8/27/24 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Patricia Sossoh (@) Case Discussants: Ravi(@rav7ks) and Kirtan(@kirtanpatolia)

CC: 58 YOF comes to clinic for cough and SOB

HPI:
Comes to clinic b/c of symptoms of fatigue and dry cough for the past 6 months. 3 months ago noticed she got tired and has been progressively unable to go for her usual long walk. The SOB have been more recurrent and sometimes occurs at rest.

No fever, chest pain, or vomiting.

PMH:
Has not seen doctor in 8 years. No HTN or diabetes

Meds:
None

Fam Hx:
No significant FH

Soc Hx:
Lives in Texas. Retired

Health-Related Behaviors:
No travel history
No animal exposure.
Smoked for past 15 years.
Drinks alcohol sometimes

Vitals: wnl

Exam:
Gen: Not acutely ill. Can talk and express concerns appropriately
HEENT: wnl
CV: No murmurs
Pulm: Inspiratory rales on both sides
Extremities/skin: Digital clubbing of fingers in both hands, normal LE

Notable Labs & Imaging:
Hematology:
Hgb: 8 (MCV 88)

Chemistry:
Na: wnl K: wnl
CRP, ESR, RF, ANA, Anti-CCP: elevated

Diagnosed with RA 8 years ago. Not on treatment and vague about how it was diagnosed

Imaging:
CT: Typical usual interstitial pneumonia with honeycombing (multiple cystic lesions b/w lung parenchyma), irregular intralobular septal thickening, and ground glass opacity

Got a bronchoalveolar biopsy, started on steroids, and antifibrotic therapy

Dx: **Interstitial lung disease 2/2 rheumatoid arthritis**

Problem Representation: 58 YOF with PMH rheumatoid arthritis p/w chronic dry cough, SOB, and digital clubbing with CT imaging c/w UIP f/t/h interstitial lung disease.

Teaching Points (Vini):
- **SOB and cough:** non specific. Hypercarbic and Hypoxic. TEMPO (acute vs chronic = > 8 weeks) and associated symptoms. Hypertension - pulm. edema, ACEi, viruses, post viral cough, inflammatory, GERD, upper airway, non asthmatic eos bronchitis, asthma, infection (geriatric population) -> could be any organism; anemia, metabolic causes.
- **Anatomic: heart** - CHF, endocarditis, **lung** - pulm. Hypert., sinuses, trachea, bronchiectasis, tracheobronchitis, tracheitis, bronchioles, alveoli (dry material, debri, inflammatory exudate, malignancy), vessels.
- **Exertion intolerance**, activation of J receptors -> overload. Heart not pumping (RV vs LV vs dilated cardiomyopathy), extracardiac causes compressing heart, interstitial lung diseases, COPD exposure - gases, smoke or toxins, allergic rhinitis, antihistamine decongestant use, malignancy, immune status.
- **1st steps clinical manag:** oximetry, spirometry, start inhaled corticoids, trial of PPI?, imaging - high resolution CT, ANA, other ATBs,CBC, blood gas, last - lung biopsy.
- **Eosinophilic vs neutrophilic predominance**.
- **Clubbing** - chronic pulmonary infections, hypertrophic osteoarthropathy: finger, bone, periosteum inflammation, arthralgia, skin changes. Related to released fibroblast growth factor of platelets, intimately related to hypoxia and local remodeling.
- 1st **Idiopathic Pulmonary fibrosis**, **Interstitial lung disease** - velcro on PE, not sens or specific. Causes: Smoke, non specific interstitial pneumonia (lupus, sjogrens, sarcoidosis,polymyositis/dermatomyositis), drug induced lung disease, idiopathic. 2nd **Bronchiectasis**: can have clubbing, productive sputum, hemoptisis. 3rd **Malignancy**: small cell, adenocarcinoma, bronchoalveolar CA. GI tract and malabsorptive disorders.
Coarctation of aorta: clubbing on Lower extremities. Other vascular stenosis.
-**Multisystem inflammatory condition**. Association RA: sinovitis, stiffness, lack of involv. of DIP joints. CRP or ESR elevation? Mixed connective tissue disease?
- **Cystic lesions**: ILD association -> Honeycombing, GGOs, septal thickening, DLCO low, reduced lung volumes (FV, TLC) -> Cycles of inflammation and destruction, deposition of particles.
- **Tx:** challenging - high steroids, cyclophosphamide. Escalate steps. BPAP, nasal cannula.