11/21/25 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**:Hee Mun (@) **Case Discussants**: Rabih(@rabihmgeha) & David (@davserantes)

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

Scribing (Shriya)

CC: Fever,Cough,SOB,Rt sided chest pain for 10 days

HPI: A 52-year-old male with 10 days of fever, dry cough, night sweats, dyspnea, and right-sided chest pain that he initially believed was a rib fracture after playing cricket. The pain is sharp and worsens with deep breaths and movement. He reports fatigue and reduced exercise tolerance and denies hemoptysis, abdominal pain, nausea, rash, dysuria, or orthopnea.

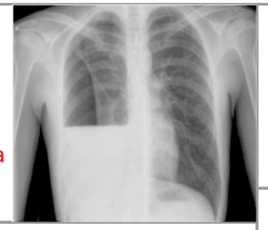
PMH:
HTN
Meds:
Amlodipine

Fam Hx:
Social Hx: Immigrated from India 10 yrs ago

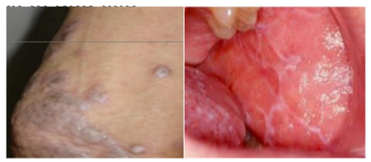
Health-Related Behaviors: chronic smoker (20 pack yrs)

Allergies: No allergy

Vitals: T: afebrile **HR**:108 **RR**: 22 **Sat**: 98%RA
Exam: Gen: mild distress but alert
CV: regular rhythm,no murmur **Abd:nl**
Pulm: markedly decreased breath sound on Rt,mild tachypnea
Neuro: nl **Extremities/skin**: nl



Notable Labs & Imaging:
CBC: Mild lymphocytic leukocytosis ,anemia
HIV/EBV/CMV /Hepatitis panel/viral :negative



CXR: large Rt hydropneumothorax with Rt upper lobe infiltrates/scarring
CT Chest:RUL small centrilobular nodules with branching linear opacities. possible RLL consolidation, calcified hilar lymphadenopathy, and loculated gas pockets within the right hydropneumothorax.

Chest tube placed Pleural drainage catheter inserted into the hydropneumothorax

Pleural fluid: pH 7.3, glucose 13, protein 4.5, LDH 1400, WBC 1340 (64% lymphocytes), RBC 3000, ADA 58.5, serum protein 5.6(protein ratio 0.82)

Pleural biopsy: caseating granulomas, AFB1+,Culture +ve for Mycobacterium tuberculosis.

Started ATT with rifampicin, isoniazid, ethambutol, and pyrazinamide.

After 2 months, he developed severe itchiness with diffuse violaceous rashes, hair loss, hyperpigmented patches, and oral lesions showing fine white lace-like lines.

Exam showed widespread lichenoid eruptions → ATT was stopped and the patient was treated with hydroxyzine, liquid paraffin, and clobetasol; skin improved, and he was placed on levofloxacin + linezolid during the interruption. After four months off ATT, lesions stabilized; rifampicin was reintroduced first, followed by isoniazid and then pyrazinamide (ethambutol avoided), and he completed 9 months of therapy from the time rifampicin was restarted

DX :Pleural TB with hydropneumothorax complicated by ATT-induced lichenoid eruption.

Problem Representation: A 52 yM with fever,cough,SOB,Rt chestpain for 10 days with Rt hydropneumothorax,centrilobular nodules and linear opacities,exudative pleural effusion complicated by lichenoid eruption post ATT(rifampin)

Teaching Points (Magnus):

Inflammation+chest -> lung (CAP), pleura (empyema), heart, pericardium

Chest pain + SOB is worrisome -> think cardiac (ACS, Takotsubo, myocarditis) vs. connective tissue (pleura, pericardium)

Pleural effusion + air (hydropneumothorax):
Trauma -> pneumothorax + bleeding
Spontaneous -> structural lung dz (obstructive, interstitial, cystic)
Rapidly progressive-> think abscess and cancer
In *women*: lymphangioleiomyomatosis (chyle) and endometriosis
A hole in the lung: Lung -> pleura vs. pleura -> lung (primary pleural tumor/infection, endometriosis)
Calcified lymphadenopathy + lymphocytic pleocytosis -> TB

Purple pruritic papules -> lichen planus, lichenoid reactions