9/15/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Kaleem* ***Case Discussants****: Ravi (@rav7ks) & Anmolpreet (@anugrewal19)*

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

Scribing (Meghna):

CC: Patient presents to the outpatient department with a 1 mo history of worsening low back pain, generalized body aches, and difficulty walking.

HPI: A 29-year-old man reports several years of chronic, mild lower back pain that has significantly worsened over the past month. It was insidious in onset, gradually progressive, worse at night, with morning stiffness, worsening with rest, and improving with exercise. It has progressed to affecting his day-to-day mobility. He reports gradual-onset body aches over the same month, had mild, intermittent episodes before that. He points to the back of both heels, around both knees, and near his elbows, though he finds it hard to localize precisely. He describes it as dull ache, worse after sitting or lying still, worse in the mornings and at night, and reduces on activity.

He also reports difficulty walking, no weakness or numbness, no tingling, no leg giving way, but stiffness limiting his movement. It's worse in the morning and after sitting, improves with activity but never fully resolves. He now has trouble walking independently. He reports b/l knee pain over the same period, with no preceding injury, with occasional swelling, worse after rest, better with movement. This has made prolonged sitting and moving around increasingly difficult.

ROS: No h/o trauma, psoriasis, eye redness/pain, burning micturition, bowel or bladder incontinence. Reports dark, tarry stools for the past 2 mo, and fatigue. No h/o unprovoked fevers, night sweats, unintended weight loss, rashes, photosensitivity, GI symptoms like diarrhea or abdominal pain or any visual problems.

PMH:
Migrating, intermittent joint pain for past few years

Meds: NSAIDs

Fam Hx: Nil

Social Hx: Nil

Allergies: Nil

Vitals: T: afebrile **HR**: 78 **BP**: 110/70 **RR**: 18 **Sat**: 98 **BMI**: -

Exam:

Gen: N **HEENT**: N **CV**: N **Pulm**: N **Abd**: N

Neuro: Power 5/5 in all major muscle groups. No focal weakness. Sensation intact to light touch in B/L lower limbs. No numbness or tingling reported, no radiation posteriorly or downward.

Knee examination: B/L effusion at knee joint, no warmth or erythema. Tenderness localized to the patellar tendon insertion. Range of motion full but uncomfortable at extremes of flexion.

Gait: Stiff, cautious with short steps

Extremities/skin: L lateral epicondyle tenderness, no swelling or warmth. B/L achilles and patellar tendon tenderness at insertion, no warmth or swelling. Difficulty extending both legs, no visible joint swelling. R big toe shows a deformity, with deviation, mild swelling of the base. Non-tender, no overlying skin changes.

Spine: Limited cervical spine movement, reduced lumbar flexion, loss of lumbar lordosis. B/L tenderness over paraspinal muscles > midline spinous process. Tenderness over B/L PSIS. FABER B/L +ve

Notable Labs & Imaging:

Hematology: WBC: 15.1 Hgb: 8.6 Plt: 250 MCV: 62.2

Chemistry: Na: 135 K: 4.8 Cl: 98.4 HCO3: N Ca: N Mg: N BUN: 19 Cr: 0.47 Glu: N AST: N ALT: 30.4 ALP: 186.8 T. Bili: 0.52 T. protein: N Alb: N ESR: elevated CRP: elevated LDH:

Infectious workup - N

Imaging:

CXR: Normal

MRI : Reduced joint space bilaterally, subchondral sclerosis, irregular joint margins, edema on STIR sequences

Dx: Acute flare of ankylosing spondylitis, with microcytic anemia due to chronic NSAID use.

Problem Representation:

A 29-year-old male, with a history of migrating, intermittent joint pain presents with lower back pain and difficulty walking. On examination, B/L knee effusion is noted, inflammatory markers are elevated and MRI shows reduced joint space with subchondral sclerosis.

Teaching Points (Kris)

Patient with **low back pain, generalized weakness, and difficulty ambulating**, first consider the **patient's age and sex**, can influence Ddx.

Assess for **red flags**, especially **progressive or worsening symptoms**, focal neurologic deficits, bowel or bladder dysfunction

Determine whether is a **systemic process** or a **localized musculoskeletal/neurologic process**.

Characterize the **gait pattern**

Clarify the **time course**:Acute, Subacute, Chronic

In a **young patient with back pain**, consider an **inflammatory etiology**, particularly **spondyloarthritis**. Ask whether other joints are involved and characterize:

Monoarticular vs polyarticular, Symmetric vs asymmetric, Axial vs peripheral, Migratory?

Morning stiffness? Improvement with activity versus rest

For **polyarticular joint pain**, the differential includes:

Autoimmune/inflammatory: rheumatoid arthritis, SLE, spondyloarthritis, psoriatic arthritis

Infectious/post-infectious: HIV, hepatitis, disseminated gonococcal infection, Chlamydia-associated reactive arthritis, viral arthritis, **IBD-associated arthritis, Whipple disease, Reactive arthritis** following gastrointestinal infections such as Shigella, Salmonella, Campylobacter, or Yersinia

If there is a **joint effusion**, perform arthrocentesis when indicated and evaluate:

Synovial WBC count and differential, Gram stain and culture, Crystal analysis, A synovial WBC **>50,000 cells/mm³**, raises concern for **septic arthritis**

Pain at a **tendon or ligament insertion** suggests **enthesitis**, which supports a diagnosis within the **spondyloarthritis spectrum**.

Perform a **skin and eye examination**, looking for:Erythema nodosum or pyoderma gangrenosum, **Uveitis etc.**

For an **acute monoarticular or markedly asymmetric swollen joint**, septic arthritis must be excluded.

On physical examination assess: Active and passive ROM, Swelling, warmth, erythema, Point tenderness, Strength and neurologic findings

Sacroiliac joint involvement suggests **axial spondyloarthritis**, including IBD-associated axial disease.

If **IBD is suspected**, ask specifically about, can do colonoscopy

Also look for extraintestinal manifestations such as: Peripheral arthritis, Sacroiliitis / axial spondyloarthritis, Enthesitis, Erythema nodosum, Pyoderma gangrenosum

Initial evaluation may include **CBC, CRP/ESR, iron studies, stool studies when infection is possible, and fecal calprotectin**. Image: spine x-ray or spine MRI