10/21/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Zachary & Jeffrey <3 **Case Discussants**: Sharmin (@Sharminzi) & Kirtan (@KirtanPatolia)

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

Scribing (Hafsa & Lera):
CC: 64Y woman with persistent **L flank pain** for 6 weeks
HPI: Intermittent -> persistent, dull ache in her left flank that did not radiate to the groin region and was was not associated with meals, urination, movement or changes in position,acetaminophen provided little relief she reported no history of preceding trauma

ROS: fatigue, decreased appetite, weight loss 2.5 kg, intermittent pain & 20-30 min morning stiffness of shoulders and hips

PMH:
MS with no recent activity

Fallopian tube carcinoma s/p **chemotherapy** c/b sensory neuropathy

Meds:
Tylenol PRN
Gabapentin
Vitamin D

Fam Hx: —

Social Hx: —

Health-Related Behaviors: —

Allergies: —

Vitals: T: 37.2 (99 f) **HR**: 88 **BP**: 138/76 **RR**: 16 **Sat**:98 RA
Exam: Gen: AO | **HEENT**: no LAD | **CV**: nl, LE pulses palpable | **Pulm**: CTAB
Abd:soft , mild discomfort on deep palpation,of the left lateral abdomen and flank, no guarding or rebound tenderness,no palpable mass or cva tenderness
Neuro: reduced vibration sensation at the toes, motor exam nl

Notable Labs & Imaging:
Hematology: WBC: 9.4 [71% N, 19% L] **Hgb**: 10.9 →*12.6* **Plt**: 488 →*274* MCV: 89
Chemistry: Na: 138 K: 4.2 Cl: 102 HCO3: 26 Ca: 9.2 BUN: 16 Cr: 0.9
Glu: 96 AST: 20 ALT: 18 ALP: 108 T. Bili: 0.4 T. protein: 7.1 Alb: 3.3
ESR: 83 →*14* **CRP**: 8.8→*2.0* LDH: 180 CK: 54 TSH: 2.15

Blood culture; neg **Urine culture;** no growth **U/A**;nl
HIV, HBV, HCV, IGRA, syphilis: neg **TTE:** neg
CT A/P: thickening of aortic wall **CTA**; diffuse aortic wall thickening from the descending aorta into the abdominal aorta with involvement of subclavian artery
Rheumatology: nl **SPEP, IFE, SFLC:** nl
PET: hypermetabolic wall thickening of aorta L subclavian origin, no LAD / masses

-> Empiric prednisone 60 mg daily initiated with improvement of flank discomfort and appetite,ROM, and reduction in stiffness of hips and shoulders,tapered over 1 yr , 9 months into taper she developed ***acute loss of vision in left eye****,reported that the vision appeared dim and and blurred,*
Visual acuity R/E ;20/20 L/E ;20/100 (+) RAPD and reduced color discrimination on L, nl EOM, inferior altitudinal visual field defect in L eye.

MRI: left optic neuritis with enhancement in anteromedial left pons and along the superficial left temporal artery

Dx; GCA (Giant cell arteritis)

Problem Representation: 64 year old woman p/w acute painless left mono ocular vision loss, LAPD,dyschromatopsia and an inferior altitudinal visual defect.

Teaching Points (Hans)

Left flank pain (subacute): anatomical approach from skin muscles to internal organs kidneys, spine, mass, obstruction, PMH sig for past fallopian cancer.

Constitutional sx w/ am stiffness: malignancy vs autoimmune eg. spondylitis., PMR(paraneoplastic), vasculitis. CT angiogram to r/o vascular cause.
s/p chemo → liquid tumour.

Thrombocytosis (400 000), ESR, CRP high: Reactive thrombocytosis: infection, inflammation tissue damage, malignancy (iron deficiency can cause a high platelet count) Get imaging Pt's presentation speaks against malignancy and infection (normal WBC), yet to be ruled out.

CT angio, PET: wall thickening of aorta an and subclavian artery.: vasculopathy vs autoimmune vasculitis (GCA age 70 -80, Takayasu age< 55). Vs infection(eg syphilis) in big artery vs IgC4 related vasculitis

Clinical course prednisone taper: Left monocular vision loss suspicious of GCA(vision loss permanent), vs optic neuritis(painful) vs uveitis vs scleritis(deep eye pain). PMH includes MS!.

MRI brain: optic neuritis w/GCA.