Case Report: Too Thick to Test

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**Case Report: Too Thick to Test**

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**H&P**

60-year-old gentleman with past medical history significant for alcoholism (6 to 12 cans of beer per day for 30+ years), hypertension, depression, anemia. Transferred to our hospital for persistent fever, symmetrical polyarthritis, and weakness. At presentation to the outside hospital one week prior to transfer, the patient was diagnosed with acute encephalopathy due to alcohol withdrawal. Fevers were occurring in the ICU intermittently with a T-max of 101.2°F without a temporal pattern. Patient was complaining of polyarthralgia particularly in the left elbows, knees, and ankles. Patient was noted to have persistent hypotension (BP 75/34, ETOH feet 10) presumed from chronic alcoholism, which was treated with IV fluids.

Patient fulfilled SPC criteria on admission and was started on broad-spectrum antibiotics for possible infection. Fevers did not resolve with antibiotics, but improved after a single dose of solutedol (50 mg) for treatment of polyarthritits.

Of note, patient was followed at Cleveland Clinic 2.5 years ago for a mysterious rash on his arms and legs. His rash was biopsied and read as dermatitis.

**Physical Exam**

**Dermatologic:** no rash, no scars

**Elbows:** left elbow effusion/loosens

**Knees:** warm to palpation, ROMI, (+) synovitis, (-) effusion

**Ankles:** R>L ankle effusion/warmth

**Neurological:**

- AAO X: Cranial Nerves II-XII grossly intact, 5/5 muscle strength U/U upper/lower extremity, tremors

**Images at OSH prior to transfer:**

- CT left elbow:
- CT head/neck:
- MRI/MRA brain:
- Xrays hands, feet, SI joints:

**Imaging**

CT abdomen/pelvis: no acute abdominal process noted

Patient had left ankle arthrocentesis performed by the rheumatology service Day 1 at our hospital. Please refer to the images of the synovial fluid and the crystal analysis.

**Labs Prior to Transfer:**

- White blood cell count: 131 bmp
- Temp: 101.2° F (38.4° C)
- Hgb: 12.9 g/dl
- Hct: 37.2
- WBC: 13.0
- Neutrophils: 8.7
- Lymphs: 2.2
- Monos: 0.3
- Eos: 0.5
- Baso: 0.1
- Platelets: 285,000
- Glucose: 102 mg/dl
- Creatinine: 0.8 mg/dl
- Total bilirubin: 1.4 mg/dl
- Direct bilirubin: 0.2 mg/dl
- Alkaline phosphatase: 524 U/L
- Amylase: 2,655 U/L
- Lipase: 316 U/L
- Uric acid: 6 mg/dl
- BUN: 13 mg/dl
- Creatinine: 1.4 mg/dl
- Sodium: 141 mEq/L
- Potassium: 4.3 mEq/L
- Chloride: 101 mEq/L
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**Imaging**

- CT abdomen/pelvis: Nonocclusive thrombus in the main portal vein.
- Hypodense mass like collection with central hyperdensity along the uncinate process of the pancreas could represent pseudocyst with hemorrhagic component.
- Continued follow up suggested.
- Uncinate calcifications consistent with changes of chronic pancreatitis.

**Discussion**

- Release of pancreatic enzymes thought to lead to lipolysis of synovial membrane leading to acute arthritis
- Most cases of pancreatitis with polyarticular intramusous fat necrosis are seen in men in the 5th decade
- MCPs, knees, ankles most common joints involved
- Patients may not experience abdominal symptoms, as in our case
- Seen more commonly in alcohol induced chronic pancreatitis
- Other cases in the literature have associated with pancreatitis of biliary origin, ischemia, pancreatic trauma, and exocrine and endocrine tumors of the pancreas
- Can be associated with dermatitis of the lower extremity, as seen with our patient. Rash can migrate to the arms and trunk.

**REFERENCES**

- No disclosures.

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