2/15/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Siva (@siva11r)* ***Case Discussants****: Zakariyya G (@pouroverguy) & Kirtan (@KirtanPatolia)*

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

Scribing (Kevin)

CC: 42 y/o man with diffuse **headache, photophobia, nasal bleeding**, weight loss

HPI: 3 wks ago developed diffuse headache [*stabbing, associated with photo- / phonophobia*] and insomnia. Epistaxis associated with fever and chills. After 2 wks + new myalgias [thighs, calves] -> **bedbound** for 3 days before presenting. Tx with analgesics.

ROS: anxiety accompanied by sensation of heat and diaphoresis, intermittent blurry vision, anorexia, 8 lbs weight loss and anorexia, enlarging dental cavity

Social Hx: born and raised in northern Brazil and recently immigrated to South-Eastern US, No known Tb contact

Health-Related Behaviors: none, beer weekly, promiscuous behaviour in the past

Vitals: T: 39.1 **HR**: 100 **BP**: nl **RR**: 24 **Sat**: 96% on 2L of O2

Exam: Gen: anxious, tremors **CV, Pulm, Abd**: nl **Extremities/skin**: nl

HEENT: L eye **conjunctival injection & mild edema**, perforating hard palate **ulcer**, non tender cervical / submandibular LAD, no parotid enlargement, dark blood in **both** nares

Neuro: generalized symmetric weakness and tremors, nl DTRs, sensation nl, **L CN VI palsy**

Notable Labs & Imaging:

Hematology: **WBC**: 3 (normal diff) **Hgb**: 10 **Plt**: 148 MCV:85

Chemistry: Na: nl K: nl HCO3: nl **Cr:** 1.2 [bl] BUN: nl Glucose: nl Ca: nl Alb: 2.7 Total Protein: 8.2

AST: 226 **ALT**: 321 **Alk**-P: 360 Bili: nl ESR: 58 **CRP**: 10.2 **LDH:** 289 **Ferritin:** 580 **CK:** 270

ID workup: COVID, viral RP, Lepto, Histo, Cocci, Paracocci, Blasto, Lyme neg.

BCx: neg HIV / HBV / HCV / Syphilis neg. **HAV AB** (+) **IGRA (+)**

AI workup: ANA, ANCA, MPO, PR3, CCP, AMA Ab, Anti-SMA Ag, SPEP, UPEP neg. RF 25 (>20), Ceruloplasmin nl

LP: 8 cm, 14 WBC [87% L], 10 RBC, glucose nl, protein 20

CT head: no acute intracranial abnormality, **diffuse moderate pansinusitis with multiple foci of bony erosions** (ethmoid roofs and planum sphenoidale bilaterally), Bony resorption of hard palate - concerning for **osteomyelitis**

MRI of the brain: partial thrombosis of left cavernous sinus, same findings of **erosive sinusitis** as above**, no parenchymal or meningeal enhancement.**

CTC/A/P: Numerous multifocal GGO in lungs with pleural effusions, no mediastinal or hilar lymphadenopathy. Liver with numerous intermediate-density lesions (2.2x1.9cm), no abdominal or retroperitoneal LAD, spleen 14cm.

Nasal Bx: atypical reactive squamous epithelium with a background of nonspecific inflammation - no evidence of malignancy, granulomas or vasculitis, mixed inflammatory infiltrate consisting of neutrophils, macrophages and small lymphocytes, stains for HSV, EBV, VZV, CMV, HPV all negative, bacterial and fungal cultures with no growth

Repeat nasal ulcer Bx: special stains for fungus and bacteria negative, no leishmania amastigotes, positive for rare copies of **Mycobacterium mucogenicum**

Transbronchial Bx of lung tissue: **chronic exudative alveolitis and vasculitis with fibrinoid necrosis**, infectious workup and AFB/fungal cultures negative for six weeks

Cytology and flow cytometry unrevealing.

Consultation of rheumatology > *3rd nasal ulcer biopsy*

> FINAL DIAGNOSIS: EBV NK/T-cell lymphoma

Problem Representation:

A 42 year-old man from Northern Brazil presents himself with a 3-week long episode of diffuse, stabbing headache, nasal bleeding, insomnia, photo- and phonophobia, weight loss, anxiety and being bed bound for 3 days prior to presentation.

Teaching Points (Glen)

-Epistaxis: true or not(GI bleed, hemoptysis). Mostly benign.

-Headache: Has red flag of photophobia(eye pathology like uveitis, optic neuritis or brain pathology like meningeal irritation by infection/autoimmune/migraine(vessels)/changes in csf pressure).

-Myalgia: viral infection/myositis. This could trigger autoimmune rxn and leading to other symptoms like insomnia, anxiety.
-CNVI palsy: nerve can be affected at pons/during its course(like meninges)/changes in csf pressure.

-Hard palate ulcer: invasive pathology. Granulomatous infection. Could be cavernous sinus thrombosis. History of alcohol use can exacerbate this.
-Cell counts could mean Pancytopenia. Trending them will help to rule out bone marrow suppression.

-Increase AST/ALT; pattern does not align with alcohol. Could be a tick bone disease. Get RUQ USS.
-Coag profile nl: Epistaxis could be structurally related.
-CSF: infection in CNS(Aseptic). Most likely viral/fungal(crypto)/leishmaniasis/spirochetes(check VDRL coz of sexual history/autoimmune(mostly cause cytosis rather than cytopenias.

-SINUS AND BONE PATHOLOGY:Infection(viral,bacterial, fungal(aspergillosis,blasto,mucormycosis),TB vs autoimmune(ANCA dx, sarcoidosis) vs Hematological malignancies & kaposi sarcoma.
-ANTIMICROBIALS; Can give ceftriaxone as prophylaxis.

-NON-TUBERCULOUS MYCOBACTERIUM: not invasive enough to explain liver abn. Still imp to investigate for other causes.
-EBV lymphoma: related to hiv, low CD4 and affects B cells.