7/20/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Jeffrey(@)* ***Case Discussants****: Alec(@) & Austin(@)*

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

Scribing (Ravi & Lukas)

78 yo female

CC: Evaluation of recurrence of GCA

Symptoms are returning especially when she stands and sits back down. Hx of biopsy proven GCA

HPI:

6 months ago had temporal headache, jaw claudication, temp artery bulge, biopsy confirmed TA. Started on steroids and Tocilizumab. Preceding couple of months, daughter is concerned having difficulty with standing and wobbling. After standing would get symptoms of headache, fatigue, presyncope. Lying down resolves the symptoms. EKG, holter, echo, CT head and neck : NEGATIVE

ESR 52

ROS: + fatigue + H/A +Presyncope, new blurry vision right eye, now in left, began suddenly- Right eye discomfort, + tearing.

First noticed walking outdoors at night.

(-) redness

(-)discharge

No joint pain, no scalp tenderness, no neuro symptoms, no GI symptoms,

2-3 months - decreased appetite

Black rash B/l lower extremities foot→ calf - Painless

Urinary incontinence when she drinks water

PMH:

GCA

Meds:

Vitamin D

Prednisone (tapered, now 10 mg)

Tocilizumab

Pantoprazole

Metformine

atorvastatin

Fam Hx:

None

Social Hx:

Retired

At home with husband

No smoking

No ETOH

Health-Related Behaviors:

Allergies:

Vitals: T: 36.7 **HR**: 82 Sitting **BP**: 134/76 **RR**: 16 **Sat**: 98 RA

Standing: 96/58 **HR** 98

Exam: Gen: no weight changing

HEENT: Cataracts, dry eyes, R > L eye cataracts

CV: -

Pulm: -

Abd: -

Neuro: 4 / 5 muscle weakness proximally bilaterally

Extremities/skin: Bruising->

on foot, shin

Notable Labs & Imaging:

Hematology:

WBC: Unremarkable Hgb: Plt: MCV:

Chemistry:

Na: K: Cl: HCO3: Cr: 0.5→ 0.9 BUN: Glucose: Ca: Mg:

AST: ALT: Alk-P: Bili: Albumin: Total Protein:

ESR: 67 CRP: <0.1 LDH: CK: 55

A1C 7.1

SPEP: M spike 2.2

Imaging:

EKG:

CXR:

Echo:

Patient taking in zero water-> due to urinary incontinence

Dx: Steroid induced Myopathy

Problem Representation:

Teaching Points (Simmy):

- **Approach to History taking:** Focusing on the Symptomatology, change over time, past treatment history, positional changes(Blood flow issues). **Past Medication History**—> Tapering dose for steroids. Metformin- Micronutrient deficiency. Atorvastatin- Leg cramps. Med rec important.
- Patients with **GCA specific:** symptoms might be present intermittently. TIME COURSE IMPORTANT. Syndrome vs complication. Vision changes in GCA is EMERGENCY. Look for other causes such as cataracts, consider the precipitating factors. Requires Ophthalmology consult. Recurring issues—> possible blockage. CT Head & Neck or CT Angiography is helpful—>Trying to localize the lesion.
- **Approach to Orthostasis(wobbly):** Repeat multiple times. Look for reversible causes(Decreased water intake due to urinary incontinence) oHTN→ HR imp(neurogenic vs non-neurogenic causes)Rx: Med Hx, Fluid Resuscitation, Dietary History. **Approach to Gait assessment:** Look for Autonomic Neuropathy vs weakness vs muscular involvement. Symmetry.
- BLACK RASH: uncommon—> Think about Ischemia and/or Necrosis. Commonly it would be painful. PICTURE helps. D/D: Hyperpigmentation, Trauma- induced, Senile Purpura. Look at other areas of the body(Adrenal Insufficiency)
- Appetite changes→weight changes: craving problems, preferences, medication induced. Glossitis changes appetite due to palatability.
- Mildly High M Spike(GCA Mimic)→Additional labs for amyloid and re-checking the biopsy. NOISE vs SIGNAL.