7/23/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Javier (@)* ***Case Discussants****: Rabih / Jeffrey*

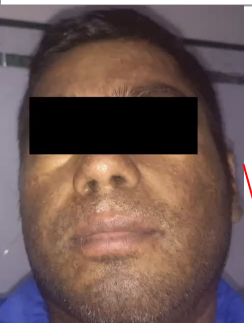
https://clinicalproblemsolving.com/present-a-case/

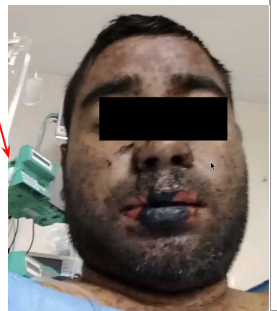
Scribing (Lourenço):

CC: 37yo male, 2 week Hx of **fever, progressive jaundice** and **blistering rash of the face and mouth**

HPI: Symptoms began 15 d ago w/ subjective fevers f/b yellowish discoloration of the skin w/ vesicular and bullous lesions on the face, and sore throat w/ persistent oral dryness (difficulty swallowing food w/o sips of water). Self rx w/ naproxen with partial improvement f/b worsening -> Oropharynx became erythematous and eroded w/ appearance of new blisters and he developed several days of watery, non-bloody stools.

PMH // Meds // Fam Hx // Allergies: none
Social Hx: recent contact w/ vzv ptn
Health-Related Behaviors: 0





Vitals: T: febrile (38.6ºC)
Exam:
HEENT: scleral and cutaneous jaundice. Dry oral mucosa. Mucocutaneous blistering rash + malar rash >> progressed to necrotic / hemorrhagic lesion of both lips
CV // Pulm // Abd // Neuro: normal

Notable Labs & Imaging:
Hb: 9.1 MCV: 88 WBC: 4.1 Plt: 114 Retic count: 4.8%
AST: 165 ALT:189 ALP: 148 Alb: 2.9
T.Bili: 11.35 D.Bili 7.77 I.Bili: 3.78 → 5.78
Negative HIV, Hep B and Hep C serologies //
Negative Dengue and Chikungunya PCR tests //
Negative tests for EBV, CMV and VZV

CT scan: marked hepatosplenomegaly.
LDH: 486 Hapto: < 10 Ferritin: 3240
TAD: IgG positive ANA: 1:1280 Anti dsDNA: high titer Anti-Smith: high titer C3: low

Ptn started on steroids for suspicion of Rowell syndrome w/ improvement.

Dx: SLE w/ Sjogren's syndrome

Problem Representation:

Teaching Points (Lourenço):

- **Identify patterns to build the DDx**. All 3 features at the beginning have some specificity >> analyze all of them separately to see were they connect.
- **Hemorrhagic / necrotic lesion of the lips** - when faced with a rash, try to understand if it's a primary skin disease, or a systemic disease. The mucosal involvement points to internal organ compromise. To make progress, either do a biopsy of the lesion, or do an internal organ inventory.
- **The sequence of events matters** - jaundice and then rash is not typical of disseminated zoster. We also have to consider the *tempo* of the disease (truly acute VS subacute with acute recognition).
- **Mixed cholestasis** - usually points to involvement of intrahepatic bile ducts (VS biliary stones with marked direct hyperbilirubinemia).
- **Pancytopenia** - think of the 4s (space occupation, substances, stem cell or systemic diseases). In simpler terms, think of bone marrow involvement or not. Before going to the marrow, a visceral organ inventory can clarify the problem.
- **Symmetric diffuse inflammation** - this points to immunological activation, either triggered by an antigen (++ intracellular virus / bacteria / drugs) or by immune dysregulation. A prolonged disease points to immune dysregulation, which can be malignant or non-malignant. The localized rash is concerning for pemphigus vulgaris, which can be paraneoplastic (++ 2nd to liquid cancers).
- **Time is a very powerful tool** - for diagnosis and treatment. Autoimmune diseases have very distinct patterns and are cyclical in nature ("flares"). Although the clinical picture isn't typical of SLE, since there was improvement with steroids, this points to autoimmunity. If there was no improvement, think of antigen stimulus.