7/2/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**:*Taghrid Tarek* **Case Discussants**: *Rabih (@rabihmgeha) & Lera (@LNovotnaya)*

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

Scribing (Javier)

CC: 53 years old man presented with gingival lesion with headache.

HPI:

53 ys old man 2 months of gingival lesion initially associated with mild discomfort that progressed to numbness localized on left jaw associated with pressure type headache treated with abs with no improvement.

ROS: Weight loss and several weeks of night sweats

PMH: Systemic Lupus Erythematosus

Meds: Hydroxychloroquine, leflunomide, Prednisone

Social Hx:
Mexico and Arizona
Sex with men, unprotected sex
Has a cat

Health-Related Behaviors:
Alcohol socially
Allergies:

Vitals: T:98.6 **HR**: 70 **BP**: 115/70 **RR**: **Sat**: **BMI**:
Exam: Gen: nl
HEENT: nl
CV: nl
Pulm:nl
Abd: nl
Neuro: Numbness over left Jaw
Extremities/skin: Ulcerative lesion gingival lesion with intermittent bleeding non tender

Notable Labs & Imaging:

WBC 5 Hb 11.8, Plt 110, LDH 250 Cr: elevated ALT nl AST nl, CMP unremarkable

Imaging:

CT chest: heterogeneous soft tissue mass in the anterior mediastinum
CT mandible + contrast : left mandibular soft tissue involvement with erosive destruction of left post. Mandible adjacent to oral lesion
Cranial MRI: enhancing lesion in left occipital bone with extension into dura, also occipital lesion

Infectious work up :

Cocci serology: negative STI: neg
Direct Syphilis serologies **TPPA: positive RPR: negative**
HIV: positive CD4 count: 215 Viral load > 1 M
LP 16 Lyphos 94% protein 54 Glucose 48
Biopsy: **Treponema Pallidum spirochete on special tinction**
Positive EBV a plasmablastic lymphoma, positive HSV

Dx: Gummatous syphilis associated with plasmablastic lymphoma
Penicillin for neurosyphilis, Biktarvy for HIV, prophylaxis for PJP

Problem Representation: Medium age man with severe inmuno compromise with multiple expositions now with a subacute multifocal progressive and invasive mass forming disease associated with cytopenia an B symptoms

Teaching Points (Lera's Fans)

Approach to Localisation:

- In this case of presentation where headache is a fingerprint, try to localize the syndrome
- Hemifacial symptoms in one side is really less probable to be localized on the brain stem, due to this fact is important to consider first face image.
- If there is one nerve involve, always to consider other nerve compromise
- **When a mass seen** → Always check if Focal / **Multifocal**?
- Never assume it is solitary!! Especially if associated with sys symps
- Important to check for Vulnerabilities in host when the illness script feels illogical: *Cancer, HIV, syphilis, TB, other STD (Gono/Chlamydia)*

Approach to Ulcerative lesions: 1) Primary (skin) i.e tissue loss from inflammation/ischemia. 2) Secondary: Ulcerative lesion ON A TISSUE GROWTH → Cancer!! (Space Occupying + destructive) VS (just Destructive)

- Focally invasive in jaw and the non invasive nature of the dura → Biopsy the tissue
- *Granulomatous (Mycobacterial, endemic mycoses, spirochete), neoplastic possibilities*

Illness script for Syphilis in Immunocompetent is DIFFERENT from immunocompromised

- ***LUES MALIGNA:*** ulcerative disease in syphilis in pts with HIV (immunocompromised)
- Syphilitic Gummas are *dural based lesions*!
- **Serologies as good as the immune system:** sensitivity decreases when Ab's are checked in immunocompromised
- **If Systemic infection in immunocompromised** → More silent infections can be brewing inside → test for them even if none of their symptoms seen
- **Non reactive RPR does not rule out Syphilis!!** → **1. Immunocompromised 2) PROZONE Phenomenon (excessive conc of Ab's)--> Important to DILUTE the sample**
- VDRL DOES not rule out neurosyphilis -> Perform LP & Rx
- **When to start PJP prophylaxis?** -> We learn CD4 <200, BUT **imp to correlate with the percentage i.e: start if <14%!!**