Case 3.1
A 59-year-old Thai female from Bangkok
Chief complaint: A 2 month history of progressive proximal muscle weakness, dysphagia, and skin rash

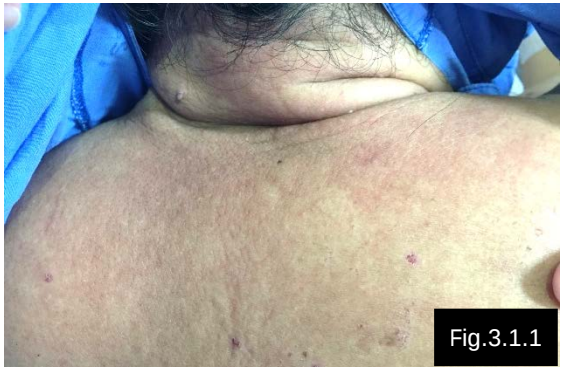
Fig.3.1.1


Fig.3.1.2

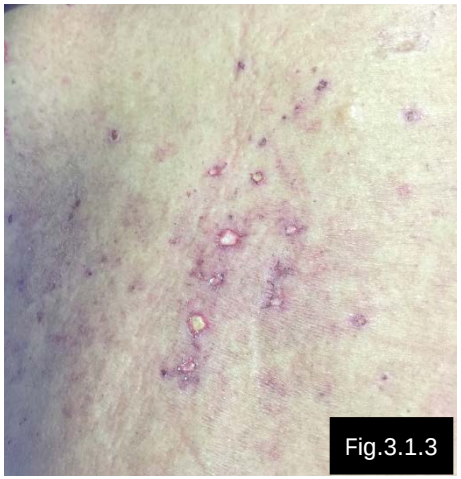
Fig.3.1.3

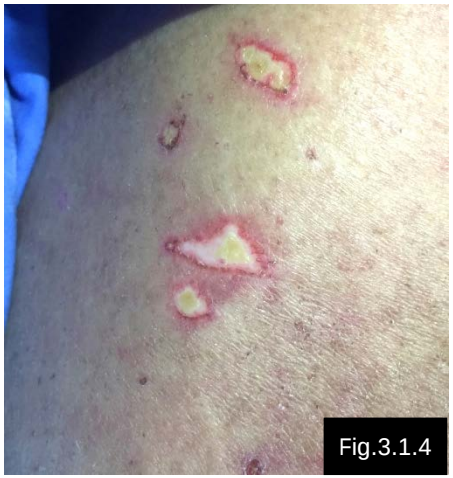
Fig.3.1.4

Present illness:
Two months PTA, the patient began to have myalgia, fatigue and weakness in both arms and legs. The progressive weakness remarkably got worse, rendering her not able to get out of bed, climb upstairs, or even comb hair on her own.

At the time, she also experienced difficulties in swallowing foods and noted asymptomatic whitish and erythematous rashes on her back.

Past history: Type2 diabetes mellitus, hypertension, and cervical cancer with complete remission 10 years ago.

Family history: There was no family history of autoimmune disease or similar lesion.

Physical examination:
- Vital signs: T 36.8 ℃, P 100 bpm, RR 20 /min, BP 178/90 mmHg
- GA: A Thai female, looks fatigue
- HEENT: no pale conjunctivae, anicteric sclerae, no oral ulcer
- Lymph nodes: impalpable
- CVS: normal S_1S_2, no murmur
- Lung: normal breath sound, no adventitious sound
- Abdomen: soft, not tender, no hepatosplenomegaly
- Extremities: no joint swelling
- Neurological examination:
  - Cranial nerve; intact all
  - Motor power;
    Upper → proximal grade 3/3 (Flexor/Extensor)
    distal grade 3+/3+
    Lower → proximal grade 1/2
    distal grade 5/5
  - Sensory; normal
  - Deep tendon reflex; decrease all
  - Plantar reflex; absent

Dermatological examination:
- Multiple, ill-defined, erythematous patches on nose, nasolabial fold, and upper back
- Multiple small porcelain-whitish atrophic papules with peripheral telangiectasia on back, measuring approximately 2-4 mm in size (Fig. 3.1.1-3.1.4)

