6/13/25 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Maddy (@MadellenaC) **Case Discussants**: Rabih (@rabihmgeha) and Reza (@DxRxEdu)*

Scribing (David)

CC: 40 yo male with a chronic indwelling Foley catheter with 1 day of lower abdominal pain and change in quality and quantity of urine

HPI: 2 days before coming to the ER her sister notes dark urine
1 day before the ER: suprapubic pain, decreased urine output (from 500cc to 200cc) and leaking of urine around the Foley.

No fever, no chills, no back pain, no dysuria, no confusion.

PMH:
Spina bifida and paraplegia
Chronic sacral wound on several previous suppressive Abx therapies (withheld now)
Foley placed one year ago to prevent contamination of sacral wounds, last exchange 2.5 weeks ago

T2DM on metformin with well control
HTN on metoprolol

Social Hx: lives with her sister full time, great support

Health-Related Behaviors: doesn't drink alcohol or smoke

Vitals: T: afebrile **BP:** nl **HR**: nl **SpO2** nl
Exam: Gen: no acute distress.
CV, Resp and abdomen: normal
Skin: urine leaking from urethral meatus with significant sediment (after exchange, normal color). No urethral discharge. Ostomy in left side of the abdomen for the sacral wounds.

Notable Labs & Imaging:
Hematology:
CBC: normal
BMP: normal. Cr normal
UA (after Foley exchange): cloudy, leukocyte esterase +, > 75 WBC, negative nitrites, moderate bacteria

Previous urine cultures (3 months prior): P. aeruginosa

In the ED urine cultures were sent from the new Foley. He was started on Zosyn. On the morning was feeling very well: no suprapubic pain.

New urine culture: > 100.000 CFU of P. aeruginosa and > 100.000 CFU of E. faecalis.
Based on susceptibilities of previous cultures, ID was consulted. Patient reported his symptoms resolved immediately after exchange, so not UTI :)
He was discharged without antibiotics.

Dx: Foley malfunction/obstruction (Reza dx: early CAUTI)

Problem Representation:

Teaching Points (Zakariyya):
Pain with foleys in situ: 1) Mech. obstruction (see if one can flush , confirm with U/S 2) Bladder Spasms
Indications for long term catheterization : Obstructive uropathy , in this case age NB, young likely NM problem/ SC , Acute urinary retention not mx by other means , pressure ulcers
In pt's with sacral wounds, suprapubic might be better
Foley + ? UTI (no dysuria, frequency etc) : : dec. urine output, suprpubic pain(local symptoms) , systemic signs of illness
Leak with foley: urine follows path of least resistance , ? obstruction (inside the tubing vs entrance blocked : stone vs clot) vs migration into urethra
When to consider giving Abx with Cath assoc. UTI : If syndrome fits , local symptoms + systemic signs/symptoms , err on side of caution (if pt unwell consider giving)
Drug of choice : Cover for Pseudomonas + usual bugs,
UA in UTI : WC (LE) , if Nitrites (E.Coli , Proteos)
" No symptoms no UTI, no Bacteria no UTI , no pyuria no UTI "
Cath assoc. UTI : all common org + S. Aureus ,Pseudo, Enterococcus ,Fungus
Before giving ABx in the ED : consider the need , possibility for resistant bugs in future
Rabih philosophy : " If pt happy , I'm happy" (if we've resolved the patients complaint , happy to send pt home with some caveats) , Pt symptoms resolved after exchange catheterization , Dx likely CAUTI , discussion on nuances of either D/C pt with/without abx , consulting ID might , by giving Abx , we trying to reduce severe infection or prevent further obstruction
Illness script for cath assoc. UTI (RLR)
When doing procedures on pt, especially in the ED, always think ahead (are we doing good or harm, will our actions contribute to