



6/13/26 Clinical Reasoning Expeditions with @CPSolvers

“One life, so many dreams” Case Presenter: Jeffrey (@) Case Discussants: Ramaswamy (@Dr_RamaswamyS)
<https://clinicalproblemsolving.com/present-a-case/>



Scribing (Jahanvi)
CC: 36 Y M (African American) present for routine annual with **no complaints**.
HPI: He denies fevers, chills, night sweats, weight loss, fatigue, bleeding, bruising, recurrent infections, dyspnea, weakness, myalgias, arthralgias, rash, abdominal pain, or neurologic symptoms.

ROS:

PMH: Rt Knee injury while playing basketball (No surgery), **patellar tendonitis** : Rt knee

Meds:

Fam Hx: NS (No autoimmune ds)

Social Hx: works as a salesman, travels frequently to midwestern US (Ohio)

Health-Related Behaviors: Multiple sexual partners (wears protections), Uses marijuana

Allergies: NA

Vitals: T: HR: BP: RR: Sat: BMI:
Exam: Gen:
HEENT: NA CV: NA Pulm: NA Abd: NA Neuro: NA
Extremities/skin: Raynauds with **periungual erythema** and nailfold capillaroscopy with dilated capillaries, puffy hands

Notable Labs & Imaging:
Hematology:
WBC: 2.8 Hgb: 9.7 Plt: 97 MCV: 82 (pancytopenia)

Chemistry:
Na: 139 K:4.2 Cl:104 HCO3: 25 Cr:0.9 BUN:13 Glucose: 91 Ca: 9 AST: 166 ALT: 104 HbA1c: 5.4 TSH: 1.8 (N) Vit B12: 612 (N), Folate: 12.4 (N) VitD: 18 (low)
Alk-P:78 Bili: 0.5 Albumin: 3.7 Total Protein: 8 Lipid panel: N (slightly elevated Tgs)
CK: 800, HIV: Neg, Hep A/B/C: neg, FTA Abs Syphilis: Positive, TB: neg, ANA: + (1:2560), RF: neg

Final Labs:
dsDNA: +, Smith: +, RNP: +, SSA: +, C3/C4: Normal, Anticardiolipin: +, Beta-2 glycoprotein: +, Lupus anticoagulant: +, Urine Protein/Creatinine: 813g/g

Imaging:
CT Chest/ Abd/ pelvis:

- **Calcified mediastinal lymph nodes**, favored reactive/prior granulomatous ds.
- Hepatosplenomegaly (16cm spleen)
- Basilar-predominant bilateral ground-glass opacities with reticulations.

Dx: **SLE/MCTD** (rarely present with pancytopenia)

Problem Representation: A 36 Y M African american presenting with asymptomatic pancytopenia, transaminitis, elevated CK, CT features of calcified LN and ground glass opacities. On physical exam, pt had raynauds and labs positive for multiple autoantibodies, consistent with features of overlapping SLE/ MCTD syndrome.

Teaching Points (Joshua Oommen)

- **Decrease in all cell lines = pancytopenia > aplastic anemia among other causes (marrow infiltration vs marrow failure vs peripheral process)**
- **Asymptomatic presentation with abnormalities (pancytopenia, hepatosplenomegaly, etc): 1) mitigation/compensation of pathologic process with redundancy or reserve 2) Chronicity of pathologic process 3) Internal Process > External Process**
- **When looking at different problems (liver abnormalities or pancytopenia) entertain a unified view AND a discrete view**
 - **Reflecting on the discrete view of problems, one can think of mimics or alternative explanations as separate explanations for abnormalities (elevated liver enzymes > muscle damage, increased bone turnover)**