Case 1

A 68-year-old Thai male from Chachoengsao

Chief complaint: A 6 month history of an erythematous and painful left shoulder

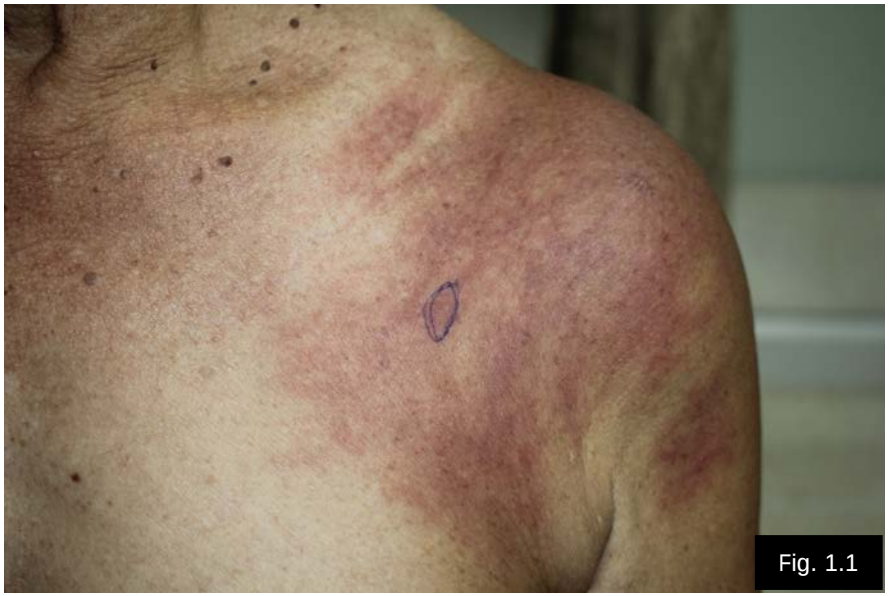

Fig. 1.1

Present illness: Two years before this presentation, at another hospital, the patient was diagnosed with rheumatoid arthritis (RA). The patient was in a stable state of health until six months earlier, when an erythematous and painful left shoulder gradually developed. Magnetic resonance imaging of the shoulder revealed subacromial and subcoracoid bursitis with bony erosions at the posterolateral aspect of humeral head and inferior cortex of the acromial process. An interventional radiologist collected yellowish bursal fluid with a volume of 2 mL using ultrasound-guided aspiration. Fluid analysis revealed absolute red blood cells of 5,000 cells/mm^3 and leukocyte count of 58,270 cells/mm^3 comprising of PMN 94%, and mononuclear cells 6%). And microbiologic investigations then revealed no evidence of infection. At the time, his increased shoulder pain deems to be an active rheumatoid arthritis per se; and another immunosuppressant, methotrexate (17.5 mg weekly), was administered orally.

Three months later, left shoulder pain was mitigated by given immunosuppressants. However, overlying rashes did extend over the left chest wall. He denied fever or other organ-specific symptoms.

Past history: The other comorbidities are as follows: type II diabetes mellitus, essential hypertension, and dyslipidemia. His current medications include hydroxychloroquine (200 mg/d), sulfasalazine (3 g/d), manidipine (30 mg/d), metformin (500 mg/d), ezetimibe (10 mg/d), and losartan (100 mg/d).

Family history: Unremarkable

Physical examination: The temperature was 37.5°C, the pulse was 78 and regular, and the respirations were 16. The blood pressure was 148/70 mm Hg. The patient was alert and fully oriented. His left shoulder was warm and mildly tender without limited range of motion or remarkable swelling. The remainder of her physical examination was unremarkable.

Dermatological examination:

- An irregular-shaped, reticulated, erythematous-to-violaceous, mildly tender, warm patch with matted telangiectasias located on his left shoulder and upper chest wall (Fig.1.1)

Histopathology (S18-031587, left shoulder):

