7/7/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Dr. Ana Valle* ***Case Discussants****: Dr. Eli Miloslavsky and Lea Bischof*

Scribing (Elena, Seeme, Krithika)
CC: 48 M with great toe pain for 1 month
HPI:Patient was at a party the night before where he hopped a fence, developed pain which is 8/10, stinging, non-radiating in the right great toe**.** Tried ibuprofen and colchicine - Sx returned, not full response.
First episode, no alcohol before, no seafood, no meat, other joints: since 2 months stiff hands, in the morning, warmth helps, stiffness lasts 2 to 3 hrs, nighttime awakenings. Endorses morning stiffness 2-3 h.
Pain on bottom of heel, right achilles tendon, plantar fasciitis, left nail looks odd, rash b/l anterior shins
ROS (-): Fever, chills, night sweats, fatigue, weight loss, no URI, no dry eyes mouth, N/V, diarrhea, alopecia, photosensitivity, Raynauds, ocular issue, low back pain, personal/family history of IBD

PMH:Allergic Rhinitis, HLD, HTN,Eczema, Rosacea,Remote history of Hepatitis A
Meds:
Hydrocortisone and triamcinolone creams, Medrol Dose Pack previously discussed
Explain dosing: Hydrochlorothiazide

Fam Hx:Father and maternal grandfather both have gout
Social Hx: Bass guitarist. Married, no children.
Health-Related Behaviors: "Social smoker" perhaps half a pack per week over last 20 years, 21 drinks per week ,Daily cannabis use, No other illicit substances.
Allergies: none

Vitals: T: 99.6 BP: 116/63 **HR**: 73 **RR: Sat: BMI:**
Exam: Gen: PERRLA, EOMI, MMM, no oropharyngeal ulceration or tonsillar exudates. **HEENT:**nl,no lymphadenopathy
CV: nl **Pulm:** regular respirations **Abd:** soft non-tender, non-distended
Neuro: AO x 4, no focal deficits
MSK: 2x2 cm anterior shin lesions c/w post-inflammatory changes, warm extremities, normal pulses, no edema, hip motion normal. R first MTP mildly tender, swollen, full ROM, MTP squeeze positive.
Shoulders, elbows, wrists, hands, fingers: L 3rd MCP, PIP and DIP tenderness to palpation without erythema, warmth and swelling. B/L MCP squeeze positive. , Knees, ankles,feet, toes-right first MTP with mild tenderness to palpation and swelling.Mtp squeeze test positive on right.

Notable Labs & Imaging:
Hematology: WBC: 6.9 Hgb: 14.2, HCT 44.4
Chemistry- Na: 138 K:4.2 Cr: 1.04 BUN: 17, GFR:89 Ca: 9.4 Ph: Mg: Glu: 93
Cl: 101 CO2 29, Ca-9.4, GFR-89
AST:22 ALT: 32 ALP: 45,AG:8, TP-7.3, Bili: tot0.8, prot 7.3 albumin:4.3
uric acid 7.3
ANA neg, HLA-B27 neg, RF 18 (mildly high), CCP < 8, hsCRP 1.1, ESR 13, Lyme ABs neg
Imaging:
XR: mild degenerative changes, no specific findings (soft tissue calcification b/w base of 3rd and 4th MCPs on the R hand)
Dual energy CT of right foot: single non specific focus of positive green color coding at the plantar aspect of the third metatarsal head.
MRI L hand 3rd digit: enhancing synovitis with bone edema- indicative of inflammatory arthritis

Treated as psoriatic arthritis with methotrexate. If isolated right toe pain occurs again, will be treated like gout.

Dx : Psoriatic arthritis, Gout

Problem Representation: 48 year old presented with great toe pain,morning stiffness in hands, achilles tendon pain and rash on bilateral anterior shins. MRI of hand was indicative of inflammatory arthritis.

Teaching Points (Lera):
Monoarthritis: ***Gout*** *– what doesn't fit?* 1st episode often *self-resolves*, typically responds to the first-line treatment like NSAIDs and colchicine.
Joint pain approach:
- ***Mechanical vs. inflammatory*** -> LIDS:
  L*ocation* (mono / poly - arthritis + what joints? If MCPs affected, suggestive of inflammatory + symmetry),
  I*nflammatory features* (morning stiffness > 30-45 min, swelling),
  D*uration* (acute vs. chronic), ***S****ystemic Sx.*
- The ***more joints*** involved, the higher likelihood of ***inflammatory*** etiology.

Rheumatic Dz breakdown:
- ***Primary approach:*** *Inflammatory arthritis* (at least 1 swollen joint) // *connective tissue diseases* (ANA+) // *vasculitides*.
- ***Isolated inflammatory arthritis****: asymmetric* -> crystalline arthropathies (gout and pseudogout), spondyloarthropathies (PsA, AS, reactive arthritis, IBD-ass), *symmetric* -> RA, PMR ***+ DDx with infectious arthritis***
- Asymmetric pattern, back affected, DIP involvement, entheseal involvement -> ***spondyloarthropathies***

Family Hx in rheumatology:
- ***Individual history*** is always more important than *family history.*
- Can be helpful if suspecting monogenic genetic disorders

Inflammatory arthritis serology: Most don't have a marker, except *RA*
- ***RF, CCP to rule out RA*** (RF ~70% specific for RA)
- ***HLA-B27.*** Better characteristics for patients *w/ axial involvement* (for peripheral predominant psoriatic arthritis sensitivity ~30% + *no correlation* b/w skin involvement and probability of PsA)
- ***ANA.*** SLE can present with arthritis as first manifestation.
- ***Uric acid.*** Not a diagnostic test on its own. Higher the level – higher the probability for gout, but can develop even with normal levels.

Inflammatory markers: good PPV for vasculitis, not so much for CTD / arthritides (1/3 will have normal levels) ***+ check for meds*** (steroids?)
Imaging pearls: ***XR*** diagnostic on later stages // ***Dual energy CT*** is sensitive gout >> CPPD // ***MRI*** detects subclinical synovitis.