6/2/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Vini (@vinibarzon) Case Discussants: Jas (@JasBajwa18) and Jeffrey (@)

Scribing (Julia)

CC: numbness and tingling in hands and feet for 5 days

HPI: 38 M presented to the OSH 5 days ago for numbness and tingling in his hands and feet (unable to ambulate) and a rash. Pt transferred for investigation and management.
5 months: Raynaud's disease (bilateral painful/frozen sensation on hands + color change when exposed to cold temp). **3 months:** persistent intermittent numbness in left arm / **1,5 month:** numbness and sharp pain LE (R -> L) "frostbite"
1 month: pain right foot + painful red rash (spreading bilaterally) + SOB on exertion + hemoptysis in the morning + blood in the nose
Saw PCP: scheduled neurologist + gabapentin (never tried steroids or other meds)
Today: Redness improving but pain persist

ROS: + joint swelling, morning stiffness, fatigue - for joint pain, fever, DVT, GI, GU symptoms

PMH:
Raynaud's phenomenon
Polyneuropathy
Vape use

Meds: none

Fam Hx:

Social Hx:
Lives w brother and sister-in-law in Cleveland
Not sexually active (6 years)
Works remodeling bathrooms

Health-Related Behaviors:
denies alcohol, drug use.
Currently vapes and previously smoked (quit 2007)
Past IV drug use

Allergies: none

Vitals: T: **BP:** 155/96 **HR**: 74 **RR:** nl **Sat:** 97% **BMI:** 21
Exam: CV: nl **Pulm:** Lungs clear to auscultation. No wheezing, rhonchi, rales
Abd: Neuro: alert, oriented x3. Moves all extremities. No focal deficits
MSK & Skin: Convalescing non blanching petechial macules on bilateral lower extremities.Violaceous small retiform patches on the abdomen.
Extremities: bilateral LE ankle pitting edema (L>R). No deformities, clubbing or cyanosis. Good capillary refill.

Notable Labs & Imaging:

Hematology:
WBC: 4.74 (neutrophilic predominance) Hgb: 10 Ht 29 Plt: 146

Chemistry
Na: 136 K: 4.2 Cr: 1.04 BUN: 16 Ca: 8.6 Glu: 96 Cl: 101 / Albumin, total protein and LDH nl
AST and ALT: moderately elevated / ALP, GGT, bilirubin, albumin, INR normal
Iron panel: Iron: 40 / TIBC nl / Transferrin sat 14.2 / Ferritin 21
B12 and folate nl / HIV and syphilis neg
p-ANCA, c-ANCA neg
UA: > 25 URBC. Otherwise nl
Polymyositis panel neg / Lupus panel neg / RNP Ab neg / ANA neg
Electrophoresis: IgM 520 (high) / IgM, IgG and IgG4 normal
Decreased C4 / nl C3
Rheumatoid factor 500 (high)
Hep C positive (> 5 million) - Genotype 3
Cryoglobulin: + IgG, IgA and IgM
K/L ratio 2.2 (high)

Imaging:
CTA: nl / US kidney and bladder: no hydronephrosis / MRI brain: nl
CT abdomen and pelvis: splenomegaly, multiple borderline abdominal nodes. Periportal edema and gallbladder wall edema.

Dx : mixed cryoglobulinemic vasculitis secondary to hepatitis C

Problem Representation: A 38 y old male presented with rash, numbness and tingling in hands and feet and rash associated with raynaud's disease and hemoptysis. Patient also had splenomegaly and arthritis.

Teaching Points (SEEME):

Approach to rash, numbness and pain:
A petechial rash can be due to extravasation of red blood cells.Numbness and tingling makes us think about neuropathy. Cryoglobulinemia can also present with raynaud like picture. Small and medium vessel vasculitis affect vessels and nerves. EGPA is most common type of vasculitis affecting nerves. IgA vasculitis and cryoglobulinemia are also worth considering. Infective endocarditis can also mimic vasculitis. Hydralazine and some other medications can also mimic vasculitis.SOB makes us think about vasculitis affecting lungs.

Approach to social history:
Lyme disease can also cause rash and neuropathy. Histoplasmosis is also common in Cleveland. Morning stiffness and raynaud make us think about a systemic disease.

Approach to Labs and splenomegaly:
ANCA vasculitis can cause transient changes on CT. p-ANCA and c-ANCA can not rule out vasculitis. Splenomegaly can be seen in autoimmune diseases or malignancy. Splenomegaly can be seen with vasculitis. Rheumatoid arthritis can cause felty syndrome causing splenomegaly.IgG4 disease can have overlap with vasculitis and pseudotumors. Sarcoidosis can in rare causes present with neuropathy.
We can think about lymphoma and igM myeloma with elevated IgM. Neuropathy and arthritis is common in plasma cell dyscrasias. Castleman disease can cause abdominal nodes.