9/16/25 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Akash Gupta **Case Discussants**: Andrew Sanchez (@ASanchez_PS) and Jeffrey Shen*
https://clinicalproblemsolving.com/present-a-case/

Scribing (Gillian Z)
CC: 87 yo female fever, fatigue, recent falls
HPI: Stable for 7 yrs until last summer (on pred 1 mg 3 days/week)
Difficulty using hands (playing piano)
Worsening fatigue, weakness
CK 690 → CK 861
Falling in the past few years, more recently
Stopped steroids (concern for myopathy)
Stopped tocilizumab due to diverticulitis
Worsening fatigue, weakness→ present to ED
ROS: no hA, no vision change, no oral/nasal ulcer, no joint swelling, no rashes, no belly pain/diarrhea, constipation.

PMH:
Giant cell arteritis: Diagnosed w/ GCA 2010, fevers 100 F,
Fatigue, night sweats, jaw pain
No headache or vision changes,
Prednisone 70 mg monotherapy until 2017→ tocilizumab; pred slowly weaned over yrs until last summer
BL temporal artery biopsy showed BL infiltrate w/ lymphs, plasma cell, neutrophils (no giant cells).
TAVR for aortic stenosis
Adrenal insufficiency (secondary chronic glucocorticoid use)
B12 def
HTN, prediabetes
BL hip prosthesis, cholecystectomy
Meds:
Amlodipine, metformine, aspirin, PoB12

Fam Hx:
None

Social Hx:
retired
Health-Related Behaviors:
No tobacco, alcohol, drugs, supplement
Allergies:

Vitals: T: 98 (up to 99.6) **HR:** 71 **BP:** 125/65 **RR:** 18 **Sat:** 96 RA **BMI:**
Exam: Gen: no acute distress
HEENT: normal
CV, Pulm, Abd: nl
Musc: 5/5 strength in shoulder, triceps, biceps, 4/5 wrist flexion, extension, right grip strength 3/5, right knee flexion/extension 3/5 , couldn't get off bed doing sit to stand

Notable Labs & Imaging:
Hematology:
WBC: 11.9 (nl) Hgb: 12 Plt: 319 MCV:nl
Chemistry:
Na: 131 K: 4.9 Cl: 97 HCO3: 27 Cr: 0.74 (baseline) BUN: 16 Glucose: 106 AST: nl ALT: nl Alk-P: Bili: Albumin: 2.9 Total Protein: 8.3 hs trop: 190
ESR: 129 – >130 CRP: 22 (reference 5) LDH: CK: 690→861 (after stopping steroids) →600s→208 Aldolase: 8;
Low titer PL7: 13, Positive CN1A antibody, TSH: 5.68 FT4: 0.94
After muscle biopsy: p-ANCA +; MPO: 113
UA: Cloudy, Neg ketones, protein 30, large blood, small esterase, RBCs 20-50
Urine protein/creat ratio: 0.61
Imaging:
CXR: Coarse bl diffuse opacities
CTA Chest PE protocol: no PE, basilar and peripheral fibrosis and honeycombing w/o effusion or ptx
CT abdomen/pelvis: normal
EMG: RU & RL extremities show electrical evidence patchy myopathic process, muscle membrane irritability
MRI: T2 signal, fatty atrophy involving left quadriceps muscle
PET CT: nl
Muscle Biopsy: Marked evidence vasculitis, abundant chronic inflammation, fibrinoid necrosis, focal fatty replacement, perivascular lymph (CD3, CD4 pos, CD20 +)
Endomysial inflammation
No evidence of inclusion body myositis
Dx: ANCA vasculitis mimicking GCA and myositis

Problem Representation: 87yo F w/ PMH of GCS tx w/ steroids + recent d/c tocilizumab p/w fever and distal-predominant weakness. On exam, mixed distal>proximal weakness that on EMG confirmed myopathic process. Inflammatory markers markedly elevated and hematuria was noted on UA. Muscle biopsy showed vasculitis and p-ANCA came back positive.

Teaching Points (Vale):
Fever: IMADE. In our immunosuppressed px w/ high burden of rheum dz -> Infection > Autoimmune > Drugs, Endocrinopathy > Malignancy.
FUO Approach:
1st pass: ESR, CBC, LFTs, BCx, UCx. Full-body imaging.
2nd pass: Echocardio, hepatitis, RPR, HIV, Quant, Bartonella, Brucella, Coxiella. ANA, Cryo, ANCA.
FUO + Rheum:
Connective tissue dz: Lupus, Sjogren, Scleroderma, Dermatomiositis, Mixed connective tissue dz +/- RA.
Vasculitis: Fever w/ subacute-chronic progression.
Crystals: Gout.
Autoinflammatory dz: Adult-onset Still's, periodic-fever syndromes.
💎**ESR>100:** In the rheum category think ANCA-associated vasculitis, crystalline-arthropathies.
💎GCA is assoc w/ polymyalgia rheumatica, which causes bursitis and synovitis + normal CK levels.
Myopathy: Proximal > distal (inclusion-body p/w asymmetric mixed weakness).
💎T-cell large granular lymphocytic leukemia can present w/ paraneoplastic rheumatologic dz (SLE, RA, Inclusion-body myositis).
Hematuria: 1st r/o mimics (ex. Period blood) -> malignancy, glomerulonephritis. **? FUO + Myositis + hematuria:** SLE.
ILD + Vascular involvement: MPA.
GC mimics: AL amyloidosis, MM, Waldenstrom's, Lymphoma.
💎Cryoglobulinemia is a dx that lives in the intersection between infection, autoimmunity and malignancy.