9/12/25 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Lourenco (@) **Case Discussants**: Rabih (@rabihmgeha) & VMR Fam

https://clinicalproblemsolving.com/present-a-case/

Scribing (Krithika)

CC: 82/M with progressive **neck pain**

HPI: Presented to ED. Posterior, insidious onset, Pain worsened with active and passive movement Malaise and fatigue x 4 months

ROS: no trauma, strength, weight loss, anorexia. No urinary or fecal incontinence.

PMH:HTN, Gout, **prostate adeno CA** ,localised- not started on radiotherapy GERD non-atrophic gastritis Derm consult: **Eosinophilic pustular folliculitis** (Ofuji Dz)- Hyper IgE, on Dupilumab

Meds: Dupilumab Leuprolide Bilastine Mirtazapine Multivitamin supplement

Fam Hx: none

Social Hx: lives in Lisbon, no pets or travel Hx

Health-Related Behaviors: none

Allergies: none

Vitals: T: 36.5 **HR:** 67 bpm **BP:** 131/82 mm Hg **RR:** 17cpm **Sat:** 99% on RA

Exam: Gen: looked pale, dehydrated, thin, uncomfortable **HEENT:** no obvious LAD

CV: RRR, nl, no JVD **Pulm:**normal CTAB **Abd: s**oft, non tender

Neuro:pain with active and passive movement, tenderness to palpation on posterior aspect of neck, limitation to movement, spurling sign neg, power 5/5

Notable Labs & Imaging:

Hematology: WBC: 13 *(monocyte predominant)* Hgb: 6.5 (bl 12. 6 mo ago) Plt: 5.6(increasing trend) , MCV: 86, **RPI:** 0.6% (low) PS- NAD

Chemistry: Na: nl K: nl Cl: nl Ca: normal Cr: 1.78 (1.02 bl), BUN: 78

AST:25 ALT: 18 **Alk-P:** 719 Bili: 0.49 Albumin: 2.67 (low) Total Protein:68.5(nl) **Total PSA:** 0.67

ESR: 89(increasing trend) CRP:118 LDH: 308 Ferritin 3000 , Folic acid-- >20, B12- 1174

SEROLOGY- neg, BLOOD C/S, URINE C/S- NEG

PBS: unremarkable **SPEP**: biclonal spike in gamma fraction, IgG 19.8 (high), IgA high, IgM nl, IgE high at 6K **sFLC ratio**: 1.87

UA: nl with neg UCx **UPCR**: 70 mg/g **UACR:** 50mg/g

Full body CT: liver steatosis without focal lesions, **no apparent bony blastic lesions**, marked degenerative changes with subchondral calcifications, Splenomegaly, disseminated LAD

Cervical MRI: paramedian disc protrusion

PET scan- vasculitis of large and medium arteries above and below the diaphragm, diffuse increased metabolism in spleen and BM (?)

ALP isoforms-liver isoform increased(t2)

BM biopsy: Old- hypercellular marrow, increased myeloid precursors, mild % of blasts, increased M:L RATIO, increased CD34 activity

MDS, MPN workup- NEG

Started on prednisolone Rx- continued to worsen

2nd BM- increased blasts(30%)

VEXAS workup: negative

Dx: GCA and CMML

Problem Representation: 82 year old female, % neck pain and associated malaise and fatigue, labs revealed elevated ALP with no apparent lytic lesions or any liver pathology, bone marrow revealed elevated levels of blasts , diagnosed GCA and CMML.

Teaching Points (Julia Z):

Approach to neck pain:

- Most of them comes from nonspecific musk pain
- Difference between back pain: pt w low back pain does have musk involvement - pain goes away w symptomatics.
- Most of neck or back pain can occur because of local problems (musc, bone). However, some of them can occur because of systemic disease (malignancy, infection) - in those cases, worry about red flags.
- Particularity of neck: diff between anterior x posterior (posterior most likely to be musk, anterior not musk)

Approach to PMH:

- Autoimmune x malignancy
  - Hx of cancer (prostate): increase the possibility of systemic cause
  - More aggressive locally based on Gleason score → more risk of aggression systematically
- Gout: very common disease, characterized by hyperuricemia, most common in the first toe, some patients will have monoarthritis

Approach to labs:

- Infection: when dealing with musk problems → osteomyelitis
- Alk-P: if elevated w elevated LFTs -> infiltrative liver disease // when elevated alone, indicates bone problem (involving the liver), specific blastic activity
  - Multiple myeloma: lytic disease -> no elevation on Alk-p, elevated Ca
  - Prostate cancer: blastic disease -> elevated alk-p, normal Ca
- Normal sFLC ratio: goes toward MGUS

Approach to Image:

- Isolated but subradiolocal Alk-P elevation → osteomalacia or diffuse infiltration of the liver
- Elevated platelets + splenomegaly → infiltrative disease (could be in the spleen, liver and lymph nodes)
- Vasculitis: pure vascular disease vs extravascular disease (endothelial phenotype) → CMML, VEXAS syndrome are the two diagnosis possible for vasculitis in this case