



# 4/12/26 Morning Report with @CPSolvers



“One life, so many dreams” Case Presenter: Seeme(@youcantsee\_me) Case Discussants: Kirtan(@KirtanPatolia) & Maddy(@MadellenaC)  
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Gillian)

**CC:** 49 yo male w/ hx tb and seronegative RA admitted to hospital for fever, progressive dyspnea, rash, and MSK symptoms.

**HPI:** 9 wks ago developed fatigue, sleepiness, rhinorrhea thought to be viral. Patient partner noticed heavy snoring and apneic episodes

1 week later developed polyarticular joint pain after crawfish night before and got short course of prednisone.

Went to rheumatology to r/o gout. TTP in back, legs, knees, and feet w/o evidence of inflammatory arthritis. Uric acid at 6.2 mg/dl but neg serologic testing except positive ANA. No evidence of erosive disease x ray.

Diagnosis of seronegative RA and right sided carpal tunnel syndrome. Started on prednisone and hydrochloroquine + wrist brace. Re-developed joint pain, sensation of heaviness, hand weakness (dropping object), numbness.

Rash on left upper arm in biceps after bitten by spider. Used otc antihistamines and cream. Skin biopsy showed dyskeratotic interface dermatitis. Not sure if it improved after 10-day glucocorticoids. Got 40 mg prednisone with improvement but then worsened w. Fatigue, swelling around eyes w/o blurriness or redness, intermittent shaking chills, poor appetite, heartburn, oral ulcers, sensation of food stuck in throat, 10 lb wt loss. He was bed bound for the week. Presented to ED for severe dyspnea + CP.

**PMH:** Tb (status post treatment 6 yrs ago) **Fam Hx:** negative **Social Hx:** previously incarcerated (last 2 yrs ago), from southeastern US. No travel, pets, animal exposure **Health-Related Behaviors:** smoked for 20 yrs quit 4 yrs ago; alcohol and cannabis use infrequently

**Vitals:** T: 105 HR: 120 BP: 98/62 RR: Sat: 60% BMI:  
**Exam:** Gen: resp distress, critically ill  
**HEENT:** aphthous ulcers under lower lip and soft palate, teeth missing, nontender cervical LAD, mild symmetric periorbital, facial, neck swelling  
**CV:** tachycardic, no m/r/g; ttp chest relieved leaning forward  
**Pulm:** increased WOB, coarse breath sounds, diffuse crackles  
**Neuro:** A&O, ½ proximal muscle weakness affecting hips & shoulder, ¾ right hand grip weakness limited by pain; mild paresthesias in all extremities  
**Extremities/skin:** faint erythematous papular eruption over knuckles, periungual erythema, erythematous/violaceous plaque w/ central ulceration and eschar on left arm over biceps w/ papulonecrotic lesions. Subcu crepitus like bubble wrap and edema on chest wall and neck. Nailfold capillaroscopy w/ abnormal dilated capillaries w/ dropout Numerous tattoos w/o erythema or tenderness

### Notable Labs & Imaging:

**Hematology:** WBC: 20k w/ neutrophilic predom Hgb: 8.1 Plt: 89k MCV: 88; **Chemistry:** nl  
CK: 500; TSH: 0.28 FT4: 0.47  
**Urine:** Udrug: neg UA: No protein or blood HIV: neg  
**Infectious:** Blood cx: neg Resp viral panel: neg (hep A, B, C, parvovirus, mycoplasma, syphilis, gonorrhea, chlamydia PCR) EBV monospot: pos Quant TB gold: positive Rocky mountain spotted fever, anaplasma, ehrlichia, crypto, histo, blasto all neg  
**Rheum:** ANA: 1:320 Anti SSA: pos nuclear antigen panel negative, anti ccp positive, P-ANCA pos but then myeloperoxidase and proteinase 3 negative. Repeat ANCA negative  
**Imaging:** EKG: serial ECG show sinus tachycardia w/o ischemia (trop neg) CT chest: interstitial markings in peripheral&posterior UL, honeycombing in lower lobes, scatter ggos, enlarged right hilar lymph node, no VTE, concerning for pneumomediastinum and pneumopericardium CT abdomen: bilateral renal cysts Induced sputum cultures sent for AFB; bronchoscopy show gram negative bacilli  
**Dx:** anti-MDA5 myositis

**Problem Representation:** 49 yo M previously diagnosed with seronegative RA presents with severe hyperacute dyspnea, fever, multiple skin findings, and proximal muscle weakness on a subacute history of rash, myalgias, oral ulcers, and fatigue was found to have anti-MDA5 myositis.

### Teaching Points (Glen)

- Rash: Distribution and morphology?
- Fever and systemic symptoms: Inflammatory process?
- Seronegative RA & TB: How were they diagnosed? Tx given?
- Seronegative RA: symptoms and classic radiologic findings of RA, but negative antibodies. Could be better labelling it inflammatory arthritis of unknown cause since no radiologic evidence.
- Snoring: no risk factors of OSA, could be a neuromuscular abn esp with heart burn and dysphagia.
- Joint pain: arthritis vs arthralgia vs myalgia (could be triggered by trauma).
- Not responding to steroids: Underdosing or steroids exacerbating symptoms.
- Oral Ulcers: Other autoimmune disease e.g Behcet.
- Post Infectious: Can cause secondary inflammatory arthritis or autoimmune disease.
- Interface Dermatitis: Unique to autoimmune diseases.
- Proximal weakness, Lung Involvement & Typical Rash: myositis like dermatomyositis[MDA5] but unlikely to cause other symptoms.
- Bicytopenia: r/o hemolytic anaemia, niritonal abn, HLH(can be triggered by SLE, still, MDA5, gauchers).
- Multiorgan involvement: MDA5 but doesnt cause oral ulcers.
- Positive anti-SSA: Correlated with severe ILD and associated with MDA5.