



11/29/25 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Franco (FrancoMurilloCh) + Sinai Baltimore Case Discussants: Yazmin (@minheredia) & Jasdeep (@JasBajwa18)
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Julia)
CC: General malaise and B/l shoulder pain
HPI: 62 yo male with 1 year of progressive fatigue. He said that could do activities with difficulty but was not able to walk more than 2 blocks due to fatigue.

Other than that, could not move b/l upper arm up to the shoulder line

ROS: no SOB / CP.

PMH:
Nephrolithiasis
Hypothyroidism
T2DM

Meds:
Metformin
Levothyroxine
Atorvastatin

Fam Hx: none
Social Hx: navy repairing ships. Pacific North. No recent travel

Health-Related Behaviors: no smoking, EtOH or drug use.

Allergies: none

Vitals: T: 37 HR: 98 BP: 120/80 RR: 16 Sat: 98% RA BMI: 26
Exam: Gen: Thin, pale HEENT: no LAD, no oral ulcers
CV: no murmurs, RRR Pulm: no wheezing or crackles.
Abd: nontender, soft, no masses Neuro: no focal signs
Extremities/skin: focal tenderness on b/l AC joints on upper shoulders
Limited range of motion on 90° on shoulder (passive and active). LE preserved

Notable Labs & Imaging:

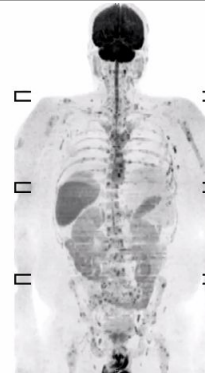
Hematology:

WBC: 3.5 (Lymphopenia 0.72) Hgb: 13.8 Plt: wnl MCH: 30
MCV:.90

Chemistry: Na, K: wnl Cr: 1.28 (Baseline 0.8) BUN: 25
Glucose: 113 Ca: 9.9 pH 3.2 AST, ALT, Bili, Alk-P: wnl ESR: 20
CRP: 2.6 LDH: 152 CK: nl Beta 2 microglobulin: 4.2
SPEP UPEP: wnl IGs wnl CEA: nl PSA 0.74 (nl)

Mycobacteria: neg Vit D: 82 (high) ACE levels: 91. U Ca high
Imaging:

Whole body MRI past hospitalization: numerous bone lesions
Bone scan: no scintigraphic evidence of osteoblastic activity.
CTAP: Chest: small to mild lymph nodes up to 1 cm, parenchyma clear.
Abd/pelvis: b/l renal calculi. No hydronephrosis. No lymphadenopathy.
Bone marrow biopsy: multifocal effacement of the marrow space by non-caseating epithelioid granulomata which are surrounded by moderately dense collagen fibrosis.
Multinucleated foreign bodies cells.
No foreign material is seen by light microscopy.
PET/CT: Marked FDG uptake in multilevel lymph nodes including lower neck, thorax, abdomen and pelvis, splenomegaly as well as multiple foci in the axial and appendicular skeleton.



Dx: Sarcoidosis

Problem Representation: 62 yo M with PMHx of DM and hypothyroidism presented with chronic fatigue, weakness and upper extremities tenderness, found to have leukocytopenia, kidney injury and multiple bone lesion

Teaching Points (Evan)

- Timecourse helpful in working out cause of fatigue. Look for organic causes 1st
- Shipyards - possible occupational exposure to Asbestos, paint, VOCs metals welding, lead
- alk phos can be normal in multiple myeloma in the absence of a pathologic fracture
- both AROM and PROM loss of shoulder can be a sign of adhesive capsulitis. Check an A1C
- bone scans look for hot spots in bone - abnormal bone activity - fracture, infection, tumor, cancer
- Sclerosing bone dysplasias can present without abnormal tracer uptake.
- normal PSA does not rule out prostate cancer.
- ASIA - autoimmune inflammatory syndrome induced by adjuvants