9/30/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****:Conan Liu (@)* ***Case Discussants****: Youssef (@) &Lera (@)*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Varsha):

CC: 62Y/M presents with altered mental status x 1 week

HPI: H/o from sons: 1 week ago - started to become disoriented, wobbly, had headache, vision changes, nausea and vomiting. Received CT /MRI head (Normal). DC on Keppra. His mentation improved but not at baseline. 2 days ago he was found confused lying in the bathroom. Taken to the hospital → ? diverticulitis. After DC his mental status did not improve → current admission.

ROS: Positive: bowel/bladder incontinence x 1 year, Multiple cavities (unknown antibiotics), no fevers/chills

PMH:
Multiple shingles episodes (recent → 6 months ago)
T2DM
HTN
Alcohol use disorder (none x 4 months)

Meds:
Glargine
Glimepiride
Keppra
Lisinopril
Metformin

Fam Hx: -

Social Hx: Lives on ranch with goat, pigs, chicken, cats, works in construction.

Health-Related Behaviors:
No smoking. Occasional THC gummies, no IVDU

Allergies: -

Vitals: T: 97.9 (Tmax 99.7) **HR**: 95 **BP**: 223/89 **RR**: 18 **Sat**: 96 **BMI**:

Exam: Gen: Confused appearing, moving all extremities

HEENT: No erythema, multiple missing teeth, existing molars with cavities

CV: RRR, holosystolic murmur on L sternum **Pulm**: normal

Abd: Protuberant abdomen, soft,no pain. Palpable liver edge 2-3 cm below ribs

Neuro: AxO to self, year, following commands intermittently, not answering health related questions, sensation intact to touch

Extremities/skin: no edema. Black linear discoloration present in multiple digits. No petechiae noted on the pads of finger digits

Notable Labs & Imaging:

Hematology:
WBC: 14.4 Hgb: 11.9 Plt: 356 MCV:

Chemistry:
Na: 134 K: 3.2 Cl: 94 HCO3: 25 Ca: 9.1 Mg: BUN: 10 Cr: 0.7 Glu: 194
AST: 39 ALT:53 T. Bili: 0.7 T. protein: 7.3 Alb: 4.1 LDH: INR: na Trop: na LA: na
UA + 20 ketones, >500 glucose, 100 protein, - nitrite/leuk esterase, - WBC, - bacteria
UDS: + benadryl and trazodone

CT Head and MRI and MRA : Normal, **CTPE and CTAP** - normal
Noncontrast MRA neck: multiple scattered periventricular/subcortical FLAIR/T2 punctate white matter hyperintensities, nonspecific/mild changes from chronic microvascular ischemia.
ICU → Rx for HTN emergency with clevidipine gtt. HTN emergency workup → - (renal artery US, renin/aldo, metanephrines/catecholamines); Started on amp, CTX, vanc, acyclovir empirically
ECHO: LVH, ~35 mmHg intracavitary gradient with Valsalva with decreased L ventricular cavity size. No vegetation
Day 5: ICU→ floor. HTN resolved, AMS + (AOx3, AOx1-2), R sided twitching, EEG - , IV thiamine, hyponatremia to 121 -> 116, WBC 14.4 → 13.7, temp 100.2
Repeat MRI - new basal ganglia and R frontal subacute infarcts
LP: pressure 27, WBC 101 99% lymph, 1 RBC, Glucose 148, protein 100
Workup sent: CSF stain and culture, HSV, VDRL, Crypto, Cocci, Brucella, TB studies, Histo, VZV PCR, autoimmune paraneoplastic panel, HIV negative

Final Diagnosis: Q fever (+ serology) meningitis with Repeat ECHO → Vegetation + → Culture negative endocarditis.
Rx: Doxycycline and HCQ

Problem Representation: 62Y/M presented with waxing/waning AMS, initially Rx for Hypertensive emergency (resolved). CVS exam revealed holosystolic murmur and initial ECHO was unremarkable. LP was performed given persistent AMS → CSF + lymphocytic leukocytosis. Extensive infectious work up was done, positive for Q fever serology and repeat ECHO revealing new vegetation, consistent with culture negative endocarditis.

Teaching Points (Mitch)

- Description of AMS:
- Drive into ACUTE versus subacute/chronic AMS
- What symptoms are outside of the CNS? I.e. Vitals (is this a shock?)
- Image negative AMS: R/o significant structural abnormalities
  - Is there a pressure issue? (incontinence)
  - Image with acute change in AMS
- Intermittent nature: endogenous or exogenous toxin/metabolic

- High Blood Pressure:
- Think about increased ICP, intracranial pathology, and suchings with AMS/Headache/Vision changes
- Wide pulse pressure hints towards aortic insufficiency or hyperdynamic state (e.x. sepsis)
- Understand what was the initial cause/provoking factor of the high BP (increased sympathetic tone, aldosterone, or volume)

- Endocarditis:
- Most common: gram positive skin/soft tissue/oral flora
- Ask about lines and devices
- Culture neg: recent Abx use, Brucella, Bartonella, Coxiella

- MRI + LP Results:
- Meningitis + Stroke: Increased pressure causing deep stroke (TB, Crypto, Cocci) versus vessel damage (VZV, HSV)