

<p>Scribing (SEEME) CC: 67 y old FM with left index finger pain HPI: 4 week history of finger pain and discoloration and now dry gangrene. 2 days ago admitted to outside hospital, came to our hospital, concerned about burning and tingling in left pinky finger one month ago. In last 9 days the discoloration got worse. Pain started 3 days ago described as constant burning pain feels like it is on a burner. PCP sent home with brace and diagnosis of Carpal Tunnel was made. Little relief with pain medication. Patient is under stress after surgery, never returned to baseline after surgery, experiencing SOB for months associated with talking(can not complete the sentence). Presence of fatigue for couple of months and difficulty with swallowing. Multiple falls history,last fall was last week, falls worse after surgery. ROS: no dizziness, no joint pain or stiffness, no ulcers or photosensitivity, no nausea, vomiting or diarrhea</p>	<p>Vitals: T: nl BP:106/88 RR: 22 HR:77 Sat:98 % Exam: Gen: well oriented, no distress HEENT:nl CV: nl Pulm: crackles at base bilaterally Abd: nl Neuro: nl MSK: left index finger discoloration, bluish discoloration in left fifth finger and tenderness</p>		<p>Problem Representation: 67 year old FM presented with left index finger pain and discoloration.</p>
<p>PMH: Depression Anxiety Hyperlipidemia Spondylosis (cervical fusion in 2024) Migraine Hypothyroidism</p>	<p>Fam Hx: Not significant</p> <p>PSH: Hysterectomy</p> <p>Health-Related Behaviors: former smoker for 50 years, drinks alcohol socially</p> <p>Allergies:NKDA</p>	<p>Notable Labs & Imaging: Hematology: WBC:nl RBC:nl Plt:</p> <p>Chemistry Na:nl K:nlCr: nl Ca:nl Mg:nl Glu:nl Cl:nl HCO3: nlAG:nl eGFR: nIAST:nl ALT:nl ALP:nl Bili: nl CRP: elevated</p> <p>Imaging: Chest X-ray: unremarkable X-ray of finger: no evidence of osteomyelitis HIV, Hepatitis :negative CT Angiogram on left upper extremity: patent ulnar artery, diminutive radial artery beyond wrist with poor perfusion to digits 1-2 MRI left hand: diffuse subcutaneous edema along second finger, degenerative changes at second distal interphalangeal joint Duplex Ultrasound Upper extremity: bilateral small vessel disease, distal microvascular occlusion TTE: patent foramen ovale (PFO) but no intracardiac shunting ANA, ANCA, RF, rheumatoid factor, cryoglobulins, complement: normal CT chest, abdomen and pelvis: unremarkable DAPT (aspirin and clopidogrel) was initiated along with rosuvastatin and amlodipine Dx : Dry gangrene</p>	<p>Teaching Points (Khashayar): Approaching the Dark Finger? Importance of paying attention to a patient who doesn't feel heard. If the patient is worried you should be worried. Initial presentation -> neuropathic type of pain (as seen with the misdiagnosis of carpal tunnel) -> how to identify this faster -> in all cases of neuropathic pain as the vasculature follows the neurons you should always be concerned about the possibility of an ischemic process -> pain in the extremity specially concerning for vascular Pipes vs pumps vs plasma -> rule out external injury specially if single finger involved. -> emboli (smallest and most distal vessels are affected first) vs the vessel wall (Thromboangiitis obliterans (Buerger's disease) is an inflammatory occlusive vascular disorder involving small and medium-size arteries and veins. There is no specific treatment except abstinence from tobacco, Arterial bypass of the larger vessels may be used in selected instances, as well as local debridement, depending on the symptoms and severity of ischemia.) vs inside the blood (cold induced disease like cryoglobulinemia) vs raynaud's phenomenon (self resolving and acute -> importance of time course) PMI -> vasculature as sole pathology vs vasculature and neurons acting together SOB -> at rest is concerning, involvement of heart and lung -> pulmonary htn -> chronic presentation vs acute development that relates to this picture The falls -> syncope, seizure, understanding the possibility of neuropathy (baseline symptoms before surgery) Looking outside the vasculature and the nerves -> looking for signs of systemic inflammation, UA to look for vascular signature in the kidneys (if the vessels of the fingers are infarction, the vessels in the heart and kidney are at danger too) Localizing the involved vessels -> check and compare the pulses, bilateral involvement invokes involvement of vessels closer to the Aorta. Arterial imaging findings The first question is whether the imaging findings is explaining the physical exam -> radial artery being more diminutive being priorly damaged vs new process -> possibility of PAD but unusual presentation -> is this the baseline of patient vs new pathology -> compressive phenomenon vs wall problem (inflammation , infiltrations) vs clot phenomenon Blue toe syndrome -> distal disease in vasculature can lead to dry gangrene, usually presents in lower extremity</p>