9/19/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Victoria Uceda* ***Case Discussants****: Youssef (@saklawiMD) and Kirtan (@KirtanPatolia)*

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

Scribing (Sam B)

CC: 27yo M with arthralgia and fever

HPI: October 2022: 1st episode of fever, arthralgia, rash, tx for Lyme disease

March 2023: returned with continuous fevers starting at 5pm, rashes in all extremities that disappear the next morning. Tx for Still's with prednisone, methotrexate, Elaris (IL1-B antagonist).

September 2023: Fever, rash, facial swelling, 4-5 episodes. Lasts a few days and then resolves. Also bl shoulder pain extending to elbows and hands

Doc following labs called him and told him to present to ED - transaminitis

Still has **"clockwork" fevers, fatigue** on presentation

ROS: No chills, weakness, joint pain or stiffness, photosensitivity, eye dryness, no respiratory difficulty, chest pain, abdominal pain

PMH: Still's disease

Meds:
Prednisone
Methotrexate
IL-1 inhibitor (Elaris)

Fam Hx:
Siblings are healthy
Father has unspecified heart condition

Social Hx:
Works as police officer, no travel Hx

Health-Related Behaviors:
never smoked or used other drugs, no alcohol use

Allergies:
Azithromycin - swelling

Vitals: T: 98.5F **HR:** 80 **BP:** 110/65 **RR: Sat: BMI:**

Exam: Gen: resting comfortably, no acute distress

HEENT: anicteric, PERRL, MMM, no lymphadenopathy

CV: normal, no murmurs **Pulm:** clear bilaterally **Neuro:** normal

nontender, nondistended **tremities/skin:** full painless ROM in xtremities, mild urticaria on both cheeks sparing the nose

Notable Labs & Imaging:

Hematology:

WBC: 3.5 RBC 4.33 Hgb: 12.4 Hct: 35.6 Plt: 63 ANC: 0.7

Chemistry:

AST: 727 ALT: 808 Alk-P: 2836 Triglycerides elevated

Ferritin: > 33,000

Fibrinogen: 177

Infectious disease:

CMV +

Imaging:

CT chest/abd/pelvis: large splenomegaly, hepatomegaly, small mediastinal lymph nodes

Bone marrow bx: markedly hypercellular with prominent hemophagocytosis, HLH in appropriate clinical context

Dx: HLH, most likely due to CMV

Plan for genetic testing for familial HLH

Tx: anakinra, targets IL1, 400mg tapered + 60mg prednisone taper

Give PJP prophylaxis due to multiple immunosuppressants - atovaquone (due to transaminitis)

Problem Representation:

Teaching Points (Zak E):

Stills : Autoinflammatory disease , classic 'salmon' rash , Rx biologics(as with all other autoinflammatory disorders) , Dx of exclusion , must exclude infections, malignancy and other autoimmune disorders

Stills : Usually monophasic, as opposed to other autoinflammatory disorders which are cyclic

High ferritin + cytopenia : HLH (look for trigger): viruses, bacteria, malignancy and autoimmune disorders , exclude mimics , exclude causes systematically , infective first, then autoimmune (trail of immunosuppression), Hematological malignancy , Esoteric cause , Familial cold autoinflammatory disorders

Pt's on biologics : concern for infection with intracellular organism

Relapsing fevers(infective) : Less chance of +ve B/C's , look for hidden clues (Lungs, Smear, Serology)

Doxy Def. Schema

Liver involvement + fever : exclude zoonotic infections

Autoinflammatory disorders : defect in innate immune system

Urticaria + arthralgia : systemic mastocytosis , Schintzler syndrome , NLRP3 mediated disorders

High ferritin : HLH, CAPS, Liver failure…

After excluding secondary causes of HLH, consider primary HLH(genes such as PFTR1, STX, UNC13D…)

HLH Rx: Immunosuppression + RX trigger