



6/18/25 Morning Report with @CPSolvers

“One life, so many dreams” Case Presenter: (Mark@MarkHeslin) Case Discussants: (@Sharminzi) and (@IbrahimOmer_)



Scribing (Nikola)
CC: 30 y/o M, 3 months of progressive low back pain, and 2 days of pleuritic chest pain.

HPI: 7th ED presentation for back pain , right before the BP started the patient was in Kentucky for 2 months, during which he developed “prostatitis” (perineal pain and dysuria), for which he received on antibiotics (unknown type) for about 5 weeks, the prostatitis resolved then and he developed the BP. The BP is really bad at night and in the morning, the pain is relieved when he stands up and walks around, it's worse when lying down. Never had BP like this before. CP better when lying down, worse when sitting up

ROS: no preceding trauma, no other joint pain, no radicular symptoms, no fevers, 40 lb weight loss, alternating diarrhea, occasional night sweats

PMH: DM HbA1c 8.5%

Meds: Insulin, metformin, no OTCs

Fam Hx: Arthritis (unspecified), father has prostate cancer, mom passed away recently due to lung cancer

Social Hx: lives in the Bay area, recent trip to Kentucky, originally from Peru, moved to Columbia and then to the US, 3 years prior to admission. Works as a truck driver.

Health-Related Behaviors: Monogamous, his dog recently died. No farm animal exposure (however drives past farm animals)

Allergies: none

Vitals: T: nl BP: 115/77 HR: 110 RR: nl Sat: 99% on RA BMI: 17

Exam: Gen: Cachectic, riving in the bed (fetal position) due to pain, “please doc I just need an answer...”

HEENT: nl

CV: tachycardic regular, no murmurs

Pulm: nl

Abd: nl

Neuro: AOx3, cranial nerves nl, strength nl, reflexes nl, sensation nl

MSK: extreme point tenderness in the very low back (sacrum), unable to to move his back

Notable Labs & Imaging:

Hematology:
WBC: 9.7 (9.2 prior, nl differential) Hgb: 15.3 Plt: 419 MCV: 89

Chemistry
Na: 135 K: 4.5 Cr: 0.35 BUN: 21 Ph: nl Mg: nl Glu: 300 Cl:102 HCO3: 21 AG: 12
CRP: <0.03 ESR: 2
Coagulation studies: nl
Trop: neg
NT-ProBNP: neg
Ferritin: 538
Urinalysis: nl

Imaging:
EKG: Diffuse ST segment elevations in the precordial leads
CXR: nl
Spinal imaging (MRI): Edema and enhancement within the bilat sacrum and iliac bones (posterior soft tissues), no joint effusion, mild degenerative changes
TTE: small pericardial effusion, normal EF, no valvular disease
Pan CT: no acute/chronic PE, focal calcified granuloma in the left upper lung lobe and calcified left upper lymph node (nothing in the lung parenchyma) additionally multiple thin linear and wedged areas in the kidneys (ddx: infarcts vs pyelo), no abdominal lymphadenopathy
PET CT: completely nl (pericardial inflammation and SI joint inflammation)
Patient started on NSAIDS and colchicine for pericarditis (CP improved)

Additional labs:
Respiratory viral panel, HIV: neg
ANA, centromere, RF, CCP, APS, ANCA, Thyroid panel, HLAB-27: neg
Urine serum Ag for blasto/histo, serum blasto ab, Cocci screen, Quantiferon: neg
Coxiella and Brucella: pending

Marks finals thoughts: fungal infections unlikely, potentially viral or idiopathic pericarditis, it could always be TB or IBD associated spondyloarthropathy or AS, tissue is the issue and a biopsy will likely provide the Dx,
Dx still pending!

Problem Representation: a 30 y/o male with progressive low back pain and pleuritic chest pain found to have normal inflammation markers, diffuse ST elevations on ECG and enhancement in the lumbar spine region as well as a calcified lesion in the left upper lung lobe.

Teaching Points (Glen):

Atypical presentation, young. Progressive could mean an indolent path(also has W/L)

Could be unrelated and should be treated differently.

Inflammation of pleura and lung can lead to acute pleuritic cp e.g PE.

- Other cant miss diagnoses are aortic dissection, spondyloarthrities.
- Aortic pathologies can cause pleuric cp as a SE of ciprofloxacin
- Pain worse lying flat could suggest an autoimmune dx (e.g SLE and IgG4 Dx). Spinal imaging would help.
- Chlamydia infection of prostatitis could lead to reactive arthritis in pt with HLA B27 predisposition e.g IBD arthropathy
- Pain could be due to a stress fracture and an infiltrative process.
- Diffuse ST elevations could be due to pericarditis(could be caused by a granulomatous inf, autoimmune dx, infections)
- W/L could be due to malignancy or a GI issue e.g malabsorption.
- Calcified granuloma could be histoplasmosis or TB. Could be systemic. Sarcoid could mimic it. Important to check HIV. Less likely causes are SLE and lymphoma
- Linear areas in the kidneys could be pylo as complication of prostatitis.
- Hanta virus and Leptosporiasis are the 2 zoonotic infections inc coxiella and brucella.
- Blastomycosis can cause prostatitis and could cause the presentation.
- TB vs IBD arthropathy at the moment (ESR nd CRP can still be nl) on NSAIDS and usually responds.