# 1/16/26 Morning Report with @CPSolvers

*"One life, so many dreams"* ***Case Presenter****: Pavandeep (@)* ***Case Discussants****: Rabih (@rabihmgeha) & Lera (@LNovotnaya)*

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

**Scribing** (Mohammed)

**CC**: 68 YO F with Fever, SOB, and SBP of 70-80

**HPI**: Previous hx of freq. admits to the hospital.
Symptoms were like a chest infection, then a general decline in her condition with on/off fever, dec appetite, mobility, and has lost >2 stones in the last 8 months (>28 pounds).
She has ongoing pain all over, and now she is confused.

**PMH**: Was admitted in Zimbabwe in Feb 2025 with chest infection, since then her health has been poor.
No known dx in Zimbabwe.

Recent 1 month admission for reduced mobility, low Hb, SOB

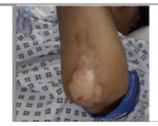
Workup:
CTPA - No PE, consolidative changes RLL, peripheral GGO, subpleural thickening.
CTCAP - hypodense areas in liver
Sputum culture
-pseudomonas
Was well for one week post discharged.

**Fam Hx**:

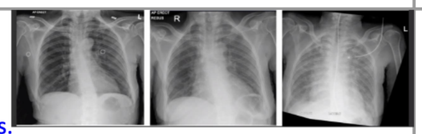
**Social Hx:**
**From Zimbabwe arrived in the UK in 2025**
**Daughter is main carer**
**Previously farmer**
**Now tailor**

Nonsmoker no ETOH. No significant surgical hx

**Vitals: T**: 37.1 **HR**: 113 **BP**: 81/50 **RR**: 20 **Sat**: 96%
**Exam: Gen**: frail, sleepy but arousable, following commands
**HEENT**: dry mucous membranes
**Pulm**: **Bibasal crackles**. Nil else
**Extremities/skin**: hypopigmented rash on elbows, palms and soles



**Notable Labs & Imaging**:



**Hematology:**
Hgb: 76 Plt: MCV:nl Blood film: isolated PMN vaculations.
Previous workup:
Malaria, TB, syphilis negative, connective tissue screen: neg and autoimmune screen: neg,
Blood Cx: staph, Urine Cx: nl, LFT: nl
ESR: CRP: 8 , CK: normal, HBV, HCV, HIV - Not detected,
Serum IgG: 27.38 (H, 16.5) Serum IgA: 5.1 (H, 4) IgM and uric acid normal.

**Imaging:**
CT head: nl
CXR: 1st: no active pathology, scoliosis. 2nd, 3rd: B/L opacification, mild cardiomegaly, congestion
CT chest: Bl patchy GGO, subpleural reticulations, Interlobular septal thickening, small b/l pleural effusion, cardiomegaly (infection vs congestion).

**Hospital course:**
**ESR 116, LDH: 411** CTD workup: negative
Fever spikes with prox muscle weakness ABG T1 RF + progressive swallowing difficulties.
ID consult: no focus of infection, nl inflam. markers.
**Rheum assessment:** Looks frail, healed Gottron's rash on elbows/knuckles, V sign and faint shawl sign, Holster's rash on thighs and knees, Progressive PM weakness + neck flexor weakness.
**Extended myositis panel:** MRI of LL
MRI: **Patchy high signal intensity change within the adductor/gluteus muscle groups** suggest myositis.
**ECHO: TR and high probability of PAH. Anti-MDA-5; POSITIVE**

**Dx: Anti-MDA-5 inflammatory Myositis**

**Problem Representation**: 68 YO F with previous hx of frequent admissions for SOB, presents with fever, SOB, and hypotension, and PMW. Had negative CK, and autoimmune markers. Her Chest CT showed Bl GGO. MRI suggest myositis in lower limbs. Diagnosed with Anti-MDA5 positive myositis.

**Teaching Points** (Sana)

**Rx before Dx**- Stabilize the septic shock first

Acute infection progressing to septic shock w. subacute infl. picture- prioritize infections, AI, malignancy

**Wt. loss:** Multifocal radio+ve ds process – multifocal infection or malignancy

**Vulnerability** to infections – endemicity, occupation, locally (recurrent infl. chest syndrome) – Wrong ds? Wrong rx? Multiple processes at play?

**Approach to the hypopigmented rash**- From previous ulcerative damage/dermatitis, AI destruction of melanocytes, infiltration

**Approach to CT**: B/L diffuse GGOs in the U>L lobes w. mild b/l pleural effusions
**GGO** - substance partially filling the alveoli (Exudate; blood; pus – inflammatory (infectious or sterile); cells; protein)
– indicative of mild inflammatory process

**Pulmonary infiltrates** (likelihood of pathology being alive {+replicant potential} infections/malignancy as opposed to indolent (AI, gout)
→ consolidation > nodules > GGO > fibrotic changes of ILD
Weight loss + GGO - Acute superimposed infection or AI (Vasculitis, inflammatory myositis & RA)
Oropharyngeal dysphagia + proximal ms. weakness – protect the airway