Patient #143

Chief Complaint: This 65 year old woman complained of pain in her shoulders, knees, and neck.

History of Present Illness: The patient had a long history of arthritis for which she was treated for seven years with non-steroidal anti-inflammatory drugs and dexamethasone. Nine months before her admission she started seeing a new doctor who tapered her steroids over four to six months. In the three weeks prior to admission her joint pain involving the shoulders, knees, and neck became much worse. She mentioned PIP (proximal interphalangeal) joint pain as well. She complained that she could hardly move, and had morning stiffness that improved after a hot bath. She denied joint swelling or redness, but complained of decreased range of motion in her knees and shoulders. She applied Ben Gay occasionally and started using a cane to help with ambulation. She had no rashes, Raynaud phenomenon, sweats, headaches or muscle tenderness. She did not notice any weakness.

She also complained of anorexia and had eaten poorly for a long time, but for the previous three weeks had taken only a few mouthfuls at a time. She had been drinking Ensure for two weeks. She denied abdominal pain, trouble swallowing, nausea, vomiting or change in her bowel habits. Her weight had fallen from 158 lbs. to 118 lbs. over the past year. Over the same period of time her Hgb had fell from 13.6 to 8.0 g/dl. After starting on iron her Hgb rose to 10 g/dl.

Past Medical History: She had a past history of hypertension and was once on hydrochlorothiazide and then Lasix, but was now on no medication. She had a multinodular goiter detected a year prior to admission. She was not on thyroid hormone. She had never been hospitalized and had had no operations. She had no allergies. She did have a history of renal insufficiency with a creatinine of 2.0 mg/dl.

Social/Family History: She is married and lives with her husband and a grandson. She does not smoke or drink. She lives on social security. Family history was unremarkable.

Physical Exam: Her temperature was 98.1^{o} F (36.7^{o}C), blood pressure 102/68 and pulse 84. She was a pleasant, elderly black woman in no distress. There were no rashes or skin lesions. There was no adenopathy. She had cataracts bilaterally which made visualization of the retina difficult.

The pupils were equal, round, and reactive to light. The conjunctiva were pale. Extraocular movements were intact. She was edentulous and had no oropharyngeal lesions. The tympanic membranes were normal. She had good range of motion in the neck. There was no jugular venous distention. The right lobe of the thyroid was enlarged with a question of a nodule. She had no breast masses. The lungs were clear. The heart sounds were normal without murmurs or gallops. The abdomen was soft and non-tender with no masses or organomegaly. There were normal bowel sounds. The external genitalia appeared normal. There were no rectal masses and the stool was guaiac negative. There was no peripheral edema. She was alert and oriented. The cranial nerves were intact. Sensation was intact to position, light touch and vibration. On walking she dragged her left foot and kept the right foot relatively extended during the swing and planting phase. Cerebellar testing including the Romberg was normal. The deep tendon reflexes were 3+ and symmetric, though absent at the ankles. The Babinski's were down going. There was no muscle tenderness. There was no joint tenderness, no effusions, and no synovial thickening. She did have Heberden's nodes bilaterally. She was able to abduct her shoulders only to 90^{o} and had decreased internal and external shoulder rotation. There were bilateral varus deformities at the knees with palpable crepitus and flexion only to 90^{o}. There was slightly diminished strength throughout but more notable at the deltoids and hip flexors. She could not stand from a sitting position without using her hands.

Laboratory Data:

			Normal
CBC	Hct	30	*38-47 %*
	Hgb	9.8	*12.3-15.7 g/dl.*
	MCV	83	*81-97 fl*
	WBC	7.5	*4-12 X* $10^{9/L}$
	Neut	69	*40-70 %*
	lymph's	21	*20-50 %*
	mono	7	*2-10 %*
	eos	1%	*<5%*
	platelet count	582	*150-440 X* $10^{9}/L$
			Normal
	reticulocyte ct	1.2	*0.5-2.7%*

Chemistries	sodium	139	*135-145 mmol/l*
	potassium	4.1	*3.5-5.0 mmol/l*
	chloride	106	*100-111 mmol/l*
	CO2	23	*24-30 mmol/l*
	creatinine	2.0	*0.6-1.2 mg/dl*
	BUN	25	*8-20 mg/dl*
	bilirubin, total	0.5	*0-1.2 mg/dl*
	calcium	10.7	*8.5-10.2 mg/dl*
	glucose	110	*65-110 mg/dl*
	protein, total	7.2	*6.8-8.3 g/dl*
	albumin	3.7	*3.5-5.0 g/dl*
	AST (SGOT)	8	*9-26 U/L*
	ALT (SGPT)	3	*7-30 U/L*
	LDH	163	*108-215 U/L*
	ALP	81	*39-117 U/L*
	CK	28	*30-125 U/L*
	PT & PTT	normal	
	Serum iron	10	*35-165 ug/dl*
	TIBC	346	*320-550 ug/dl*
	ferritin	307	*18-186 mg/ml*
	B-12	600	*>200 pg/ml*
	folate	11.3	*>2.5 ng/ml*
	ESR	75	*0-30 mm/hr*

Urinalysis: trace protein, no glucose, 3+ Hgb, 10-15 WBC's per HPF, >100 RBC's per HPF, 10-15 squamous epithelial cells.

Urine culture: negative

Chest X-ray: small pleural effusion, mild tracheal deviation to the left and a question of a large thyroid. There were no pulmonary infiltrates.

EKG: normal

ANA: negative

RF: negative

VDRL: negative

Serum electrophoresis: no significant abnormalities.

Urine electrophoresis: normal

Radiographic joint survey: evidence of osteoarthritis at multiple joints.

The patient underwent flexible sigmoidoscopy and was noted to have a 5 mm polyp at 30 cm. A single column barium enema was normal, though a right renal calculus was detected. An upper GI was notable for an active duodenal bulb ulcer. An EMG was non-diagnostic but showed changes of irritation in proximal muscles suggestive of an inflammatory myopathy.

Muscle biopsy: no inflammation.