9/29/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Jahanvi)* ***Case Discussants****: Sarah, Kuchal and Ravi*

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

Scribing ():

CC: 58 M presents with pain and numbness in his right leg

HPI: He presents after he had 1 episode of cough and dyspnea which woke him from sleep.After he developed pain and numbness in his right leg.

Intermittent headaches + pressure behind left eye + slight blurring of vision.

Had a mango and the next start feeling something in the neck

PMH: Rheumatoid Arthritis
Chronic back pain, received spinal injections
But no surgery.

Meds: Used to be on Methotrexate, pain medication for the back pain including spinal injections.

Fam Hx: Brother had multiple myeloma

Social Hx: truck driver, lives in NC

Health-Related Behaviors: No smoking, no drugs, occasional alcohol use

Allergies: Denied

Vitals: T: **HR** : 105 **BP**:140/88 **RR**:20 BPM **Sat**: 96% on room air

Exam: HEENT: Visual acuity 20/20 right eye , 20/25 left.Tenderness over left temple and scalp.Thyroid markedly enlarged

CV, **Pulm**, **Abd** and **Neuro**: Normal

Extremities/skin: right leg warm and normal coloured. Left ;eg was examined and not swollen. Movement at left hip and ankle caused pain. Left ankle had Tenosynovitis. At the left hip pain was localized over the greater trochanter and reproduced with active movements consistent with greater trochanteric pain.

Notable Labs & Imaging:

Chemistry: Na:138 K:4.1 Cl:102 HCO3: 24 Ca: low 6 ionized calcium .91 PTH :145
Vit D :9 low Mg: BUN:14 Cr: 0.9 Glu: 120? AST: ALT: ALP: T. Bili: T. protein: 7.2
ESR:100 CRP: 22 LDH: TSH :120.FT 4<.1
Blood culture no growth.
HIV,HBC, HCV, Quanto IFN gamma Parvovirus Monospot all negative
ANCA screen all negative,Rheumatoid factor negative. Anti-CCP negative
The serum IgG4 concentration was 186 mg/dL

Imaging:

CXR: Right upper lobe infiltrate
CT: no PE, thyroid enlargement, ground glass opacity (maybe by aspiration)
Partially cystic and solid 1.5 cm lesion posterior left upper lobe
→ Hip pain: controlled by analgesics but the patient felt more change in the hip
Gluteal tendinosis, fluid in the trochanter… greater trochanter syndrome
High uric levels… Gout
Temporal artery biopsy showed no arteritis
CE MRI: Subtle enhancement of optic nerve sheath.
CT neck massive thyroid extending into substernal mediastinal.

Iv calcium gluconate and oral calcium and discharged on levothyroxine,Patient also had a thyroidectomy. Biopsy showed dense lymphocytic plasma infiltration.
Final Diagnosis: **IgG4 thyroiditis**

Problem Representation: 58-year-old man with RA presents with acute right-leg pain/numbness in the setting of a broader multisystem inflammatory syndrome characterized by headache and visual symptoms, markedly elevated inflammatory markers, inflammatory periarticular findings, pulmonary lesions, thyroid enlargement, and optic nerve sheath enhancement, with negative infectious and autoimmune workup and negative temporal artery biopsy.

Teaching Points (Kris)

1. Acute shortness of breath
Clarify the pattern first:Sudden vs progressive,Exertional vs at rest Orthopnea/PND?
2. Lower-leg numbness:Localize anatomically before calling it disc herniation,Unilateral vs bilateral,Dermatomal vs stocking distribution
For RA specifically, remember that the classic spinal manifestation is cervical involvement, especially C1–C2 atlantoaxial disease, not primarily lumbar disease.
3. Temporal tenderness:Jaw claudication,Visual symptoms?
4. Pain reproducible with movement
musculoskeletal or mechanical/nerve-compression process.
5. Autoimmune/systemic workup
6. Thyromegaly + upper mediastinal/upper-lobe mass
For an anterior mediastinal mass, remember the 5 Ts:Thymoma,Teratoma/germ-cell tumor,Terrible lymphoma,Thyroid, Thoracic aortic aneurysm
If CT suggests continuity with the thyroid, a substernal goiter or thyroid mass moves higher on the list.
7. Thyroid evaluation
If there is thyromegaly or suspected thyroid mass:
TSH, Free T4,Thyroid ultrasound for cervical thyroid anatomy/nodules
If there is severe hypothyroidism, bradycardia is common, but not obligatory. Other concurrent processes can produce a normal or elevated heart rate, so tachycardia would make you look for another explanation rather than exclude hypothyroidism entirely.
8. Hypocalcemia and PTH
First ask: Is the calcium truly low after correction for albumin?Magnesium?
Phosphate?Creatinine/eGFR?25-OH vitamin D? PTH?
9. Optic nerve sheath enhancement
Consider:Optic perineuritis, Sarcoidosis, IgG4-related disease, Granulomatosis with polyangiitis or other vasculitis, Syphilis,Other inflammatory/infiltrative disorders
10. Putting everything together
If this patient has: likely to be systemic autoimmune disease