WBC, gram stain neg, neg for crystals
Urine gonorrhea neg,, Quantiferon, Parvo B19, HepB/C neg,
CD4 414
Imaging
MRI Wrist: L side w/ soft tissue edema and tenosynovitis; R side w/ ulnar flexor bursitis
MRI Shoulder: active synovitis on R shoulder; L shoulder unremarkable
LP: normal
Broad spectrum abx was given due to suspicion for septic arthritis.
Sexual activity w/ multiple partners.
Rectal swab + for chlamydia, + N. gonorrhea

Final dx: Disseminated gonococcal infection

→Reminder: Swab all mucosal surfaces!

Problem Representation: 58M w/well controlled HIV and sexually active w/ multiple parners p/w 1w of joint pain and confusion. Found to have fever, tenosynovitis and bursitis.

Teaching Points (Kiara):

- **Why Rheum?:** You can connect all the dots, patients are amazing, every day is a challenge!
- **Joint pain assessment:**
  - Active (Self movement) vs passive (outside force)
  - Mono (Crystal) Oligo, Poly (RA)
  - Inflammatory (Eg. Morning stiffness) vs Non-inflammatory (Eg. Mechanical-pain w certain act)
  - Pattern: Migratory, localized, peripheral, relapsing
- **Red flags:** Abrasions, rash, GI/GU symptoms, fever
- **Inflammatory markers:** ESR, CRP can be increased in women, elderly. If > 100 think about infection, malignancy, some vasculitis like GCA. ESR takes more time to decrease than CRP
- Increased fluid in joint? → **Aspirate!** → **Color, WBC** (200 is nl, 200- 2000 Non inflam, 2000+ Inflammatory-RA, PA, RA, septic). **Probability of septic?** → gram and cultures! **Crystals** (gout, pseudogout).
- **Tenosinovitis + HIV:** TB, HIV itself,
- **HIV associated arthritis:** Non destructive RA, painful articular Sd (excruciating painful joint for 24h and self resolves)
- ***What to do next?*** Cover w/ broad spectrum atb. **NOT "Rheum panel"** → order labs according to clinical suspicion. Go back and check what we've missed.
- **Disseminated gonococcal infx:** Purely arthritis vs triad (migratory polyarthralgia, tenosynovitis, dermatitis). Only ¼ have GU compromise. RF young healthy, sexually active, women peripartum. -ve cultures don't rule out, perform all mucosal swabs. Tx w/ Ceftriaxone 1g IV (CDC 2021).