04/26/24 Morning Report with @CPSolvers

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

CC: diffuse joint pain

HPI: 60 yo man with one month of intermittent pain in asymmetric multiple joints (left knee, left wrist, both ankles) and, several painful red bumps on left leg for the past 2 weeks. Pain worsens at night and shows slight improvement with NSAIDs. He had similar kind of diffuse joint pain 2 years ago, presumed to be osteoarthritis, but he didn't have hip pain.
Pain improved since then, but never completely resolved.
ROS negative: joint stiffness, fever, night sweats, weight loss, other rashes, oral ulcers, dry mouth, eye pain, eye pain, hematuria, diarrhea.
No history of trauma.

PMH:
HTN

Meds:
Amlodipine, NSAIDs

Fam Hx: uncle had factor V Leiden deficiency. Patient denied SVT or PE.

Soc Hx:
Heavy alcohol use for many years. Travel to Thailand for multiple occasions.

Health-Related Behaviors:

Allergies:

Vitals: T: afebrile, **HR:** 78, **BP:** 150/90, **SpO2** 96% RA
Exam:
HEENT: no eye redness/tenderness, no scleral injection, no irregularity in pupils, no oral ulcers, no cervical LAD
CV: no murmurs. Palpable peripheral pulses.
Pulm: clear
Abd: no tenderness, no hepatosplenomegaly
Neuro: strength and sensation intact
Extremities/skin: swollen erythematous left knee with reduced range of motion, mildly to both ankles and left wrist join. Tender erythematous subcutaneous nodules up to 25mm over pretibial, malleolar and crural regions. Hand: no deformities, no nail pitting, no dactylitis.
Axial joint: lateral flexion test > 10 cm (nl). No other rashes from head to toes (including gluteal cleft)

Notable Labs & Imaging:
Hematology: normal. Hgb: normal
Chemistry:
AST: 100, ALT: 70, Alk-P: nl, Br nl.
ANA negative, RF negative, CCP negative, ANCA negative, alpha1-antitrypsin neg, IgG4 negative, C3 and C4 normal. CRP 153
HIV, HBV, HCV, gonorrhea, chlamydia, syphilis negative
Imaging:
CXR: normal. Knee Rx: degenerative changes, join space narrowing and osteophytes in the left knee. Wrist and ankle X-rays normal.
Arthrocentesis: yellow cloudy, WBC 10.000 (PMN 50%), no crystals, no bacteria.
Skin biopsy: lobular panniculitis, neutrophilia, extensive fat necrosis.
He was treated with NSAIDs and steroids without improvement. He presented with another complaint: mild diffuse abdominal pain without radiation, without nausea/vomiting. Lipase: 23.000
CT scan: pancreatitis with acute portal vein thrombosis extending to the splenic vein and SMV, suggestion of small fistula between the two.

Dx: PPP (Pancreatitis - Panniculitis - Polyarthritis) syndrome

Problem Representation: 60 yo M with 2 year history of intermittent joint pain now presenting with asymmetric polyarthritis and panniculitis without systemic symptoms. After developed pancreatitis.

Teaching Points (Anmol):
I] Joint pain: not necessarily joints problem, diffuse tendon, ligament, bursal problem; *more joints involved*:- has high probability of involvement of joints.
II] Monoarthropathy (crystalline) , (1 joint involved)
oligoarthropathy (crystalline + autoimmune →spondyloarthropathy - AS, IBD, psoriatic), infection, OA (<8 joints involved)
polyarthropathy: almost always autoimmune (exceptions- viral infections, chikungunya; *Common to all : infection!*
III] Rash: morphology is the key! ***Painful red bumps on leg***→ 1.Erythema nodosum (hypersensitivity reaction) or its differentials. *Med history* esp antibiotic is important! 2. Erythema induratum : painful ulcerative lesion 2/2 TB i.e. tuberculid skin eruption/ 3. Leukemia cutis/ 4. insect bite/ 5. trauma
IV] Palpable purpura on lower extremity is not necessarily biopsied because it mostly shows ***LCV.*** Similar case with erythema nodosum which shows ***panniculitis*** but we biopsy it when:
1. Involvement of sites other than leg
2. Associated ulceration (because classically blood vessel not involved)
3. Persists more than a week.
V] Case**: Oligoarthritis**→ crystalline causes more likely especially **gout** which can cause panniculitis as well.
VI] Lofgren syndrome: we suspect sarcoidosis and it is a specific acute clinical presentation of systemic sarcoidosis!
Chest X-Ray is advised to look for hilar adenopathy.
VII] PPP: Pancreatitis , Panniculitis, Polyarthritis : is just another cause of synovial crystals apart from gout, CPPD; secondary to **alcohol abuse**; **Serum lipase** would help! YELLOW synovial fluid is very unusual! (**lipase** leaks into systemic circulation and breaks down fat to cause panniculitis, and there is a lot of adipose tissue surrounding joints which is destroyed causing yellow synovial fluid and destroying the joints)
Therefore imaging the pancreas would help!