01/17/24 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Yazmin (@minheredia) **Case Discussants**: Sharmin (@Sharminzi) and Maddy (@MadenellaC)*

CC: 31 yo M with bilateral upper extremity swelling and pain

HPI:
Patient presented after having 3 days of BUE edema and pain located in forearm, wrist, lateral/medial epicondyles, shoulders. The pain was not relieved with NSAIDS. The patient noticed the swelling became progressive and included a dull throbbing pain and tingling. The same symptoms happened a year prior with self-resolution.
ROS: Intermittent left sided chest pain. No SOB, coughing, weight loss, fever, rashes or mucosal ulceration, facial swelling, abdominal pain, change in urinary symptoms.
Mentioned discoloration in fingers on cold weather but didn't medical seek attention

PMH: Chronic recurrent polyarticular arthritis with no treatment

Meds:

Allergies: Ibuprofen

Fam Hx: Possible Raynauds in mother, dx with RA and SLE

Soc Hx: no tobacco and alcohol use, but chart shows previous admissions for alcohol intoxication

Health-Related Behaviors: Denied drug use

Vitals: BP: 129/87 **RR:** 16 **T:** 36.5 **HR:** 108 **SpO2**: 97% on RA
Exam:
Gen: Discomfort, but not in acute distress
CV: RRR. Chest wall pain is reproducible to palpation not to respiratory efforts.
Pulm: CTAB
Abd: wnl
Neuro: decreased grip strength in both hands related to the pain but no motor deficits, no focal neurologic deficits
Extremities/skin: tenderness to palpation in wrists,glenohumeral joints, epicondyles, medial and lateral malleolus ankle joint tenderness, only wrist joints had effusion. Multiple callus and ulcerated lesions on fingertips. Cervical C-spine tenderness in C3-6

Notable Labs & Imaging:
Hematology:
WBC: 8.9 Hgb: 11.7 MCV: 77.5 Plt: 207
Chemistry:
Na:138; K:3.6; Cl:106; HCO3:24; BUN:7; Cr:0.7; glucose:84
AST:572; ALT:160; Alk-P:215; T. Bil:2; Direct:0.2; ESR:3 CRP:4 TSH: 2.95
UA: 3+ protein 3+ blood UPCR: 1.07 Urine protein: 282 Urine Cr: 263, UPCR ratio: 1.07 UDS: negative
Hepatitis panel,HIV negative, CK: 7587 Ferritin:1292, SSA/SSB:2/8, RF: (-), AntiRNP antibody:135 , Anti Jo: 7, C3:8, C4<1, ANA positive, titer 1:2560, antidsDNA 388, anti Sm antibody 290 , CH50 (Total complement): <12.5 (nl is 38-89)
Imaging:
CXR: Enlarged cardiac silhouette concerning for cardiomegaly vs. pleural effusion
Bedside POCUS: Revealed a large pericardial effusion
Further workup: MRI findings consistent with myositis, and a renal biopsy consistent with Lupus nephritis, patient was started on prednisone and hydroxychloroquine
Dx: Systemic Lupus Erythematosus with myositis and Lupus nephritis III

Problem Representation: A 31 year old male presented with bilateral upper extremity swelling and edema for 3 days accompanied by intermittent left sided chest pain which was reproducible to palpation along with tenderness to palpation in multiple joints with a large pericardial effusion seen on POCUS

Teaching Points (Harry):
-upper extremity edema is not gravity dependent. if paired with lower extremity edema think of a systemic process leading to diffuse edema/anasarca; if isolated to upper extremities consider impaired drainage (can interrogate with physical exam maneuvers such as having patient elevate arms) vs joint inflammation/swelling
- For edema: can be broken down into inflammation vs pressure changes
-Polyarticular arthritis (5 or more joints) ddx: infectious (Lyme vs HBV, PV19, HIV, rheumatic fever), crystalline disease, SLE, RA, adult Still's disease, Sjogren's, spondylarthropathies (AS vs PA vs IBD), SS, vasculitis
-Patients with autoimmune diseases are at increased risk for thrombotic events and cardiovascular disease, including MI
- Remember, AST elevations can be related to myositis and not just the liver
- Multiple system involvement with serositis, cytopenias think SLE, MCTD (esp if RA flavor)
-anti-dsDNA is 90% specific for SLE; anti-smith is 99% specific for SLE; anti-RNP is also seen in SLE (40-60% sensitivity) and MCTD (95-100% sensitivity)