9/10/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Jas (@)* ***Case Discussants****: Rabih (@) & Simmy (@)*

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

Scribing (Varsha):

CC: 60 y/o M with h/o Left inguinal hernia repair (5/27/26) presents with 3 day h/o fever (103F).

HPI: hernia pain x years, procedure went well. 2 days later: fever, chills, R flank pain, hip pain, R anterior thigh numbness(few days after Sx, no tight clothing/belts), generalised ab pain.
Went to another hospital - pain meds and and antibiotics (zocin and vanc → mesh infection?)
Fever again (103) constant, flank pain got worse 9/10 stabbing in nature, radiating to R lateral hip. Now has sore throat and dry cough x 4 days.
Was also treated for possible pneumonia recently.
Burning pain in ant thigh when trying to walk, radiating to back

ROS: no dysuria/hematuria

PMH: no contact with healthcare in 30 yrs

Meds: cyclobenzaprine, phenazopyridine, tylenol

Sx: L inguinal hernia repair

Fam Hx: mother MI, grandmother: T2DM

Social Hx: lives alone, pet dog and parrot, contact with bird droppings, no tick bites

Health-Related Behaviors: divorced, sexually active, intermittent condoms, 4- 5 partners, no contacts in last few months, cruise + (no complaints).
Smoking 1pk/day x 19 years, alcohol, marijuana, cocaine

Vitals: T: 103 F **HR**: 75 **BP**: 180/100 **RR**: 18 **Sat**: 95 **BMI**:
Exam: Gen: ill appearing
CV: regular rate and rhythm
Pulm: CTAB
Abd: tenderness + in UQ, hernia site: normal
Neuro: antalgic gait +

Notable Labs & Imaging:
Hematology:
WBC: 5.8 (relative neutropenia, lymphocytosis (reactive lymphocytes 5%), Hgb: 12.4 Plt: 254. WBC: 3.1 and Plt 149 (outside)

Chemistry: Na: 133 K: wnl Cl: wnl AST: nl ALT: 59 ALP: 145
ESR: 33 CRP: 147 LDH:175
Pro cal: 1.32, TSH: wnl
UA: normal
Imaging:
CT ab/pelvis: mild fat stranding consistent with post op changes, wnl
CT chest: scattered pulmonary micronodules, no consolidation/effusions
MRI lumbar spine: normal
Hip X RAY: wnl
Prior to Sx: profound fatigue, lack of energy, warmth + did not record temp
Infectious panel: EBV IgG +, IgM -
CMV, HIV, syphilis, lyme, leptospirosis, Ehrlichiosis : negative

PS: lymphocytosis, neutropenia, reactive lymphocytes

Anaplasma + : 1: 256
h/o of hike → no tick bite recollection → fatigue
Started doxy → 48 hrs → burning pain and gait improved

Dx: Anaplasmosis

Problem Representation:60-year-old man with persistent high-grade fever following inguinal hernia repair, associated with fatigue, flank pain, and antalgic gait, found to have relative neutropenia, lymphocytosis with reactive lymphocytes, unrevealing imaging, and a negative initial infectious workup (including EBV and CMV), ultimately diagnosed with anaplasmosis based on positive serology

Teaching Points (Lourenço)

- **Fever:** results from widespread immune activation, either due to an antigen, or due to automatic activation. Try to see if there are localizing findings (++ in the interfaces with the outside world).
- **TMI**: whenever there is history overload, pursue the physical exam to focus the following evaluation.
- **Timing of presentation**: a patient that presents with a disease that has been going on for a while, the probability of a life threatening diagnosis is low. When the physical exam is tame in comparison to the complaints, imaging is key to clarify the extent of the disease.
- **Finding a source of inflammation**: imaging is king. However, it can miss blood-based or liver diseases (e.g., intracellular organisms, such as viral hepatitis).
- **Acute presentation VS acute discovery of subacute / chronic disease**
- **Atypical lymphocytosis:** think of intracellular organisms such as virus, parasites or bacteria (e.g., anaplasma, ehrlichia). Rule out sneaky extracellular bacteria such as TB and syphilis. Specially, when paired with Faget sign.