6/24/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Jahanvi (@jahanvi_grover)* ***Case Discussants****: Kirtan (@KirtanPatolia) & Ravi (@rav7ks)*

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

Scribing (Varsha)

CC: A 34-year-old man PMHx of Crohn's disease presents for evaluation of weakness and fatigue. Several days before the presentation, he noticed difficulty climbing stairs. He found himself pulling his body upward with his arms because his legs felt weak. It was associated with pain in b/l anterior thighs. By the time he reached the top of the stairs, he felt exhausted and unexpectedly fell asleep.

HPI H/o tingling, numbness, muscle twitching, and pain involving both arms and his left leg .H/o chronic low back and hip pain. He has pain in his hands associated with numbness/tingling that he attributed to carpal tunnel syndrome. Flexing his neck and looking downward causes electric shock-like sensation radiating down his arm. H/o intermittent headaches x 1 year more in frequency now, worst in the morning and improved with pain meds. C/o severe fatigue, the need to take naps and falling asleep frequently.

ROS:

+ for occasional night sweats (on and off x 10 years), No abdominal pain, diarrhea, hematochezia, oral ulcers, fevers, weight loss, or inflammatory eye symptoms. No recent infections or illnesses.

PMH:
Crohn's disease

Meds:

Azathioprine
Acetaminophen
Multivitamin
Zoloft

Fam Hx: -

Social Hx: -

Health-Related Behaviors: -

Allergies: -

Vitals: T: afebrile **HR**: 82 bpm **BP**: 153/94 mmHg **RR**: 16 **Sat**: 99% on RA **BMI**: 31

Exam: Gen:

HEENT: wnl **CV**: wnl, **Pulm**: wnl, **Abd**: wnl

Neuro: N tone, No fasciculations or atrophy, weakness of R 5th finger abduction, ⅘ of R 5th finger FDP, L hip flexion ⅘ , R hip flexion ⅘, Pain + R cubital tunnel and medial elbow, + Patrick's test on the L, - Patrick's test on the R, Reflexes: 1+ B/L in UL and LL, plantar mute

MSK: L achilles enthesitis, hip pain on FABER test → B/L sacroiliitis?, No other synovitis or restricted ROM

Notable Labs & Imaging:

Hematology:

WBC: 5.8 Hgb: 15.1 Plt: 250 MCV:

Chemistry:

Na: 141 K: 4 Cl:106 HCO3: 27 Cr: 0.8 BUN:22 Glucose: 70 Ca: Mg:
AST: 34 ALT: 26 Alk-P:60 Bili: 0.4 Albumin: 4.3 Total Protein:7.6
ESR: 8 CRP 0.3 LDH: CK 58 Uric acid: 5.6 HgA1c 6.5%
Vitamin B12 612 pg/mL, MMA 0.13 µmol/L, Cu 98 µg/dL, TSH 1.6 µIU/mL,Vit D 16 ng/mL
SPEP/IFE negative, ANA, ENA, C3/C4, RF, CCP, HLA-B27 negative,
HIV, syphilis,TB gold, hepatitis A/B/C negative

Imaging:

X Ray L hip: OA changes and sacroiliac joint abnormalities

Sleep study:+for mild-moderate obstructive sleep apnea

MRI C and T spine: T spine: small multilevel disc protrusion, C6- C7: R paracentral disc osteophyte complex, b/L uncovertebral hypertrophy→ mild canal stenosis, SC compression, moderate L foraminal neural narrowing, severe R neural foraminal narrowing, focal T2 hyperintensity at this level

Further ROS: frequent sweats and sweat rashes, oily skin, acne, multiple skin tags, dental issues and cavities, erectile dysfunction x 1 year

IGF1: 1077 (54- 310), Prolactin 160, GH wnl, testosterone wnl,

MRI Pituitary: 1.8cm sellar mass

Patient underwent Transsphenoidal resection of pituitary adenoma IHC + for GH & Prolactin

Dx: Acromegaly due to mixed Growth hormone and prolactin secreting macroadenoma

Problem Representation: 34Y/M with PMHx of Crohn's presented with ⅘ of weakness & fatigue with ROS + for night sweats, increased day time sleeping, headaches, skin tags, hyperhidrosis, acne, Erectile dysfunction, premature degenerative MSK changes (as evidenced by imaging), with exam revealing HTN, elevated BMI and blood work + for elevated HbA1c, IGF and prolactin. MRI revealed 1.8cm sellar mass → + for pituitary adenoma and was diagnosed with Acromegaly due to mixed Growth hormone and Prolactin secretion.

Teaching Points (Vanessa)

With respect to **past medical history diagnosis:**

1. Understand how diagnosis established (clinical syndrome, pathology, exclude alternative diagnosis).

2. Crohn's disease - where does immune system target (within bowel or outside), how immune complications can tie into his current presentation of weakness.

Weakness:

1. Understand a pt symptoms (i.e. what they mean by weakness and the location of it, how is it impacting their function). Understand the true extent of weakness. This degree of weakness is quite abnormal.

Buzz Words: (system 1 thinking)

1. Night sweats - systemic inflammatory response, chronic infection, malignancy

2.Lhermitte sign - flexion of neck → electric shock sensation down through body. Etiologies (MS, transverse myelitis, neuromyelitis optica, cervical spinal disorders, nutritional def affecting posterior column - B12 and copper)

When there is a lot going on → **try and localize**

-**Weakness**→ blood (excess or deficiency), muscles (myopathy/myositis), nerves, spinal cord (possible underlying structure disease - OA apparatus, meninges)

-**Headaches** →red flag (worse in am). Understand headaches through the lens of meninges, vessels (arteries/capillaries/venous sinus), intracranial pressure.

-**Sleep disorders** →hypothalamic/pituitary/brain stem axis

-**Muscles** →innervation of diaphragm/? weakness causing hypercapnia

Meds - look for those with narrow therapeutic window/toxicity
Azathioprine - can cause myalgia/myositis. ?Trial of taper.
Immunosuppression - not mount typical signs(fever, wbc). Increased risk of infections and malignancies due to immune dysregulation.

Exam findings that you can't localize → additional investigations helpful.
C-spine defects can produce weakness in all extremities. Exam of reflexes may be flawed.
C-spine ligaments may be involved, especially with other ligament involvement (Spondyloarthritis)

Hb is normal + HCO3 elevated → suggestive of chronic hypoxia.
Sacroiliitis - bilateral (inflammation), unilateral (OA).Negative data helps make progress →left with CNS.
Discordant data →What is actually dysfunctional to pt →**substance and endocrine effects** (cortisol excess →skin tags, DM (**GH excess).**