Histopathology (S16-000885, Back):

- Superficial perivascular lymphocytic infiltration and vacuolar alteration of basal cell layer with epidermal atrophy and scale crusts (Fig.3.1.5)

- Direct immunofluorescence showed epidermal nuclear staining suggestive of connective tissue disease (Fig.3.1.6)

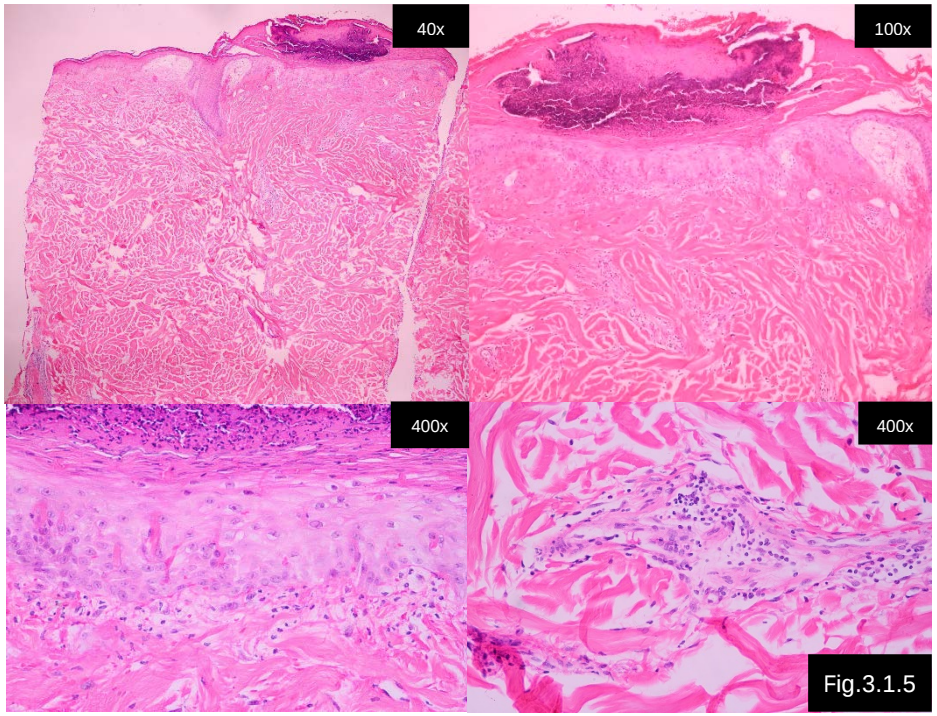

Fig.3.1.5

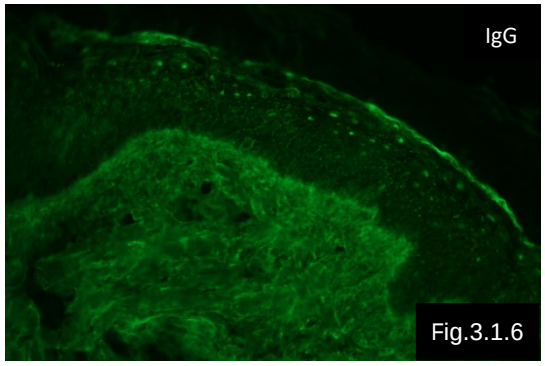

Fig.3.1.6

Laboratory investigations:

