4/30/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Varsha(@)* ***Case Discussants****:Rabih (@) &Lourenco (@)*

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

Scribing (Sarah B)

CC: 55 year old male presented with headache and blurry vision.

HPI:

Headache and blurry vision in temporal and retro orbital areas for the last 8 days. It increased in intensity and peaked at 24 hrs. Pain aggravated by movement. Gradual peripheral field blurring. Prior ocular-orbital trauma from surfboard injury requiring surgery with placement of Teflon support plate. R eye dominant with stable L eye impairment.

6 mo prior, developed trunk, back, and upper extremity rash which was bruise-like after working on cables covered in muddy liquid in a manhole. Rash progressed to blistering channeling lesions that made it impossible to use hands. He was given antibiotics and steroids for presumed hypersensitivity reaction and rash faded over time. He developed flexural pustules at blood draw sites on arms and on dorsum of MCPs. 4-5 pustules remained on upper extremities. No diplopia, muscle weakness, numbness, tingling, N/V, bleeding, and no relief with OTC medications. Admits polyarticular joint pain/stiffness, lower extremity swelling, L ear pain and tinnitus, subjective fevers, 25 lb wt loss.

PMH:

Ocular trauma - at age 17

Type 2 DM

CAD

Social Hx: 40 beers weekly previously but stopped drinking in the last year, 25 pack/year smoking history, plant technician job, no animals. No travel.

Vitals: T: afebrile **HR**: 104 **BP**: nl **RR**: nl **Sat**: nl

Exam:

HEENT: BL upper eyelid swelling with intact movements but L eye pain. MMM no ulcers. R helical ulcer on ear. No LAD.

CV: RRR, no murmurs rubs or gallops

Pulm: CTAB **Abd**: soft NT, ND **Neuro**: nl

Extremities/skin: Slowly healing R hypothenar eminence lesion at site of prior biopsy with raised edges. R 2nd/3rd MCP pustules. Calves painful to palpation, localized area with linear erythema. R>L 1+ pitting edema to mid-tibia. R>L carpometacarpal squaring and Heberden nodes on multiple fingers. Fourth PIP joint tenderness without synovitis.

Notable Labs & Imaging:

Hematology:

WBC: 4.6 (Norm diff) Hgb: 13.8 Plt: 239 MCV:

Chemistry:

Na: 136 K: 3.9 HCO3: 23 Cr: 0.8 BUN: 15 Glucose: 236 Ca: 9.4

AST: 12 ALT: 17 Alk-P: 82 Bili: Albumin: 3.1 Total Protein: 8.3

ESR: 40 CRP: 4.3 LDH:

Thyroid panel normal UA: 2+ protein CK: 105 Uric Acid: 8.3

HIV, quantiferon, HCV/HBV, RF, ENA, CCP ANCA, complements normal/negative. Serum cryptococcal antigen neg, IgG 1850 (H), IgA 933 (H), IgM normal, IgG4: 216

Blood cultures -, CSF normal, Toxo IgM positive/IgG negative

RPR negative

Imaging:

Hand XR: Osteophytes and narrowing of joint space

Lower Extremity US: Thrombophlebitis without DVT.

CT Chest/Abdomen/Pelvis: Normal

MRI Brain/Orbits: BL dacryoadenitis and optic perineuritis of L eye

Bone Marrow Bx: Normocellular bone marrow with trilineage hematopoiesis, occasional myeloid precursors with cytoplasmic vacuoles, negative for increased blasts, significant dysplasia and monotypic plasma cells. ***UBA1 gene testing positive.***

Dx: VEXAS

Problem Representation: 55 year old male with 6 month history of blistering rash found to have optic perineuritis, thrombophlebitis, and elevated immunoglobulin levels.

Teaching Points (Eugene)

Localizing eye pain

-Anterior eye disease e.g corneal ulceration, conjunctival disease, usually transmits pain.

-Posterior eye disease usually is painless e.g amaurosis fugax, retinal disease. However inflammatory causes may be painful

-Pain in eye without redness - less likelihood of superficial anterior eye disease.

Eye pain + Blurry vision + Headache:

-may suggest increased itraocular pressures or partly raised intracranial pressures or inflammatory cause (uveitis, optic neuritis).

Systemic features

-Weight loss + polyarticular pain + skin lesions + raised inflammatory markers + thrombophlebitis : consider systemic inflammatory process, autoimmune(space occupying types: e.g igG4 disease, sarcoidosis, histiocytic disease) or infectious causes(HIV, syphilis (but does not definitively explain arthritis or dactylitis; less likely malignant

Interpreting Noise in Labs

Toxo igm -false positive, cryptococcal igg iga raised with neg crypto antigen - not diagnostic