3/17/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: (Eugene@EugeneBondzie)* ***Case Discussants****: (Ravi@rav7ks) & (Mengyu@zhoumy07)*

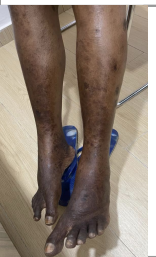
https://clinicalproblemsolving.com/present-a-case/

Scribing (Seeme)

CC: 36 yr old F with 3 months of fatigue, joint pains and 1 month of evolving rash

HPI: 3M ago developed **insidious onset fatigue** and reduced exercise tolerance, progressively worsening, Followed by generalized **joint pains** involving both small and large joints symmetrically, no swelling, deformity, or morning stiffness. A month after, she developed numbness and abnormal sensations described as **burning, coldness, and tingling in both feet and legs**, with no associated limb weakness or gait disturbance. Also noticed skin lesions, not itchy, not painful and non-ulcerating. She reported intermittent retrosternal **chest discomfort**, worse when lying flat and relieved on sitting up, associated with palpitations but no exertional component.

ROS: occasional night sweats



PMH: not significant

Meds:
-

Fam Hx:
-

Social Hx: Health-Related Behaviors:
-

Allergies: NKDA

Vitals: **T**:36.8 **HR**:108 **BP**: 118/72 **RR**: 18 **Sat**:98% on RA

Exam: **Gen**: appeared chronically ill and pale

HEENT: nl

CV: nl

Pulm:nl **Abd**: nl **Neuro**: nl

Extremities/skin: livedo-reticularis-like mottling over both lower limbs and non-blanching purpuric lesions scattered on the trunk and extremities. symmetrical joint tenderness affecting the wrists, knees, and ankles, without swelling, deformity, or restriction of movement.

Notable Labs & Imaging:

Hematology:

WBC: 8.2 Hgb:6.1 Plt:203 MCV:88

Imaging:

Ekg: sinus tachycardia and T-wave changes in leads II and aVF.

Echo:grade I diastolic dysfunction

Chemistry:

Na: 133 K: 4.5 Cl:nl HCO3: nl Cr: 0.53 eGFR: 142 BUN: 12.9 AST:nl ALT: nl Alk-P: nl Bili: nl Albumin: nl Total Protein:nl ESR: 150

Reticulocyte count: 3%. HIV, Hep B and Hep C : neg

Peripheral blood film: normocytic normochromic anemia, no schistocytes or blasts. LDH 320 U/L. Haptoglobin normal

Direct Coombs test: positive.

UA: 3–4 RBCs +trace protein.

Urine protein–creatinine ratio: 0.25 g/g, ANA: 1:400,

Complement levels: C3 0.55, C4 0.08

Anti-double stranded DNA antibodies: high titer.

RF: neg, anca: neg, APLS antibodies: neg

Dx: SLE (Systemic Lupus Erythematosus)

Problem Representation: A 36 y old FM presented with fatigue, joint pains and evolving rash for 1 month associated with burning and in tingling in feet and legs. Rash appeared as livedo reticularis like mottling over both lower limbs and non-blanching purpuric lesions on trunk and extremities along with tender joints of knees, ankles and wrists. Coombs test was positive and reticulocyte count was found to be elevated. High titer of anti-double stranded antibodies was present.

Teaching Points (Krishna)

- **Rash:**
- Primary skin or footprint of Systemic disease
- **Nature of the rash** (macule, papule, purpuric, nodular) +/- Secondary changes(scaling, fissuring). Purpura- Bleeding problem/Vessel problem(Non-blanching, Reticular pattern hints at vessel)
- **Site/Distribution**(Involve palm,**soles**; centri-petal/fugal)
- **Symptoms:** Pain, itching, joint swelling; associated fever
- **Associated involvement**(hint systemic nature)- **Skin + Joints**- Immune complexes can deposit in those sites; Infection (Bacterial, viral, spirochetal, fungal)

Footprints for a systemic disease: Rash + Joints + Nerves

Vasculitis, Autoimmune disease, infection, Malignancy

- **Typical(3S's- Symmetric, sensory, slow) vs atypical neuropathy** (AIDP, AIP, Autoimmune; B-Vitamins,C- Cauda equina, D- Drugs/heavy metal toxicity)
- **Joint involvement** - monoarticular/polyarticular
- **Vasculitis**(Immune complex, antibody- ANCA mediated, complement-mediated, cryo-mediated; Vasculitic-like: Endocarditis, malignancy); Livedoid lesion- Medium vessel

Footprints for Inflammation: Multi-organ involvement(skin, rash, joints) + Low Hb + ESR

Anemia

Low Hb→ when RPI is low(<2)- Marrow; when high(>2) - blood loss (sequestration, destruction–intracorpusular (membrane)or extracopusular→intravascular→ MAHA extravascular → AIHA)

Haptoglobin- can be tricky to interpret (Hemolysis + Inflammation → falsely normal)

DCT positive: Check if IgG + or C3 positive