



5/2/25 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Dr. Jeffrey Shen Case Discussants: Rabih (@rabihmgeha) and Maryana (@maryanamribeiro)

Scribing (Lera)
CC: 42 F presented to hospital with **pain, numbness, and tingling** in hands and feet.

HPI: Has a Hx of heavy periods, during which feels "bone grinding" (arthritis) in hands, feet, and knees. Now this feeling started to be **more persistent** and not related to periods. Over the past 3 weeks **new numbness and tingling**, that was intermittent -> persistent. Also has **trouble feeling the bottom of feet** -> had a **fall**. Started having **fevers** -> Rx w/ NSAIDs -> AKI.

ROS (-): fever, cough, SOB, chest pain, rashes, muscle weakness, eye problems.

PMH: GERD
AAV 2 y ago-> DAH and renal failure (Dx: renal Bx, p-ANCA and MPO +) AUB (heavy bleeding). COVID 5 y ago -> PE

Meds:
 Rituximab
 Pentamidine (PJP Px)
 Eliquis
 Tylenol
 Ibuprofen
 Famotidine
 Medroxyprogesterone

Fam Hx: DM2, no malignancy / AI

PSH: tubal ligation

Health-Related Behaviors:
From Mexico (last visit 10 y ago). No exposures / recent travel.
 Monogamous with husband. Previously alcohol-use disorder.

Vitals: T: 101.4 BP: 128/72 HR: 98 RR: 20 Sat: 94% on RA
Exam: Gen: not in acute distress.
HEENT: no sinus tenderness, no cervical LAD, nl conjunctiva.
CV: RRR, 2+ peripheral pulses, nl S1/S2 without additional sounds.
Pulm: **intermittent loud wheezing**, bl fine crackles at bases. **Abd:** normal.
Neuro: nl CN II-XII. **Decreased sensation over:** dorsum of L thumb, R hand tip -> wrist, L foot -> ankle, R foot -> mid shin. Motor exam nl, reflexes nl, Babinski negative, proprioception nl. **MSK:** no rashes, no synovitis, mild tenderness at wrists and ankles, but no effusion / warmth.

Notable Labs & Imaging:
Labs 72 h before presentation (admitted for fevers + AKI):
CBC: WBC: 15 (88% neutrophils) Hgb: 9.4 (bl) Plt: 513 MCV: 90
CMP: Na: 132 K: 4.8 BUN: 48 Cr: 2.8 (bl 1.1-1.2) Glu: 104 Cl: 105 **HCO3:** 19
Alb: 2.6 **Total pr:** 8.4 **AST:** 76 **ALT:** 48 ALP: 220 **ESR:** 84 **CRP:** 8 CK: 38
UA: 2+ protein, 1+ hematuria (on period), **UPCR 1.6.** pANCA and MPO (+)

Tests 72 h after hospitalization:
Echo: no vegetations. **Infxn:** negative BCx, UCx and sputum Cx, but no LP. HIV, syphilis, gonorrhea, chlamydia, HBV, HCV, TB GOLD, Histo negative.
Rheum: positive ANA (1:160), but negative ENAs, C3 and C4 nl.
Vit B12: 247 (slightly low), MMA nl. **IF Abs:** 13 (very +).

-> **Received Empiric ABx for presumed CAP -> fever and pain resolved.**
 Numbness in feet and hands persisted. Cr went down to 1.9.
Ankle and wrist XR: some soft tissue swelling.
NCS and EMG: early motor predominant distal axonal polyneuropathy.

-> **Getting ready to be discharged, but fever came back, pain and tingling getting worse.** Cr uptrend 1.9 -> 2.5. Neuro exam: new 4 / 5 symmetric weakness on ankle plantar flexion and dorsiflexion. Urine micro: **RBC casts.**

Dx: **AAV flare.**

Problem Representation: 42 yo f w PMHx of AAV post DAH+ renal Bx. p w/ mononeuritis multiplex sxs + fever for 3 weeks. PE: fever, wheezing, tender joints. Labs: AKI, IF Abs +. Tx w/ ABxs. Fever back -> EMG w dist. Ax. polyneuro. + RBC Casts compt w AAV flare.

Teaching Points (Vini):

- Vasculitis: Small (AAV - autoimmune), medium, Large.
- New onset disease vs AAV Complication such as flare
- Autoimmune cause: Sustained remission w/ immunosuppression - HPI - question validity of diagnosis. Revealed to had a classical presentation of AAV w DAH and proven renal Bx.
- Environmental exposures - considering ddxs (infection - HIV, drug induced lupus, immunosuppression - cancer, vit deficiency, lead poisoning, paraneoplastic)
- Unilateral - local vs bilateral symptoms - systemic etiology.
- On rituximab - susceptible, risk of B cell deficiency.
- If high suspicion of flare, empirically imm. sup. before further invest.
- febrile + neuropathic + arthralgia = small spectrum of poss. diag.
- PE: febrile, dec. distal sens., no lymphad, tender joints, pulm. wheez., - Slowly progressive neuropathy vs demyelinating vs **mononeuritis multiplex** -> best next step=ENM. Most sugg. of neuro etiol. than MSK
- Labs: neutr. Leukocytosis, Cr, inflamm. High ESR/ CRP. ANCA - varies accord. dis. activity (less reliable than dsDNA in lupus pts.
- Could the pt be hiding an infection? Inf that cause subacute neutrophilia - inf that hide eg: abscess, granulomatous dis. (TB, mycosis). DDx: Leprosy - subacute gran. dis. from latin america.
- Neg rheum and infec. Workup. Intrinsic Factor AB +.
- Improved after ABxs. After nerve studies comp. w/ distal axonal polyneuropathy - very rare and compatible with vasc phenomena.
- DDx diffuse leprosy vs AAV infiltrating the nerves.
- Acute interim. Porphyria vs Guillain Barre (but pt had reflexes) vs NO poisoning.