



# 4/15/26 Morning Report with @CPSolvers



“One life, so many dreams” Case Presenter: Mitch O'Meara (@) Case Discussants: Sharmin (@) & Sam (@)  
<https://clinicalproblemsolving.com/present-a-case/>

**Scribing (Julia)**  
**CC:** unwitnessed fall  
**HPI:** 35 female presented on the ED after a family member found her unconscious on the bathroom. On the ED, she was resuscitated and denies lightheadness, palpitations or pre-syncope symptoms, as well as post-ictal status, bowel or urinary incontinence. She also complains of progressive fatigue, generalized weakness, thigh pain and easy bruising for the past few weeks previous to the current presentation. For the past month, reports SOB. She also noticed chills for the past few days.

**ROS:** Denies fever, CP, vomiting, diarrhea.

**PMH:**  
Chronic Osteomyelitis (amputation workup being done)

**Meds:**  
Methadone a month ago (stopped before presentation)

**Fam Hx:** none  
**Social Hx:** Lives with her daughter  
Current unemployed  
**Health-Related Behaviors:**  
Polysubstance use disorder (Meth, cocaine, benzo)  
Social alcohol use  
**Allergies:** none

**Vitals:** T: 37.5 HR: 136 BP: 86/48 RR: 24 Sat: 85 on RA (94% on 6L) BMI: 24  
**Exam:** Gen: appear very sick  
**HEENT:** significant dental caries, no obvious abscess. Purpura and petechiae on gums. CV: no murmur, no JVD Abd: nl  
**Pulm:** breath sounds diminished through all lungs  
**Neuro:** AO, 5/5 strength, light touch and pain sensations and CN nl  
**Extremities/skin:** bruising and purpura on the thighs. 3+ pitting edema to the mid-thighs, wound on R knee



**Notable Labs & Imaging: Hematology:**  
WBC: 11.9 | Hgb: 6.7 | Plt: 35 | MCV:87  
**Chemistry:**  
Na: 128 | K: 3.2 | Cl: 85 | HCO3: 26 (anion gap 17) | Cr: 1.55 (baseline 0.9) | BUN: 51 | Glucose: 107 | Ca: corrected 9.2 | Mg: 1.6 | AST: 38 | ALT: 8 | Alk-P: 166 | Bili: 1.7 (D: 0.7 / I: 1.0) | Albumin: 1.4 | CK: mildly elevated | ESR: 71 | CRP: 301 | LDH: 359 | Troponin 5 | Lactate 4.7 | PT 18.6 | INR 1.7 | aPTT 28 | Fibrinogen 109  
UA: non infectious. Some red blood casts.  
Utox: positive for opioid, xylazine RVP neg | HIV neg, Hep B and A neg | Hep C positive  
Blood culture: positive for MSSA

**Imaging:**  
EKG: sinus tachycardia | CT head: normal | Legs x-rays: no fractures. Negative.  
CXR: consolidations on the right middle lobe. Patchy b/l opacities.  
CTA: interstitial edema, widespread B/L nodular/cavitary lesions  
CTPE: segmental and subsegmental b/l septic-appearing emboli  
→ ED started on broad spectrum atb + IVF + norepinephrine for presumed septic shock  
Echo: large vegetation on the tricuspid valve with severe tricuspid regurgitation

**Dx:** Endocarditis complicated by MSSA

**Problem Representation:** 35 female with PMHx of polysubstance use disorder and chronic osteomyelitis presents with septic shock, acute respiratory respiratory failure, and diffuse purpura, with imaging concerning for septic pulmonary emboli and lab evidence of multisystem organ dysfunction and DIC.

### Teaching Points (Evan)

- Falls without pre or post symptoms > cardiac workup as these type of falls point away from vasovagal
- Fall - cardiac, environment, MSK, neuroaxis (sensory, strength)
- Hx of IV drug use - immunocompromise
- Purpura with necrosis - endocarditis, DIC
- Nutritional deficiencies - thiamine
- Approach bicytopenia as pancytopenia - bone marrow failure, increased peripheral destruction
- DIC - look for source of infection in septic patients - UA, dental, cardiac
- Widespread cavitary lesions in lungs - septic emboli, immunocompromise - fungal inf
- In patient with pulmonary embolisms want to check rest of body to assess for future insult
- Vanco not ideal for MSSA due to lack of altered binding site