6/05/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: (Jeffrey Shen@) Case Discussants: (Youssef@saklawiMD) and (Mark@Mark_Heslin)

Scribing (SEEME)

CC: 29 y old FM presented with abdominal pain and arthritis

HPI:

Patient was in a flare a month ago described as joint pain and stiffness with coughing, mold was found in the apartment. 1 week later she developed a viral illness.

7 days ago: viral illness returned with malaise, diffuse arthralgia, subjective fevers, nausea and dizziness.

3 days ago: diffuse poorly localized abdominal pain, urgent care told her that it was constipation and laxatives started.

On day of presentation: found unresponsive at home,EMT was unable to wake her, was intubated, blood tinged respiratory secretions, was given IV lorazepam due to suspicion of seizure Also given IV antibiotics for suspicion of infectious meningitis and pneumonia.

PMH:
Seropositive rheumatoid arthritis
anxiety

Meds:
Sertraline
Prednisone
Methotrexate

Fam Hx:
Lupus in grandfather
Colon CA and sarcoidosis in paternal aunt

Social Hx:
Drinks on occasions and marijuana use.

Health-Related Behaviors: herbal remedies, pet turtle

Allergies: NKDA

Vitals: T: 100 BP: 104/74 **HR**: 106 **RR and Sat: on vent**

Exam: Gen: intubated and sedated
HEENT:dry blood on lips and lacerations on lips and tongue, some cheilitis and oral ulcers
CV: tachycardiac, no murmurs
Pulm: coarse mechanical breath sounds on vent
Abd: hypoactive bowel sounds
Neuro: sedated, minimal spontaneous movement, absent clonus, negative babinski, 3+ patellar reflexes
MSK: synovitis of MCP 2-3 bilaterally ,bilaterally in wrists, knees and ankles.

Notable Labs & Imaging:

Hematology:
WBC: 15 (83%neutrophils) Hgb:8.7 Plt: 205 MCV:74

Chemistry
Na:136 K: 3.3 Cr:1.9 BUN:26 Ca:nl Ph:nl Mg:nl Glu:266 Cl:103 HCO3:15
AST:128 ALT: 162 ALP:114 protein: 6.1 albumin:2.9 CK:1286
UA SG 1.012, ph:5.1, protein 2+, glucose 2+, ketones 1+, negative for blood
UDS: + marijuana +benzos
CSF: normal WBC, RBC, protein, glucose. Viral panel negative. Cultures negative. AFB and fungal Cx pending. Crypto Ag negative.

Imaging:
CTA:No pulmonary embolisms.Bibasilar dependent consolidations consistent with aspiration pneumonitis in the setting of recent seizure and altered mental status. No effusion or lymphadenopathy
MRI Brain: Symmetric T2/FLAIR hyperintensities involving bilateral parieto-occipital white matter consistent with PRES in the appropriate clinical context.
EEG: Diffuse slowing, nonspecific, toxic/metabolic.
Bilateral hand X-rays: Periarticular osteopenia with no signs of erosive disease or deformities. No CPPD seen.
– Rheum: ANA 1:640, ENA panel negative, RF+ (high titer), CCP-. C3 and C4 wnl. ANCA negative. APLS negative.
Quant TB, ID: Respiratory viral panel, HIV, Hep A/B/C, syphilis FTA-Abs, G/C, Histoplasmosis Urinary Ag, EBV PCR all -ve. Blood cx negative, urine cx negative
CSF: GAD65 ,low titer positivity on autoimmune encephalitis panel, otherwise negative. Ammonia level: normal. Folic acid: high, vitamin B12 : low-normal at 268, thiamine: low at 46 (wnl >70)
CT Abdomen pelvis: dilated bowel loops without transition point consistent with ileus. Radio-dense mass in ileum
Blood smear: basophilic stippling, urine and blood porphyrins : elevated , blood lead levels: elevated
Husband confirmed use of new chinese medication. Lead chelation done.

Dx: Lead poisoning

Problem Representation: A 29 year old FM presented with abdominal pain and arthritis

Teaching Points (SEEME):

-Rheumatoid arthritis may also have CNS manifestations. Medications used to treat rheumatoid arthritis like methotrexate can cause ILD and pneumonitis. Prednisone increases risk of ulcers, GI manifestations and psychosis.
-Anyone with autoimmune disease can have manifestations of disease (complications) or association with other autoimmune diseases (like SLE) or a complication of immunosuppressive medication is also likely because arms of immunity are dysfunctional. Immune system compromise can also increase the risk of malignancy. For AMS we can think about MIST (metabolic, infection, structural, toxins)
- RF can be seen in diseased like Sjogren syndrome, endocarditis related glomerulonephritis, infections and malignancies. It is non-specific.
-Turtles can cause salmonella infections.
- Lacerations on tongue can be due to seizures or intubation injury. EEG should be considered.HSV and Behcet's can cause oral ulcers.
- for abdominal pain VIPO (vascular, infection, perforation, obstruction) can be considered.
-CK and creatinine can be elevated as a result of underlying disease. HSV can be initially missed on LP, acyclovir can be started especially in immunocompromised patients. LP can be normal in CNS vasculitis
- SCAN should be considered in AMS (sugar, CT, airway, narcotics or urea). Checking ammonia and thiamine level is important. When patient is not eating for a long time thiamine can be low.
-GAD65 can be associated with stiff person syndrome, type 1 diabetes and paraneoplastic syndromes like limbic encephalitis.
- heavy metals can cause neuropathy , encephalopathy and seizures. We can get microcytic anemia and basophilic stippling in lead poisoning. MDS, folate and B12 and other heavy metals can be associated with basophilic stippling. Acute intermittent porphyria can also present with abdominal pain. Lead toxicity can cause type II RTA Fanconi syndrome.