- CBC: Hb 13.8 g/dL, Hct 40.7%, Plt 176,000 /mm^3, WBC 3,640 /mm^3 (N 69%, L 26%, M 5%)
- AST/ALT: 25/23 U/L
- ALP/GGT:42/13 U/L
- TB/DB: 0.5/0.2 mg/dL, TP/Alb: 62.5/29.8 mg/dL
- Coagulation profiles: INR 1.21, PT 14 seconds
- Electrolyte, renal, and thyroid functions: within normal limits
- ESR: 79 mm/hr
- Serum creatinine kinase level: 2,637 IU/L
- Anti-nuclear antibody (ANA) positive fine speckled 1:1,280 (anti-nRNP 1+, anti-sm 1+)
- Myositis-specific antibodies: negative
- Antiphospholipid antibodies: negative
- Serum cryoglobulin: negative
- Electromyography (EMG): irritative myopathic change in left quadriceps and myopathic change in deltoid and biceps. This finding suggestive of inflammatory myopathy
- Nerve conduction study (NCV): no evidence of polyneuropathy
- Muscle biopsy: many vacuolated fibers with wiped out appearance, mild to moderate perifascicular atrophy, and presence of perivascular cellular reaction compatible with dermatomyositis
- Chest x-ray: no abnormal finding
- CT chest and abdomen:
    - No evidence of ILD, small non-calcified pulmonary nodules on both upper lungs
    - Suspicious for local recurrence CA cervix with posterior bladder and bilateral distal ureteric involvement
    - Multiple peritoneal metastasis
    - A 0.7 cm right iliac node and 0.8 cm paraaortic node, could be pathologic nodes

Case 3.2

A 26-year-old Thai male from Bangkok

Chief complaint: A 3 month history of multiple asymptomatic whitish and erythematous rashes on back

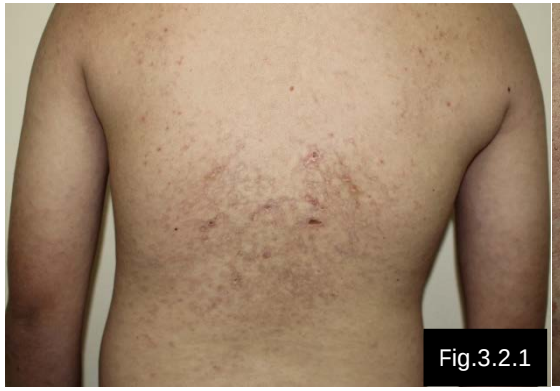
Fig.3.2.1

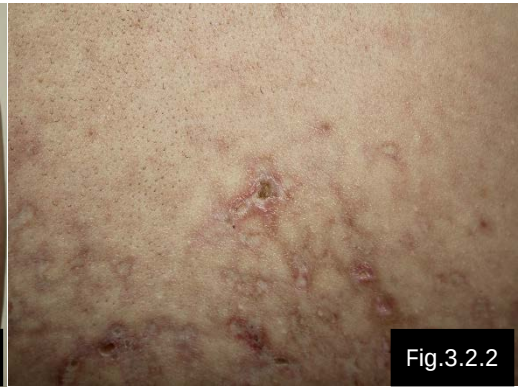
Fig.3.2.2

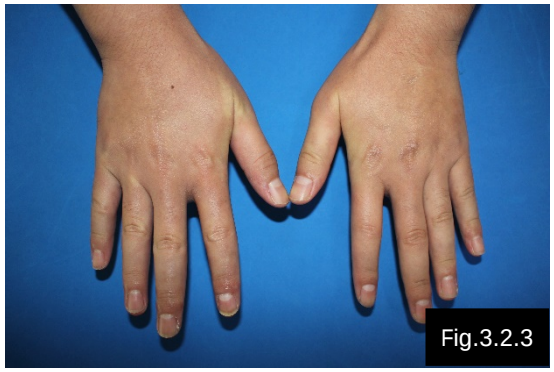
Fig.3.2.3

Present illness:

The patient gradually developed asymptomatic whitish and erythematous rashes on back for 3 months. He also complained of hardening of the skin of the fingers and forearms

He had a history of Raynaud's phenomenon

No history of photosensitivity, arthralgia, weakness, or weight loss

Past history: He has no underlying disease

Family history: There was no family history of autoimmune disease or similar lesion

Physical examination:

- Vital signs: T 36.5 °C, P 70 bpm, RR 18 /min, BP 128/70 mmHg
- HEENT: no pale conjunctiva, anicteric sclera, no oral ulcer
- LN: no lymphadenopathy
- CVS: normal S_1S_2, no murmur
- Lungs: normal breath sound, no adventitious sound
- Abdomen: no hepatosplenomegaly
- Extremities: no joint swelling
- Neurological examination: good consciousness, motor power grade 5 all

