12/18/25 Morning Report with @CPSolvers

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

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

Scribing (Eyron)

CC: 69/M with malaise, myalgias to lower limb thigh to calf in the last few weeks. In the last week, noted painless rash in both lower limbs.

HPI:

1 month after discharge from hospital for MI, noted malaise, chills, myalgias, non-exertional. Later developed rash.

ROS:

No chest pain or dyspnea. No arthralgias. No headache or vision loss. No abdominal pain, nausea, or vomiting. No bleeding. No changes in medications.

PMH:

Urothelial bladder lesion s/p TUR and BCG (15 sessions)
NSTEMI s/p 2 stents in RCA (June 2025)
HLD

Meds:

Omeprazole
ASA
Prasugrel
Candesartan
Rosuvastatin

Social Hx:

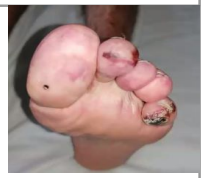
Lives alone, works as a butcher

Health-Related Behaviors:

Smoker 40 pack years
No EtOH

Vitals: T: 36.8 **HR**: 95 **BP**: 110/70 **Sat**: 97% RA
Exam: Gen: NAD
HEENT/CV/Pulm/Abd/Neuro: wnl, no murmurs
Extremities/skin: erythematous, violaceous, palpable, non-blanchable, non-tender lesion in the lower limbs from the knee to the ankle, no lesions on the palms or soles, no edema

Notable Labs & Imaging:



Hematology:

WBC: 6 (normal diff) Hgb: 10.5 Plt: 159k MCV: 96
Coags wnl INR 1.2 PTT 30 Fibrinogen wnl
Iron nl **Ferritin** 800 Tsat 37 | **B12/Folate** wnl

Chemistry:

Na: 136 K: 4 Cl/HCO3: nl Cr: 0.9 BUN: 20 Glucose: 90 Ca: 9.5 Hba1c: 3.7%
AST: 325 ALT: 425 Alk-P: 100 Bili: 1.2 Albumin: 3 Total Protein: 6.5
CRP: 3.3 LDH: 360 CK 120 **Haptoglobin** undetectable C3/C4 wnl
UA - no wbcs, no hematuria, no albuminuria
Coombs Direct/Indirect (+) - IgG/IgA (+), C3/C4 (-), Cryoglobulin (-)
Serologies: EBV IgG (+), Parvovirus IgG (+) HIV, HCV, CMV IgG/IgM, neg HBsAg (-), anti-HBsAg (+), anti-HbcAg (+), VL (-)
SPEP, light chains wnl
Skin bx - small vessel vasculitis with fibrinoid necrosis with negative Ig and C3 deposits
ANA (+) 1:1280, anti-chromatin (+), anti-smith (+), anti-ribosomal P (+), anti-dsDNA (+), anti-beta2 glycoprotein IgG (+), anti-cardiolipin IgG (+), lupus anticoagulant (-), ANCA (-), RF nl, CCP nl, cryoglobulins nl, anti-mitochondrial (+)

Imaging:

TTE wnl | **CXR**: wnl | **PET** wnl | **Abd US** - mild splenomegaly 14cm

Skin lesions were improving on low dose prednisone - though developed necrotic regions on the toes
2-3 months after, pt developed superficial venous thrombosis in great saphenous vein
Pt started on MMF with improvement of symptoms

Dx: SLE with secondary APLS

Problem Representation:

69/M with PMHx of urothelial bladder lesion s/p TUR and BCG, NSTEMI s/p stents p/w myalgias and painless, purpuric rash to lower limbs, found to have splenomegaly. Labs suggestive of autoimmune hemolytic anemia. Skin biopsy revealed small vessel vasculitis with fibrinoid necrosis with serologies revealing high ANA titer and antibodies c/w SLE and APLS.

Teaching Points (Eugene)

New onset rash:

-Systemic cause vrs external.
-palpable purpura: presumed systemic small vessel vasculitis

Myalgias & malaise:

-suggest systemic inflammation.
-Subacute course means inflammatory markers may be mildly elevated.
-Approach to systemic inflammation : consider antigenic stimulus (infection priority due to morbidity (i.e. alive and replicating fast); or inert and slow (drug stimulus); malignancy. Try to answer qx for symmetrically inflamed or aggressively inflamed.

Labs:

-Elevated liver enzymes, normal CK (true liver injury): problem to identify (diffuse (ie exogenous causes from drugs, infection/ endogenous cause from autoimmune, wilson etc) vrs focal lesion (imaging to help)
-Anemia, Raised LDH, undetectable haptoglobin, +ve coombs, low HBA1C but normal glucose- suggest autoimmune hemolysis. Preserved platelet and normal coag test r/o TMA, consumptive coag. Next step to identify primary systemic cause vrs secondary.

Why elderly presenting this way: purely primary (late onset) or triggered by an aggressive antigen (malignancy, BCG syndrome)