10/02/24 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Brett Montelaro (@BrettMontelaro) **Case Discussants**: Steph (@StephVSherman) and Zaven(@sargsyanz)*

CC: 43M with intractable diarrhea and polyarthralgia 2 weeks ago.

HPI: 2 weeks ago, developed non-radiating periumbilical abdominal pain, loss of appetite and diarrhoea.
5-6 Diarrhoea episodes of yellow brown stool with rare frank hematochezia over last 2-3 days. Potential melena early in the course. Irrespective of PO intake. No nausea/vomiting or dyspepsia.
Myalgias/arthralgias worst in knees and legs. Intermittent numbness in distal extremities. Endorses fever, fatigue but not weight loss.
"Black urine" without flank pain, dysuria or gross hematuria.
3 days before presentation, went to urgent care, was diagnosed with DM, HTN, HepC

PMH: DM, HTN, HepC

Meds: Enalapril, HCTZ

Fam Hx: none

Soc Hx: No IV drug use, no tattoos, monogamous relationship

Health-Related Behaviors: Quit smoking 20y ago, drinks alcohol sporadically, migrated from Mexico

Allergies: NKDA

Vitals: T: 38.4 (101.1F) **HR:** 103 **BP:** 157/94 **RR:** 17 **SPO2** 97
Exam: Gen: uncomfortable, NAD
HEENT: EOMI, no icterus, no oral lesions
CV: no murmurs or gallops **Pulm:** CTAB
Abd: periumbilical tenderness to palpation without guarding or rebound, rectal exam showed blood.
Neuro: strength and sensation intact, reflexes symmetric and intact, overall unremarkable
MSK: pain on active and passive motion in elbow and knees bilaterally. No redness or swelling in the joints.
Extremities/skin: warm and diaphoretic, no rashes, shotty cervical and left inguinal lymphadenopathy (non-tender, mobile)

Notable Labs & Imaging:
Hematology: WBC 20k (neutrophil predominance) Hb 12.3 HCT 37.1 Plt 172k
Chemistry: HCO3: 18 BUN: 56 Cr: 1.5 AST:81 ALT:83 Alk-P:73 Lipase nl
Urinalysis: 300 mg/dL Protein, 60 RBCs, WBC & leukocyte esterase neg
Infectious work up: blood culture, enteric Gi panel, HIV, RPR neg
Hep C viral Load 93.8K
Other labs: CK 356, LDH 365, ESR 40, CPR 74, **cryoglobulins +,** low C3, RF +ve, ANA 1:160, anti-CCP neg

Imaging:
CXR: unremarkable
Plain films of joints normal
TTE: nl
CTAB: Mesenteric edema and fat stranding
Abd US: coarsened liver echogenicity
EGD: erosive gastropathy, H pylori +
Colonoscopy: ileal diverticula, erythematous rectal mucosa, 2mm polyp

Dx: **Mixed Cryoglobulinemia 2/2 Hep C**

Problem Representation:43 M p/w 2w diarrhea and polyarthralgia fever, fatigue, myalgia,numbness in distal extremities found to have cryoglobulins, low complement levels, and positive rheumatoid factor.

Teaching Points(Parisa):
Framing →New onset paresthesia; blood in diarrhea; myalgias / arthralgias indicative of inflammatory symptoms; UA diagnostic tool; Infectious vs non-infectious
Acute and chronic diarrhea combined with arthralgia (reactive arthritis; skin lesion nail changes) post bacterial like salmonella w/ possible neuropathy → post inflammatory;
HCV→ extrahepatic complication (Dermatologic manifestation porphyria cutanea tarda; peripheral neuropathy; vasculitis(cryoglobulinemia; renal membranous proliferative GN)
Medication history→ HCTZ ACE inh drug induced pancreatitis
UC extraintestinal manifestation: eyes; joints; skin
Acute intermittent porphyria → abdominal pain; neuropathy; ask about previous episodes; try to find a pattern to diagnose a rare syndrome
Absence of leucocyte plastic vasculitis small vessels in skin makes all small vessels vasculitis less likely.
Inguinal LN→ people can have upper limit normal→ look for other LN (supraclavicular; epitrochlear) ; other sign of enteritis colitis (cross sectional imaging)
Decision about empirical Abx → mental status; BP; duration Sx
Unusual clinical presentation→ uncommon prolonged bac infection→ yersinia
Rapidly progressive GN might be linked to vasculitis HCV cryoglobulinemia→ ANCA; anti GBM; Renal Bx → consider other types of vasculitis IGA Henoch
Mesenteric edema → arterial inflammation; embolism, thrombosis
Starting steroid in GI vasculitis requires considering benefits of reducing inflammation vs risk enteric perforation.
RF (IgM targets Fc portion of IgG) is used in cryoglobulinemia testing is positive in 80% actual sensitivity is less in real clinical practice.
Hallmark HCV cryoglobulinemia often involves the skin, especially in type 1, and is made worse by cold exposure, while its absence is uncommon.