3/8/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Glen* ***Case Discussants****: Rahul (@RahulPottabath1) & Lera (@LNovotnaya)*

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

Scribing (Seeme)

CC: 60 y/o woman p/w chief concern of runny nose/sinus drainage

HPI: Sx began 1mo ago with a runny nose. Then some thicker discharge, just on R side, then crusting on inside, then nose got swollen, red. and hard. Early on took oral OTC antihistamines as thought it was allergies and did not help. Now the nose is itchy and peeling as well. Not tried topicals. Did use some vaseline on q-tip intermittently, last time 3 days ago. Nose stable in appearance for the last week. More visible from outside now, including some swelling over the R maxilla and induration of the R tragus starting today, leading her to seek care today.

ROS:

Never had anything like this before, no fever, no night sweats, no visual or aural symptoms, eating and drinking fine, no medication changes

PMH:stage 4 pancreatic adenocarcinoma s/p Whipple w/ pancreatic insufficiency, currently on palliative chemo insulin pump for pancreatogenic diabetes,HTN ,Depression ,R parotidectomy for pleomorphic adenoma 5 y ago, c/b recurrent sialocele

Meds:insulin, Creon venlafaxine,atenolol-chlorthalidone ,ondansetron ,chemo (gemcitabine + paclitaxel)last received 2 weeks prior

Fam Hx: Ovarian CA-mother MGM with pancreatic CA

Social Hx: Retired, lives with dog

Health-Related Behaviors: Smoking but quit 20 y ago

Allergies: NKDA

Vitals: T: 36 **HR**: 70 **BP**: 154/88 **RR**: 16 **Sat**: 98 % on RA **BMI**: 25

Exam: Gen: nl

HEENT: R nasal ala erythematous, swollen, indurated, mildly tender to palpation, L nasal ala mildly erythematous but not swollen or indurated,

R nares with crusting, no purulence, turbinates erythematous though no significant edema, obvious blockage, or foreign body,L nares and turbinates wnl R maxilla area (inferior lid dermatochalasis) with mild edema and erythema,no sinus tenderness, no cervical LAD, no parotid swelling

CV: nl **Pulm**: nl **Abd**: nl **Neuro**: nl **Extremities/skin**: nl

Notable Labs & Imaging:

Hematology:

WBC: 3.8 (nl differential) Hgb:11.6 Plt: 346 MCV:83.5

Chemistry:

Na:137 K: 4 Cl:96 HCO3: 28 Cr:0.81 BUN: 18 Glucose: 164 Ca: 8.8

AST: 19 ALT: 22 Alk-P: 316 [high] A1c = 6.9%

Given seeming lateral spread of condition, will treat with oral abx, covering Strep and MRSA (amox-clav + doxy for 5d). Follow-up by phone in 2d. If no improvement, refer to specialist for assistance with diagnosis & management (likely Derm over ENT), patient was improving after 2 days and no recurrence 3 months later.

Dx: Nasal Vestibulitis:

Pearls: Inflammation of the nasal vestibule, anterior part of the nasal cavity, just inside the nostrils, often of a follicle (folliculitis); Septum ***not*** usually affected (as most hair follicles located in the vestibular skin and mucosa). Fever and systemic sx usually ***absent***

Causes →usually bacterial, typically staph

Risk factors → nasal trauma (nose picking, frequent blowing of nose such as from allergies or preceding URI, piercings)

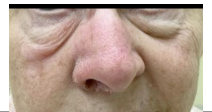
\Immunosuppression (***not*** a/w nasal steroid use)

DDx = facial cellulitis, non-infectious (inflammatory) chondritis

Treatment = warm compresses and topical mupirocin if mild, oral abx if appears more widespread







Problem Representation: 60 y old FM with PMH of pancreatic adenocarcinoma and pancreatogenic diabetes presented with isolated right sided nasal discharge, crusting and swelling.

Teaching Points (Manaswini)

Localising the Runny nose

1. **Rhinosinusitis :** Mucosa being involved. Commonly acute and would need symptomatic treatment
2. **Mimics that can be life threatening -** Is there CSF leak? Are there associated neurological symptoms(nerve palsies)? Dental conditions (reactive inflammation in maxillary sinuses that spread from the teeth)

To do: Thorough Dental exam, Ear exam(eustachian tube connects middle ear to nasopharynx), check for the LN's at all the levels

Time course is crucial: Subacute -chronic progressive? Or is it episodic making it look acute

Assess vulnerability: Important to note base rate

- Infections pt is susceptible to: Viral(rhinol/influenza)fungal(aspergillus, rhizopus/mucor)/TB *OR* is there a polyp/bleed? Asking Exposure & trauma History. H/O malignancy?
- Assess need for empiric antibiotics and imaging

U/L involvement →suggests anatomical change or involvement or the ear on the same side

Approach to Labs: Check GGT to check if from Bone(Normal) or Liver(Raised). Do we need to invest cognitive energy on raised ALP? → related to post surgery?. *We find out that the baseline ALP is high in our patient.*

H/O pleomorphic adenoma can skew the approach-check facial nerve involvement(Facial nerve courses through the gland)

Fun Fact: Gustatory Sweating/FREY's syndrome: Post parotid gland surgery, parasymp fibres from auriculotemporal **(5thCN)** that accompanies the facial nerve(**7th CN**) course regenerates haphazardly to innervate the sweat glands instead of the salivary glands→ Pt sweats every time pt thinks of food/eats