01/26/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Gordon Farley ***Case Discussants:*** *Rabih Geha(@rabihmgeha) and Reza Manesh(@DxRxEdu)*

CC: 87 year old male presented with Bilateral lower extremity rash for 1 week

HPI:
1 month prior: lower extremity edema around ankles- wore compression stockings to help
7 days prior: took off the compression stockings & noted the sudden appearance of painless bilateral LE rash below the knees
3 days prior: fall→struck the chest→ chest trauma- chest pain & dyspnea, went to PCP- worsening chest pain and progressing rash.

PMH: Hypertension
Atrial Fibrillation
Melanoma
Surgical Hx:
-MV repair
-Moh's surgery (for melanoma)

Meds: Rivaroxaban
Amlodipine
Hydrochlorothiazide
Rosuvastatin

Fam Hx:
Soc Hx: lives with wife at assisted living facility.
Retired army veteran

Health-Related Behaviors:
No smoking /alcohol/drug intake
Allergies:No

Vitals: BP:165/101 **T:**Afeb **HR:**106 **RR:**20 **SpO2:**98% at 2L O2 (baseline:RA)
Exam:
Gen: no acute distress
HEENT and CV: mild volume overload; positive JVD
Pulm: decreased breath sounds at right lung base
Abd and Neuro: wnl
Extremities/skin: 1+ bl pitting edema to the ankles;warm & perfused;bl joint deformity at PCP & MCP;raised palpable 1-2 cm petechiae upto knees,ulnar deviation of hands,hyperkeratotic lesions on scalp

Notable Labs & Imaging:
Hematology:
Hgb:8.6 MCV: 84 WBC:11k with neutrophilia,monocytosis,lymphopenia
Plt: 306
Chemistry:
Na:134|K:4.3|HCO3:32|BUN:32|Cr:1.23(baseline:0.9)|AST:26|ALT:22|
Alk.P:87|Albumin:nl|T.Bil:1.3| T.protein:7| ESR, CRP nl
UA:10-20 WBCs, 20-50 RBCs, proteinuria |NT-proBNP:3000
INR:3 PTT:40 PT:33,|RF elevated to 46| Mildly positive CCP, mildly low VitC| negative ANA,ANCA,Scl-70, rickettsial antibody, cryoglobulin|
Hep panel and HIV: NR| UPCR:0.91
Blood culture-GPCs in chains and clusters; Strep mutans; presumed to be from oral source; poor dentition seen in the pt.
Imaging:
CXR: pleural effusion at right lung base; CTPE: negative for clot; no consolidated process ;global cardiomegaly; dilated pulmonary artery
Murmur heard when the pt was admitted on floor
TTE: severe MR, moderate TR; prior TTE(2yrs ago): mild MR and TR
TEE: vegetation, worsening valvulopathy
Outpatient dermatology skin punch biopsy: LCV
Dx: Infective Endocarditis; started on 6 weeks i/v Ceftriaxone

Problem Representation: An 87 year old male with PMH of HTN, A.Fib and MV repair with poor dentition presented with worsening B/L LE rash for 1 week along with B/L pitting edema at ankles with proteinuria, hematuria and positive blood culture

Teaching Points (Umbish): **Rash** > Skin vs Systemic?

1. Width, depth, evolvement, areas involved (Rabih)
2. Half the population has venous stasis by age 50! (Prof Rez)
3. Quality of rash> erythematous, confluent etc.
4. Purpura is the most common derm. finding in endocarditis (Andrew)
5. Is the rash causal or contributory? Sequence of events gives a lot!
6. **New cardiogenic pul. edema**> endocardial(acute valvular), myocardial (acute MI), pericardial effusion (eg malignancy)
7. HTN in HF pts scary!!!
8. **Nephrogenic pul. edema**> back pressure towards kidney and heart.
9. Asymmetric lung exam does not rule out HF!
10. Hematuria with palpable petechiae(no blanching)/purpura(coalesce)/ecchymosis: **leukocytoclastic vasculitis =** warrants biopsy!
11. **Management: 1 gm methylpred. Plus urgent biopsy! ANCA, Anti-GBM**
12. Men who are smokers tend to have high serology(RF etc) as well as extra articular manifestation.
13. **DDx:** RA, Libman sacks endocarditis, vasculitides
14. HTN, LE edema, proteinuria = **NEPHRITIC** syndrome
15. **Gram pos cocci**> clusters are staph, in chains enterococci or streptococci,
16. New murmur appreciated, poor dentition, artificial valve: suspicion for endocarditis high!