6/9/25 Morning Report with @CPSolvers

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

Scribing (Julia)
CC: R leg Swelling

HPI: 22 yo presenting for R Leg swelling for 1 day, no trauma the day before but reported slipping off his couch onto his flexed R knee 2 weeks prior. GLF 2 weeks prior, w/ spasms Knee warm to touch and has been spasming more. Worsened spasticity over the last two weeks, punches his leg

Swelling improved Crp has normalised- 4 days later

ROS (-): fever, rash, no penile discharge, changes in urinary frequency

PMH:
Traumatic spinal cord injury ~ 6 years ago on T6 (WC bound due to LE paralysis, LE spasticity Neurogenic bladder + bowel) Depression

Meds:
Baclofen
Gabapentin
Naproxen
Oxybutynin

Fam Hx:None known

Social Hx:
Lives w/ family member (grandmother)

Health-Related Behaviors: no EtO, no tobacco use (former smoker), daily cannabis, no travel or animal exposure
Sexually active , no condoms
Allergies:

Vitals: T: 36.4 BP: HR: 108 **RR:** 103/62 **Sat: 100% RA BMI:** 22,3
Exam: Gen: No acute distress
HEENT:nl
CV: nl
Pulm: nl
Abd: nl
Neuro: no LE sensation,or motion possible
MSK: edema of R knee, small area of warmth and no marked erythema, extend to mid thigh, no inguinal LAD. Swelling extends proximally into his thigh though not firm. Good inguinal and DP pulses on R. Able to ROM the knee without issue but induced a spasm.

Notable Labs & Imaging:
Hematology:
WBC: 8 nl diff. Hgb: 12.2 (14.7 years ago)
Chemistry
ESR nl CK 200(ULN171), INR PTT nl CRP 54.4
UA: nl
HIV neg, Trep AB neg , Urine gonorrhea and chlamydia neg.
Imaging:
LE US: no DVT
POCUS: no significant effusion of suprapatellar recess
X ray r knee: Small suprapatellar soft tissue effusion and soft tissue swelling which is non specific. No acute osseous abnormality. Pt advised he possibly has a ligament or meniscus injury status post trauma.
CT Scan: No acute fracture, no joint effusion, nonspecific curvilinear peripherally enhancing **fluid** in the **deep** aspect of the anterior compartment of the thigh with horseshoe shaped, 3-4 cm in AP dim. 1-1.5 cm in transverse dim. and at least 20 cm in craniocaudal dim. hematoma over abscess

Dx : Deep bleed (2/2 NSAID, spasticity, muscle atrophy, punching)

Problem Representation: A 22 year old presented with right leg swelling and warmth for 1 day. Ct scan showed fluid in the deep aspect of anterior compartment of thigh. Diagnosis of deep bleed was made.

Teaching Points (SEEME):
Approach to leg swelling:
We can think about DVT or cellulitis. We can look for risk factors and medications patient is taking. We can localize to joint, skin or bone. When wounds are noticed like pressure ulcers, they can get worse with superimposed infections.
Approach to vitals and exam:
WE can have knee swelling with ruptured cysts, bone or tendon issues. We should also think about articular and periarticular structures. We can think about any portal of entry and US and MRI can help us further.
Approach to infective arthritis:
Gonococcal infection, Chlamydia, HIV and syphilis are worth considering in sexually transmitted causes of arthritis. Also reactive arthritis can be considered. Many individuals have genetic predisposition. HIV antigen antibody test is positive after 12 days while PCR can also be used. RPR and VDRL can be used to test for syphilis.
Approach to complex regional pain syndrome:
It is a complex regional pain syndrome characterized by chronic pain, neurovascular and neuropathic symptoms.
Approach to inflammation/ tissue swelling:
-Deeper space infection should be ruled out. We can think about myositis. Compartment syndrome is also worth considering. Focal myositis can be seen in diabetes and infectious causes. When we have intermittent symptoms we can think about diseases which cause flares and can wax and wane.
-Fluid in anterior department makes us think about bursitis, fluid or blood.