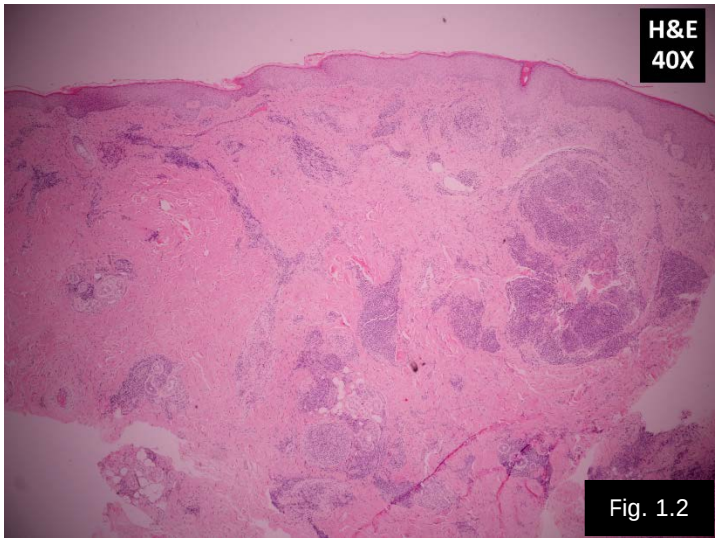

Fig. 1.2

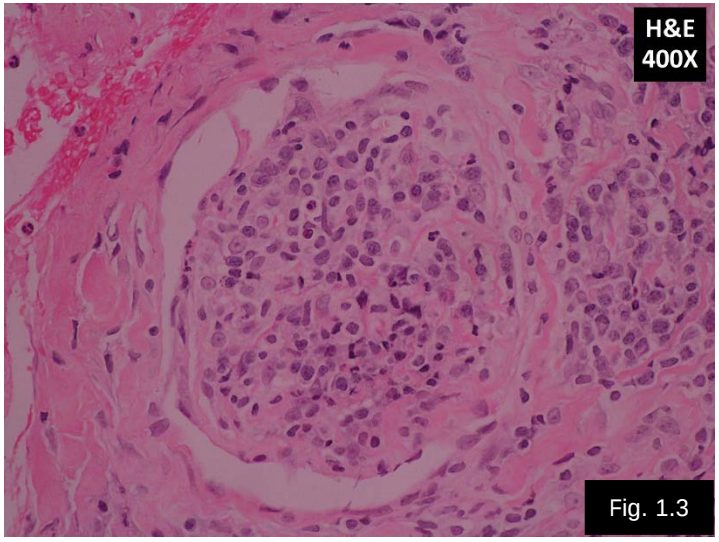

Fig. 1.3

- Dense nodular mixed inflammatory cell infiltrate of mostly lymphocytes, histiocytes, plasma cells, and a few neutrophils in the dermis
- Some aggregates of histiocytes as well as plasma cells and neutrophils within dilated vascular channels

Immunohistochemistry (S19-013657, left shoulder):

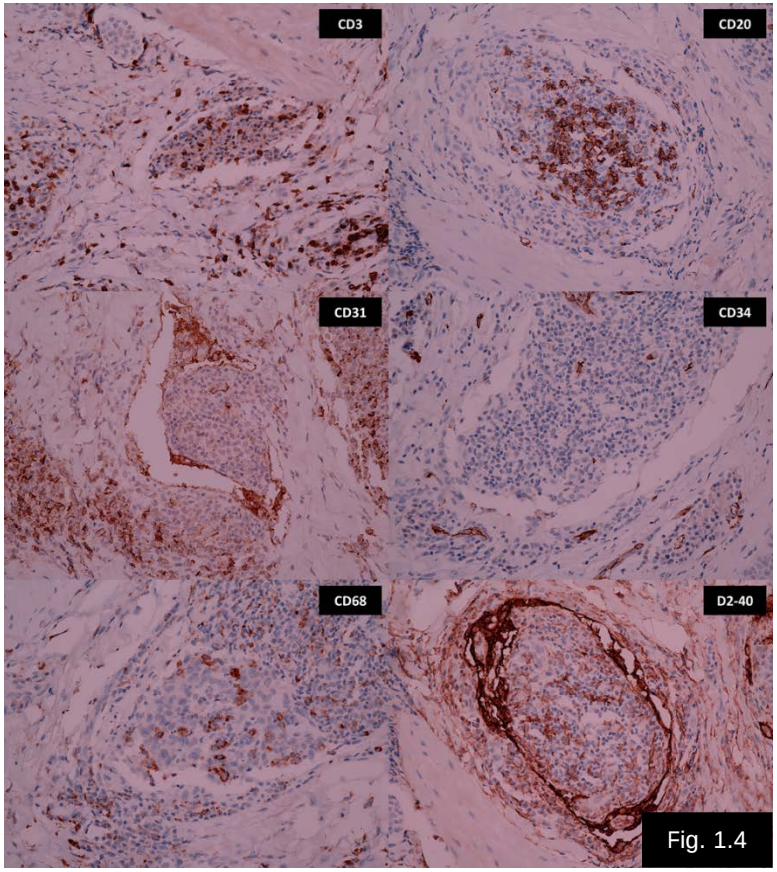

Fig. 1.4

- Scanty positive CD31 staining for vascular structure, positive D2-40 for lymphatic vessels and positive CD68 staining for mononuclear histiocytes
- Negative CD34 staining for vascular structure

Laboratory investigations:

- CBC: Hb 10.9 g/dL, Hct 33.9%, Plt 319,000 /mm^3, WBC 7,920 /mm^3 (N 72%, L 20%, M 6%, E 1%, B 1%)
- ESR: 73 mm/hr, CRP 11.92 mg/L
- AST/ALT: 27/16 U/L; ALP/GGT 54/46 U/L, TP/Alb 78.9/30.7 g/L, TB/DB 0.3/0.1 mg/dL
- BUN/Cr: 16/1.07 mg/dL
- Anti-CCP: 16.7 U/mL, RF 32.5 IU/mL
- HbA1C: 6.06%
- CXR: unremarkable

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