7/4/26 Complexity^2 with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Jeffrey Shen (@)* ***Case Discussants****: Kirtan Patolia (@KirtanPatolia)*

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

Scribing (Seeme)

CC: 52F with **acute L shoulder pain,** that started abruptly during the night, **L UE** weakness

HPI: Presents with acute severe left shoulder pain that awakened her from sleep approximately one day prior to presentation. Within hours she developed inability to lift the left arm marked proximal left upper extremity weakness paresthesias involving the left shoulder and upper arm and numbness.

ROS: subacute weight loss and early satiety, constipation and diarrhea, intermittent axillary LAD for 4 years
Reports chronic numbness involving the left thumb, index finger, and middle finger chronic bilateral foot numbness from the midfoot distally

PMH: Seropositive RA
Osteoporosis
GERD, HLD, T2DM
depression

Meds: MTX
Hydrocortisone
Prednisone 5-15 mg

Vitals: nl Exam: Gen: thin,**white plaque on tongue, ulcers hard palate**, bl axillary **LAD**
CV, **Pulm**, **Abd**: nl
Neuro: CN nl. Proprioception deficit [?]. R UE nl, **L UE ⅘ in deltoid and biceps,** 5/5 in other parts of UE, **bilateral LE weakness** ⅘ R & ⅗ L, 3+ reflexes in lower extremities, absent in biceps L,preserved in L triceps.
Extremities/skin: salt and pepper skin, sclerodactyly, no active synovitis

Notable Labs & Imaging:
CT head: no bleed, lesions in skull
MRI brain: scattered white matter lesions, ill defined skull base abnormalities-post traumatic osteolytic lesions
Hematology: WBC: 6 Hgb: 9.4 **Plt**: 531 MCV: 96
Chemistry: nl **UA**: nl, **ESR & CRP:** high
Hiv, syphilis, hep A B C, quant TB: neg
Nutritional: Vit B12, D, A, K , albumin and protein - all low
ulcers :candida albicans positive
ANA: 1:2560**, ACA** high**, anca, complements and AI panel neg**
EGD & colo: both nl. **Random Bx:** gastric nl, esophageal - nonspecific esophagitis
CT A/P: L paramediastinal mass 4 cm, cervical hilar, axillary LAD, BL pleural effusions, liver nodular lesions
SPEP, IFE, SFLC, UPEP:nl
MRI spine: T12 compression fracture, osseous lesions c5,c6,t7,t11-L1 spinal cord compression
Axillary Biopsy : CD20 positive, BCL positive cyclin D1 neg, large follicles with attenuated mantle zones, CD20 positive follicular lymphoma grade 3
Biopsy of vertebral lesions: germinal center B cell lymphoma

Dx: Follicular lymphoma with Richter's transformation into B cell lymphoma with systemic scleroderma with conus medullaris and plexopathy

Problem Representation: A 52 y old FM with PMH of RA, osteoporosis, GERD, HLD, T2DM presented with L shoulder and and left upper extremity weakness with osteolytic bone lesions associated with LAD.

Teaching Points (Sana)

Define the problem: localization, time course
Numbness/tingling- Attributable to DM alone? r/o other causes
Pain:
Source - Osteoarticular? Neuropathy (classically length dependent - axons affected first d/t relatively lower metabolic support), Radiculopathy (often pain predominant syndromes)? Spinal cord? - exam indicative of peripheral localization.

Asymmetric distribution:
- Compression
- Vascular phenomenon (e.g. mononeuritis multiplex)
- Autoimmune (e.g. idiopathic brachial plexitis)
- Further testing: MRI spine w/ vasc. Protocol, EMG NCS

Salt and pepper skin + sclerodactyly : Systemic sclerosis? Scleroderma

Wt. loss:
-d/t scleroderma? Pan GI ms. involvement (achalasia, constipation) -> reduced PO intake?
- Protein losing enteropathy? Pancreatic vs intrinsic bowel wall pathology?
- Malignancy? MCTD associated w/ increased r/of solid and hematological malignancies.

Lung + Bone:
- Granulomatous disease (TB, histo, blasto, cocci, nocardia)
- Neoplastic causes
- Histiocytic disease, genetic causes…
- Autoimmune
  - ANCA associated vasculitis vs Sarcoidosis