# 11/12/25 Morning Report with @CPSolvers

*"One life, so many dreams"* ***Case Presenter****: (Jeffery Shen)* ***Case Discussants****: (Kirtan@KirtanPatolia) & (Sharmin@Sharminzi)*

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

Scribing (Seeme)

**CC**: 24 y old african american male with diffuse itching, fatigue and joint pain for 3 months

**HPI**:

Patient was scratching initially and his mom brought attention to it, he observed nodular hyperpigmented lesions on arms but whole body itching present.

Joint pains more with outdoor activities, no SOB just limitation in activity followed by joint pains in wrist, knees and ankles, intermittent episodes.

**ROS**: denies rash/ulcers, neck swollen sometimes, dry eyes and mouth. No chest pain or tightness and no muscle weakness. 9 months ago- had fever, SOB,arthritis, red eyes-given steroids and antibiotics. Diagnosed with uveitis 2 episodes

**PMH**:
Asthma-no treatment

**Meds**:
Ibuprofen
tylenol

**Fam Hx**:
AI diseases and cancer in family
Mother-SLE, breast cancer
Cousins- 2 crohn's disease, sarcoidosis

**Social Hx:**
Tobacco and marijuana
No pets

**Allergies**: NKDA

**Vitals: T**: afebrile **HR**: 92 **BP**:136/ 80 **RR**:20 **Sat**: 96

**Exam: Gen**: appears well, no acute distress

**HEENT**: eyes appear normal, no erythema or conjunctival injection, mildly tender fullness in area of submandibular and parotid area, cervical lymphadenopathy

**CV**: wnl **Plum:** wnl **Abd**:wnl **Neuro**: no CN palsy, muscle strength normal, no focal deficits

**Extremities/skin**: legs and arm excoriations no rash, small hyperpigmented patches/ plagues nodular with excoriation and hyperpigmented in forearm. Subcutaneous nodules in lower extremity bilaterally. Thick synovium in ankles and wrists bilaterally. Normal range of motion in wrist

**Notable Labs & Imaging**:

**Hematology**:

WBC: 4.5 Hgb: 13 Plt: 172 MCV: 84

**Chemistry**:

Cr: 1.6 BUN:22 AST: 246 ALT: 236 Alk-P:489 GGT: high Bili: 1.3 Albumin: 3.8 Total Protein:9.4 TSH:13.2 (high) free T4: 3.4 (low) CK: 55

ESR: 36 CRP: nl LDH: nl

Quantiferon TB, HIV, hepatitis, syphilis treponemal AB, western blot Lyme, Histoplasma urine antigen:negative

IgG:2800, IgA: 400 IgG1 and IgG3: high

SPEP UPEP: polyclonal hypergammaglobulinemia

Anti mitochondrial. ANA, RF, CCP, ANCA, anti smooth muscle antibody:negative

2+blood, protein

**Imaging**:

CT C/A/P: mediastinal, hilar, mesenteric diffuse lymphadenopathy, mass like lesion in liver, Biopsy cervical lymph node: non specific inflammation

Kidney biopsy: mesangial IgA deposition

Lymph node biopsy: Inflammation with non caseating granulomas

Transbronchial biopsy: AFB and fungal Cx and cytology negative, non caseating granulomas, **next generation sequencing: NOD gain of function mutation**

**Dx: Blau syndrome**

**Problem Representation**: A 24 y old M presented with itching, fatigue and joint pain for 3 months with some hyperpigmented nodules in forearm and diffuse lymphadenopathy.

**Teaching Points (Evan)**

**-Pruritus - skin lesions or no skin lesions at any point. Exogenous (creams, meds, foods) vs endogenous (bilirubin, kidneys, endocrine, rare - autoimmune)**
**-Entire body itching > systemic = infections and autoimmune**
**-With derm findings look for associated problems.**
**-Young pt presenting - more serious because they don't often go to hospital**
**-Exertional intolerance - consider CV, pulm - ultimately muscles are making you work - is disease affecting the muscles**
**-SLE, sarco - we can scrutinize PE for these**
**-episodic uveitis > look for infections - 1st think syphilis(MC) and lyme > HIV, TB. autoimmune - sarco (AA is RF, genetic), IBD/Crohns - GI symp can be minimal**
**-sarco - rule out TB, histo, nocardia, mycobacteria, lymphoma - don't want to suppress immune system if underlying infection**
**-neg ANA makes SLE less likely. Labs are demonstrating infiltrative pattern.**
**-need biopsy to further clarify**
**-young pts think about monogenic > polygenic**