

CASE DISCUSSION

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DPH
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Case:

- 69 year old woman
- 6 month history of myalgia and weakness
 - Previously independent – Now needing assistance to mobilize around the house
- No rash
- Exposure to statin – continued to take until time of admission
- ROS
 - Nil concern found

PMHx:

- BLIND
 - Pigmented retinopathy
- Prior HEPATITIS B
- IMPAIRED GLUCOSE TOLERANCE
 - Most recent HBA1c 4.1
- Hypertension
- Migraines
- Dyslipidaemia
- Medications:
 - Inhibace Plus – 5/12.5mg PO OD
 - Atorvastatin 40mg OD (was taking up to day of admission – GP letter indicated it had been stopped)

SHx:

- Lives with husband
- Normally fully independent
- Never smoked
- No alcohol intake
- From Samoa, has lived in NZ for 30 years
 - DOESNT SPEAK ANY ENGLISH

Examination:

- Afebrile, Vitals stable
- HR 80, regular, HS 3+2+0
- Chest – scattered creps at left base only
- No lymphadenopathy
- Breast examination normal
- Abdomen SNT, normal Bowel sounds – difficult to examine due to midline scar - ? Fullness in lower abdomen
- Joint examination unremarkable
- No rash seen
- Extensive muscle weakness
 - 4/5 distally
 - 3/5 Proximally in upper limb and 2/5 proximally in lower limb
 - Cant lift head of the bed, Cant sit up from lying without assistance

Basic Investigations:

- U&E normal
- ANA 1:80
- B12/folate normal
- Ca/PO₄ normal
- CRP 2
- FBC normal
- Hep C negative
- TSH normal
- CK 14000
- ALT 293, AST378, rest LFT's normal
- Tnt 1600
- Hep B Serology
 - Hep Bs Antigen negative
 - Hep Bs Antibody Positive
 - Hep Bc Antibody Positive
 - "Consistent with immunity to hepatitis B due to past cleared infection"

More extensive Investigations:

- Myositis Blot
 - Anti Ro-52 Weakly positive
 - HMGR Auto Antibodies 37.8
- EMG
 - "The neurophysiological evidence is consistent with severe myositis"
- MRI STIR
 - "Increased STIR signal in the left anterior thigh, mostly in the left rectus femoris muscle - supportive of myositis"
- ECHO – Mild diastolic impairment only
- Lung function
 - Pt Unable to do test
 - Beside Peak flow consistently 350ml with PT
 - ABG:
 - PO₂ 76
 - PCO₂ 44

Malignancy Screen:

- Mammogram
 - A small cluster of indeterminate calcifications in the retro-areolar region
 - Awaiting further investigation
- CT Chest/Abdomen/Pelvis
 - Abnormal appearance of the uterus with a markedly thickened endometrium and possible cervical mass

Histology:

- Endometrial Biopsy (via Pipelle)
 - Endometrioid adenocarcinoma
- Muscle biopsy not obtained
 - Significant delays and already enough information to confirm diagnosis
 - Elected to not delay Tx any further

Progress:

- Started 60mg OD prednisone
- Full MDT review and outpatient allied health follow-up arranged
 - Decided best for rehab in the home due to language and Vision issues
- No significant change so far
- Discussions underway re hysterectomy
 - Need to get steroid dose down
- Looking to start IVIG

Difficulties with this case:

- No English
 - Should we use family to translate or get a formal translator in?
 - Small community – a formal translator we used already knew the patient
- Clinically blind and combined with no English made inpatient care very hard
- High dose steroid and risk of Diabetes
- Immunosuppression and risk of Hep B Reactivation
- Surgery on high dose steroids
- Malignancy AND high HMGR