5/17/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: Hafsa (@HafsaSaeed) **Case Discussants**: Kirtan(@KirtanPatolia) & Noah (@noahnakajima IG)

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

Scribing (Sana)

CC: 60 y/o male presenting with fever, reduced level of consciousness and hypoxemia

HPI: Two episodes of non-bilious vomiting with no hematemesis after an episode of binge drinking. Subsequently lost consciousness that night & discovered unresponsive by his son the following morning, f/b admission and t/t for acute alcohol intoxication at a peripheral clinic. Over the next week, he developed high-grade fevers, new onset dyspnea with tachypnea & productive cough with purulent sputum prompting transfer to a 3° care facility. Wife reports recurring episodes of generalized tonic-clonic seizures throughout the course of hospitalization, 2-3 times/day.

ROS: (-) chest pain, hematuria, dysuria, abdominal swelling, yellowing of eyes, hematemesis or melena, vision changes, impaired memory or limb weakness

PMH: Alcohol Use Disorder

Meds: -

Family Hx: -

Social Hx: -

Health-Related Behaviors:

- Alcohol consumption (5 bottles/day x 40 yrs)
- Smoking (20 packs/yr)

Allergies: -

Vitals: T: 37.6 °C **HR**: 112 **BP**: 88/68 **RR**: 22 **Sat**: 96 on 4 L O_2

BMI: 16

Exam: Gen: Moderately wasted & dehydrated. AO to self only.

HEENT: Mild conjunctival pallor. No scleral icterus.

CVS: prolonged CRT

Pulm: ↓ed air entry b/l and crackles in posterior lung fields bilaterally.

Abd: nl

Neuro: GCS 8/15 (E2V2M4), speech markedly reduced and dysarthric. Horizontal nystagmus elicited, b/l restricted lateral conjugate gaze. Tone globally ↓ed.

Extremities/skin: Multiple abrasions across face and neck, consistent w. recent trauma or falls.

Notable Labs & Imaging:

Hematology:

WBC: 12K → 8.7K; Hgb: 8.5→6; Plt: 108K→53K; MCV: 64

Chemistry:

INR: 1.2 PT: 12.9 aPTT: 28

Na: 124 K: 3.6 Cl: 107 Cr: 1.1 BUN: 14 Glucose: 64 Ca: 8.8

AST: 17 ALT: 28 Alk-P:236 T.Bili: 0.6 D.Bili: 0.2 Albumin: 2.9 Total Protein:5.3 ESR: 54 CRP: 127

PBS - occasional schistocytes

UA: 1+ Ketones; BC: nl; LP: nl;

GS: mixed polymicrobial picture w. both GPC and GNB

Imaging:

CXR: heterogeneous opacities w. patchy confluent airspace distribution b/l lower lobes (R>L)

Brain CT: Subtle hypodense lesions in the basal ganglia

Dx: Aspiration pneumonia 2/2 Wernicke's Encephalopathy

Problem Representation: 60 y/o M k/c/o alcohol use disorder presenting w. fever and AMS, o/e found to be malnourished w. b/l crackles, dysarthria, nystagmus and restricted lateral conjugate gaze. CSF gram stain +ve for GPC & GNB with subtle hypodense lesions in basal ganglia seen on brain CT.

Teaching Points (Siva)

1. Alcoholism + fever- pancreatitis,aspiration PNA,withdrawal(hyperthermia-excess SNS)?
Urine drug screen(OH+drugs)?
Fever >48 hrs -think of infections(immunosuppressed-OH,cirrhosis)
2. Delirium tremens-high mortality,hospitalization is needed to monitor. Rx-BZDs . Imaging
3.CN 3,4-midbrain,6(pons) -PPRF -responsible for horizontal gaze. Vertical gaze- Midbrain nucleus (connected by MLF).
Cerebellum-fine tuning eye movements.Defect in any of this causes gaze abnormalities. Wernicke ?
r/o structural causes is important before going into substance hypothesis(empiric rx should be started-thiamine).
Thiamine 750 mg q8hrs-required dose.(not low doses-no ADRs anyway)-Dx and rx.
4. Smear-acanthocytes (cirrhosis)-can be misinterpreted as schistocytes(MAHA physio).
quinine(gin and tonic)-can trigger TTP(ADAMTS 13 inhibitors) and they can get self resolved(?)
Basal ganglia lesions- Bleed,toxic necrosis,infarct
Mammillary bodies (thiamine)
Viral infection affecting basal ganglia-WNV,equine encephalitis.
Chronic OH history-Acquired hepatocerebral degeneration-Mn deposition (in cirrhosis);(genetic-wilsons).