Dermatological examination:

- Multiple atrophic porcelain-white macules with periphersl telangiectasia on reticulated erythematous to brownish background on the back
- Sclerodactyly and sclerotic skin up to elbow without ulceration or pitting scars
- Periungual erythema and ragged cuticles (Fig.3.2.1-3.2.3)

Histopathology (S19-020673, Back):

- Wedge-shaped necrosis in papillary dermis
- Homogenized eosinophilic, altered collagen with sparse lymphoplasmacytic infiltration within the entire dermis (Fig.3.2.4)

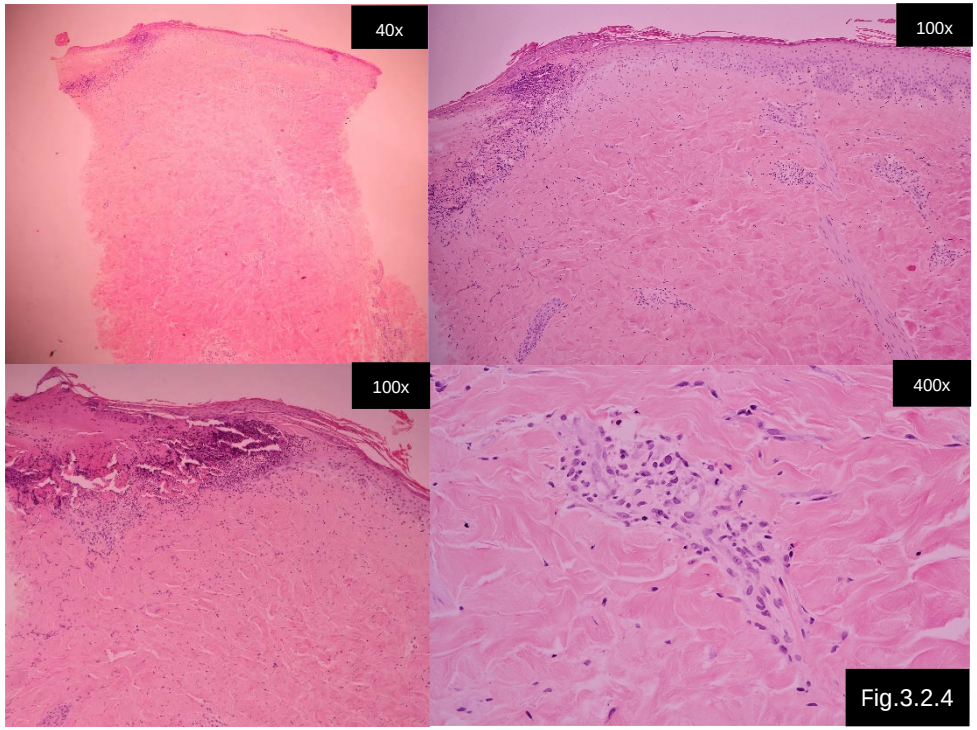

Fig.3.2.4

Presenter: Taptim Stavorn, MD
Consultant: Kumutnart Chanprapaph, MD

Laboratory investigations:

- CBC: Hb 13.8 g/dL, Hct 40.7%, Plt 176,000 /mm3, WBC 3,640 /mm3 (N 69%, L 26%, M 5%)
- ALP/GGT:114/311 U/L
- TB/DB: 1/0.4 mg/dL, TP/Alb: 82.5/36.9 mg/d
- Creatinine 0.6 mg/dL
- Urinalysis: protein negative, no cells
- UPCR: 0.2
- ESR 11 mm/hr
- C3 0.48 g/L (0.9-1.8), C4 0.07 g/L (0.1-0.4)
- ANA positive >1:1,280 homogeneous and nucleolar pattern (nRNP/Sm 3+, Sm 2+, anti-Ro 3+, anti-scl70 3+)
- Antiphospholipid antibodies: negative
- Myositis profile: Ro3+, Ku borderline
- Chest x-ray: no abnormal finding
- Anti-dsDNA: pending