10/11/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: *Shreyas Nandyal* **Case Discussants**: *Kirtan (@KirtanPatolia) & Lourenco (@lourenco_garcia)*

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

Scribing (Sana):

CC: 30 M p/w 2d of fevers, chills and diffuse rash

HPI: Rash began on his arms and spread across the body over 48 hrs. HIV dx 6 wks ago, started on bictegravir. 2 prior hospitalizations - most recent 9 days prior to presentation. Presented w/ 102 F fever, rash that was painless & non-pruritic, also reports mild cough for past 1 month, 15 pound wt. loss, generalized weakness and slowed thinking.

ROS: discomfort with bowel movements

PMH:
newly Dx HIV [6 w ago]

Meds:
Biktarvy
+ 2 meds

Fam Hx: DM, Pancreatic cancer

Social Hx: Recently moved to Chicago from Arizona(since unable to care for himself), Artist (used to work in a warehouse)

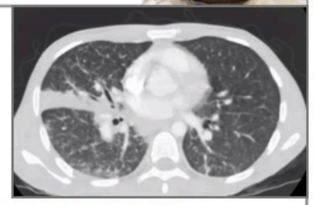
Health-Related Behaviors: Sexually active w/ men and women.

Allergies:doxycycline

Vitals: T: 38.5 **HR**: 94 **BP**: 100/53 **RR**: 20 **Sat**: 97% on RA **BMI**: 18.3

Exam: Gen: no acute distress | **Neuro**: AO x 3, no FND / neck stiffness
HEENT: no LAD | **CV**: tachy, S1 S2 nl| **Pulm**: Clear b/l
Abd: soft non tender, mild hepatosplenomegaly
Extremities/skin: diffuse erythematous maculopapular Eruptions, papules coalescing into plaques + desquamation on the hands, legs and back. No bullae, no mucosal involvement.





Notable Labs & Imaging:

Hematology:
WBC:12 N [L 1.2, CD4 45 -> 301] | **Hgb**: 9.1 | Plt: nl | MCV: 85
PBS: teardrop cells, schistocytes, spherocytes

Chemistry:
Na: 131 K: 4.9 HCO3: 26 Ca: 9.2 Mg: 1.8 BUN: 20 Cr: 0.9 Glu: 88 Phos: 4.1 Cl: 96
AST: 56 -> 500s **ALT**: 120 -> 500s ALP: 164 T. Bili: 0.4 T. protein: Alb: 3.4 Lipase: 27
LDH: 220 **Ferritin:** 709 **BCx**: neg UCx: neg **RPR**: neg **CrAg**: neg **ANCA:** neg

Imaging:
CXR: b/l lung opacities concerning for multifocal pneumonia or aspiration

Shifted to ICU w/in a day d/t tachypnea, tachycardia and BP falling to 79/44 despite fluids. Empiric Vanc and cefepime started.

Con CT C/A/P : b/l pulmonary nodules, consolidation in post rul, extensive LAD, splenomegaly w/ innumerable small hypoenhancing splenic lesions and mild periportal edema.

USG Liver: Hepatomegaly w/ hyperechoic parenchyma

6 wks ago -> gluteal abscess Rx w/ doxy -> rash. Dx w/ HIV and started on Biktarvy. Later hospitalized for pneumonia and possible splenic abscess and discharged on TMP-SMX & fluconazole. U. histo, aspergillus galactomannan and cryptococcal Ag neg.

3v wks ago-> presented w/ confusion and agitation & lactic acidosis. CT head, MRI Brain and LP were unrevealing.

*BAL done, **transbronchial biopsy**: Granulomatous infl w/ spherules consistent w/ coccidioides. **Coccidioides IgM** +ve.*

BCx neg ATP thus vanc and cefepime stopped, fluconazole switched to liposomal Amphotericin B -> prednisone 60 mg.

Dx: Paradoxical Immune Reconstitution Syndrome.

Problem Representation: 30 M w/ recent HIV dx p/w 2 d fever, chills & diffuse maculopapular desquamating rash. Exam +ve for mild HSM w/ no mucosal involvement of rash. Labs show schistocytes on PBS, CD4 count of 301, elevated AST and ALT and negative BCx. CXR +ve for b/l lung nodules and transbronchial biopsy +ve for coccidioides IgM.

Teaching Points (Glen)

-Diffuse Rash: localised or systemic[immunosuppression]. Infections, autoimmune, malignancy. Mode of HIV acquisition(STI, IVDU) and HIV timeline?

-Systemic Involvement: CNS, inflammatory symptoms.
-Rash after HIV related meds: ?due to meds (TMP-SMX for PCP prophylaxis, doxycycline). Rule out deep systemic disease related to low CD4, Imaging helpful especially with weight loss.

-IRIS: Can cause rashes after HIV meds. Warehouse exposure makes him vulnerable. Unmasking vs paradoxical.
-Hepatosplenomegaly: ?infiltration including bone marrow leading to teardrop cells. Rule out hemolysis.
-B/L Lung GGO: infections(bacterial, fungal, viruses, parasites) due to immunosuppression. ? resp failure leading to ICU admission.

-PBS: Abnormalities better trended to determine severity.
-New Onset AKI: could be explained by systemic disease. Rule out UTI.
-Tissue Biopsy: Will help diagnose certain organisms e.g herpes viruses, EBV, HHV. Cultures also helpful.

-Cause of Deterioration: IRIS from coccidiomycosis.