6/10/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****:Kevin (@allein.zu.haus)* ***Case Discussants****: Sharmin(@) & Prof Reza (@)*

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

Scribing (Hafsa)

CC:77 y/o female presenting to ER respiratory infection

HPI: cough + sputum with yellow mucus ongoing for few mo -> disappeared -> developed again last week. Treated with amoxicillin and clarithromycin with no improvement, reports same symptoms last year in Turkey and resolved spontaneously. Admitted to ward started on iv ampicillin sulbactam and azithromycin, however dyspnea worsened and was dependent on supplemental O2(nasal cannula), 9L/minute, noted clinical improvement while on piptaz, however was later found on the floor{clinically dead}, rosc achieved after 12-15 mins and moved to icu, went into septic shock

ROS: (-) fevers, n/v and (+) general weakness

PMH:
RA [prednisone & mtx]
Asthma
Hep b
Gastritis
HTN, Hyperuricemia
HF NYHA 1, T2DM
H/o thrombosis

Meds: Prednisolone
Ramipril, Torasemide
Methotrexate, Amlodipine
Salbutamol, Metformin

Fam Hx: -

Social Hx: lives with her children

Health-Related Behaviors: -

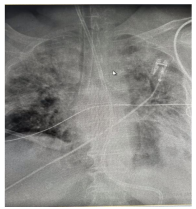
Allergies: -

Vitals: T: **HR**: nl **BP**: nl **RR**: **Sat**: 90% on RA **BMI**: morbidly obese
Exam: Gen: unwell,breathing heavily ,coughing intermittently.
CV: nl **Pulm**: basal crackles **Abd**: nl
Neuro: no deficits(anisocoria noted while in icu)
Extremities/skin: edema on the extremities

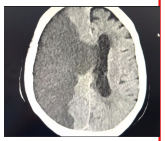
Notable Labs & Imaging:

Hematology:
WBC: 11 Hgb:11 Plt: MCV:92
Blood gas: nl Lactate: 2

Chemistry:
Cr: 0.8 (bl) -> 1.5 Albumin: 33.74 (low)
ESR: CRP: 15.6 **LDH**: 450 pct;nl
Hemolysis labs: neg



Imaging:
EKG: normal sinus rhythm[nl]
CXR: unspecific shadows
BCx: neg
Ua: neg
HRCT: milk glass phenomenon in both lungs (multiple hyperdensities/GGO)
Started on ciprofloxacin, meropenem
Repeat CXR: suggestive of ARDS
-> progressed to septic shock -> anisocoria
Head CT: Malignant infarct with midline shift



Dx: Septic Shock 2/2 Alveolitis/PCP, leading to ICH due to DIC & Exitus letalis.

Problem Representation: 77y/f immunocompromised with RA on mtx and prednisolone presenting with recurrent respiratory symptoms with cxr showing unspecific shadows and HRCT suggestive of ARDS complicated by septic and malignant infarct causing midline shift and herniation

Teaching Points (Preethi)

Approach to acute pulmonary syndrome: subacute episodic→ can be similar illness from before vs new syndrome on top of an underlying lung disease eg., bronchiectasis.

Patient with autoimmune disease-> think about medication side effect/autoimmune flare/superimposed manifestation of the disease/secondary autoimmune disorder.

Important to get ambulatory saturation to see if they are hypoxemic, if at baseline, they are saturating at 90-92% on RA

Bibasilar crackles: wet or dry? Pulmonary edema vs ILD etc.

Immunocompromised pt + pulmonary symptoms + high LDH = important to do an infectious workup including PJP.

- **Dx & Tx approach: pulmonary workup (respiratory viral panel, AFB, bronch and BAL if feasible), broad spectrum abx, PJP prophylaxis, HFNC, escalation of care given oxygen requirement and acuity of case.**
- **Albumin is a negative acute phase reactant.**
- **CT scan of the chest helps to understand the etiology ILD vs DAH vs other. Findings on the CT & timestamp approach: Honeycombing (chronic), bronchiectasis (subacute), GGO (acute)**

Reason for Code Blue? PE, aspiration, Vfib arrest? Stabilise pt first.

Think about pneumothorax in pt with sharp CP and PJP PNA (vulnerable cysts).

ICH, midline shift, herniation of brain (unequal pupils on exam) iso of sepsis could be DIC.