Patient #181

Chief Complaint: This 68 year old black male presented with fever and arthralgias.

History of Present Illness: The patient was well until 4 weeks prior to admission when he developed arthralgias in his wrists and shoulders. He also developed fatigue. He began taking ibuprofen, but developed abdominal pain and an upper gastrointestinal bleed. Esophagoduodenogastroscopy showed several gastric ulcers, and he was treated with ranitidine. Ibuprofen was discontinued, and he was started on salsalate (Disalcid), with some relief of his arthralgias. One week prior to admission, the arthralgias again worsened, and he developed fever. He denied joint swelling, rash, headache, chest pain, abdominal pain, or history of anemia.

Past Medical History: No prior illnesses or hospitalizations.

Medications: Disalcid, ranitidine.

Allergies: none known.

Family History: noncontributory.

Social History: He is divorced, and lives alone. He denied tobacco, alcohol, or illicit drug use.

Physical Examination: Well developed, well nourished black male in no acute distress. BP 110/60; pulse 120; respirations 20; temperature 102^{o}F (38.9^{o}C).

The head was normocephalic and atraumatic. The conjunctivae were pale. The sclerae were anicteric. The pupils were equal, round, and reactive to light and accommodation. The fundi were normal. The oropharynx was benign. The neck was supple. There was no lymphadenopathy or thyromegaly. The lungs were clear. The heart had normal S_1 and S_2, no gallops, and no murmurs. The abdomen was soft, without tenderness. There was no hepatosplenomegaly or masses. Rectal examination was normal; the stool was guaiac negative. The extremities showed no joint swelling; there was pain in the shoulders on abduction to 90^{o}. There was no cyanosis, clubbing, or edema. Neurologic examination was normal.

Laboratory Data:

			Normal
CBC	Hgb	9.3	*14.0-18.0g/dl.*
	Hct	28.2	*42-52%*
	MCV	73.9	*84-99 fl*
	WBC	9.2	*4.8-10.8 X $10^{9/L}$*
	Neut	73	*40-70 %*
	lymph's	14	*25-45 %*
	mono	2	*2-12 %*
	bands	10	*0-10 %*
	eosinophils	1	*0-6 %*
	platelet count	390	*150-400 X 10^{9}/l*
Chemistries	sodium	139	*135-149 mmol/l*
	potassium	4.4	*3.5-5.3 mmol/l*
	chloride	101	*98-108 mmol/l*
	CO2	25	*24-32 mmol/l*
	BUN	14	*6-20 mg/dl*
	creatinine	1.0	*0.5-1.5 mg/dl*
	glucose	92	*70-110 mg/dl*
	protein, total	6.6	*6.0-8.0 g/dl*
	albumin	2.2	*3.6-5.0 g/dl*
	bilirubin, total	0.4	*0-1.2 mg/dl*
	AST (SGOT)	35	*0-50 U/L*
	ALT (SGPT)	43	*0-70 U/L*
	ALP	97	*40-125 U/L*
	CPK	12	*21-232 U/L*

		Normal
PT and PTT	normal	
ESR	100	*0-10 mm/hr*
Serum iron	62	*50-150 ug/dl*
TIBC	186	*255-419 ug/dl*

Urinalysis: no protein or blood; microscopic examination normal.

Chest X-ray: normal heart and lungs

EKG: sinus tachycardia, but was otherwise normal.

CT scan of the abdomen: unremarkable

Serum protein electrophoresis: no monoclonal spike;

Immunoelectrophoresis: normal.

ANA : positive at 1:40

Rheumatoid factor: negative.

HIV antibody: negative.

PPD: negative

anergy screen: no reaction to mumps or Candida antigens.

Blood cultures x 8 showed no growth.

Bone marrow biopsy: normal hematopoietic cell lines and stainable iron; culture for bacteria, acid-fast bacilli, and fungi were negative.