3/15/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Julia(@)* ***Case Discussants****:Kirtan (@KirtanPatolia) & David (@davserantes)*

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

Scribing (Vanessa)

CC: 58 yr old male 2 days of productive cough, congestion, sore throat, myalgia, sob

ROS:
No headache, dizziness, no nausea, vomiting, diarrhea, dysuria

PMH:
HIV on ART
COPD

Meds:
Albuterol
Bictavy
Atovaquone
Apixaban
Gabapentin
Vit B12
Vit B3
Budesonide
Tiotropium
> Adherence to all medications

Social Hx:
Resides in sober living home (Tobacco, Alcohol, Illicit drugs)

Vitals: T: 36.4 **HR**: 87 **BP**: 115/80 **RR**: 21 **Sat**: 96% room air **BMI**:
Exam: Gen: mild respiratory distress with increased wob
Pulm: wheezing
CV: normal **Abd**: normal **Neuro**: normal **Extremities/skin**: normal

Notable Labs & Imaging:



Hematology:
WBC: 10.5 (81.5% N, relative lymphopenia)
Hgb: Plt: MCV:
Chemistry:
Cr: 1.2 Ca: 7.8, corrected 8.9
Albumin: 2.6 Total Protein: 5.4
LDH: normal
CD4 169 →160 on repeat
RVP: Negative

Imaging:
CXR: interstitial opacities RML
Treated empirically for COPD exacerbation and CAP (CTX + Doxy for 3 days) -> ongoing symptoms
CT Chest: diffuse, centrilobular GGOs with bronchial wall thickening and scattered mucoid impaction of lower lobes -> Reflect chronic infection bronchiolitis with possible etiologies (including NTM)
Trace left pleural effusion with compressive atelectasis

Sputum: PJP PCR positive

Dx: COPD exacerbation with airway centered bronchiolitis
(With early PJP stage or colonization due to lack of features)

Problem Representation: A 58 year old male, with a past medical history of HIV on ART and COPD, presents with 2 days of productive cough, congestion, sore throat, myalgia and sob, that hasn't resolved in clinical setting despite empirical Tx.

Teaching Points (Gillian)

With both lower & upper respiratory symptoms + myalgias:
- acute: more likely viral > bacterial or fungal
- chronic could be autoimmune diseases like sarcoid, gpa, egpa

Sore throat evolution:
- If it resolves→viral infections
- If it does not resolve, additional symptoms and pmh help to clarify ddx

Immune compromise + sore throat
- Still most likely common viral syndromes
- more likely to get lower airway disease either from prolonged infection w/ common pathogens or atypical pathogens

HIV is not just immune compromise but also immune dysregulated state. Other than infection, rare complications

Causes of low CD4 count in HIV (<200)
- Most common medication adherence
- Acute illness (need to trend them)
- Long untreated with very low nadir
- Resistance
- Other medications

In HIV, patient's symptoms and labs may not tell the whole story because they cannot mount a full response. Imaging might be more central and continue work up even with a positive test

Centrilobular GGOs:
- Infectious: viruses, atypical bacteria, mycobacteria (tb and non-tb mycobacteria)
- Non-infectious: hypersensitivity pneumonitis, respiratory bronchiolitis
- In immunocompromised patient: HSV or VZV, mycoses even without nodules, parasitic (toxo–in transplant patients usually present cardio pulm)

If a patient may need a bronchoscopy, it is good to do when they are stable in case decompensate

Normal LDH does not rule out PJP; PPV for beta-d-glucan is between 85-90%

Atovaquone not very good for PJP prophylaxis: resistance fast to develop, insufficient dose