9/16/24 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Dr. Appledene Osbourne (@)* ***Case Discussant****: Dr. Lianne Gensler*

CC: Left great toe swelling

HPI: 30 yo male with history of psoriasis and psoriatic arthritis on risankizumab p/w swelling of L great toe. About 1 week ago developed acute onset pain, swelling, redness and warmth of the L great toe. Recently returned from a trip to Las Vegas where he stated he drank a significant amount of alcohol. He has has episodes of swelling on the 5th L toe in the past. Ibuprofen 800mg once or twice daily without significant relief of symptoms.
(-): Trauma, pain in other joints. No pain, eye pain or redness. No chronic abdominal pain, diarrhea or history of IBD.

PMH:
Psoriasis: Dx 11 years ago. Managed on topicals until 3 years ago then developed >50%BSA involvement. Started on adalimumab and then switched to secukinumab.
Psoriatic arthritis: A year ago developed joint pains in R shoulder, b/l wrists, L fingers, bl knees, L ankle and L foot. Intermittent swelling in his L 5th toe. HLA-B27 +. Asthma, Obesity, Dyslipidemia.
Meds:
Last dose of risankizumab (150mg q12) was 3 weeks ago. Albuterol inhaler prn.

Fam Hx:
Father hx of psoriasis and psoriatic arthritis.

Soc Hx:
Employed in IT, drinks 2-3 beers/week. No tobacco.

Allergies:
None

Vitals: T: 36.8 C **HR:** 66 **BP:** 126/80 **RR:** 16 **SaO2** 100%
Exam:
Gen: No acute distress.
HEENT: No conjunctival injection, PERRLA, no photophobia. No rash or nodules. Normal oropharynx.
MSK: Normal exam of the shoulder, elbows, wrists, hands, hips, knees, ankles. L 1st MTP w/ warmth, swelling, tenderness, erythema with mild tenderness and erythema extending proximally to midfoot. No enthesitis at the insertion of the Achilles.
Extremities/skin: 0% BSA, no rash on scalp, ears, umbilicus, gluteal clefts. Normal nails. No subcutaneous nodules noted.
CV, Pulmonary and Abdominal exams were unremarkable.

Notable Labs & Imaging:
Hematology:
Pre visit CBC: unremarkable. BMP, LFTs: normal.
CRP: 16 (NR 2-7.5)
ESR: 26 (NR 0-20)
Historical labs: HLA-B27 positive, RF negative, CCP 21 (NR 0-20), ANA negative, Uric acid 8 (NR 3.5-8.5)
Post visit labs: HLA-B5801 negative. Uric acid: 9.8. CBC, BMP and LFTs remained unremarkable.
Imaging:
XRay from 1 year ago: Hand and Foot: joint alignment and spaces preserved, no erosions. AP pelvis: bl joint spaces preserved, unremarkable pubic symphisis, SI joints normal.
Post-visit imaging: Dual-energy CT of L foot: No definitive erosive changes. There is faint capsular hyperdensity along the medial aspect of the 1st MTP joint and within adjacent soft tissue demonstrating no definitive uric acid deposition on spectral images. May represent earlier partially treated tophaceous change. The 1st MTP could not be aspirated, prednisone taper was provided with 2 week follow up. Patient came back 6 weeks after with a new episode of acute L toe swelling + L ankle swelling. Ankle was tapped and showed MSU crystals.
Dx: Gout

Problem Representation: A 30yo M w/ PMH of Psoriasis, Ps arthritis p/w L great toe swelling. Exam confirmed L 1st MTP swelling extending to the midfoot. Uric acid was elevated. Ankle tap on recurrent episode showed MSU crystals.

Teaching Points:(Kuchal)
Psoriasis. Prevalence of Psoriatic Arthritis in pts with Psoriasis is 20%, more likely in pts with: (a) Higher primary burden of Psoriasis, (b) location of their initial lesion, eg. nails, intergluteal fold, scalp lesions increased risk of association of arthritis. (c) Obesity. (d) Rx with certain drugs.
Important to differentiate acute symptoms as that due a Flare vs secondary diagnosis. - Flare can occur in patients on Rx, and those with multiple joints involvement. # Pts with Psoriatic arthritis are at 2 fold increased risk of Gout than general population due to increased cell turnover Vs Infections Vs Reactive arthritis
IL 23 inhibitor: Risankizumab.
if the patient presents with swollen joint. Important Dx: (a) X-rays, (b) Gold standard is Synovial fluid analysis, (Non inflammatory:< 2000 cells, infectious >50,000 cells) Gout is due to monosodium urate crystals.negative birefringence, needle shaped crystals.
(c) Dual energy CT: low energy CT scan
Psoriatic Arthritis Dx: 15% develop manifestation of psoriasis and arthritis simultaneously; FH: Paternal inheritance; Occasional H/o Trauma (Koebner phenomenon); insidious onset, No back involvement; Typically in the lower extremity, or can present with typical symmetrical arthritis picture; Dactylitis rules out Psoriasis. RF negative, and Nail dystrophy present in Psoriatic Arthritis.
Inflammation around the Joint- classically present in Gout! # Tophi are erossive.
#Loeffler syndrome: erythema Nodosum, Periarthritis → Sarcoidosis
Severe Psoriatic arthritis if HLA B27 positive. # Mid foot presentation is not common in Rheumatoid arthritis. # Serum Uric acid: Risk of Gout flare is about the Flux of the serum level, not necessarily the actual serum level. Patients with higher uric acid level greater risk of Gout. Unique site of Greater Toe(Podagra): is a mystery, maybe to do with temperature, most Distal joint have cooler temperature promoting precipitation of of the crystals. # Colchicine treatment to be started within 48 hours of acute flare onset, for it to be effective. #Allopurinol : Uricosuric. Increased risk of precipitating Steven Johnson syndrome. R/o risk in the patient before starting them on it.
During Acute flare : suppress the inflammation, and start with urate lowering therapy, except in certain patients. Target for Uric acid is serum level of 6.
during a flare: Uric acid level neutralises, Pseudo normal. Therefore, even a normal level during a flare, is high. Best to test the Sr.Uric acid between two flares.