



# 6/4/26 Morning Report with @CPSolvers



"One life, so many dreams" **Case Presenter:** Austin (@) **Case Discussants:** Rabih (@) & Kevin (@)  
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Rahul)

**CC:** 32 Y/M found to be altered witnessed by bystander.

**HPI:** Patient is unknown, primary thought process is likely alcohol intoxication which is unclear at this point.

Patient is from South Asian descent. Well groomed and nourished.

Patient is a **visitor from India.**

**T:** afebrile **HR:** 88 bpm, **BP:** 155/101 mmHg, **RR:** 17/min **Sat:** 99@RA  
**Gen:** not able to follow commands, somnolence, irritable. Not cachexic.  
 Neck exam: Unclear about neck rigidity. No meningitis signs.  
**Neuro:** spontaneous limb movements noted. Normal tone or reflexes. Not able to verbalize.  
**Extremities/skin:** bandage at the left upper arm. Old track marks on the leg and arm. No stigmata of liver dz.

**Notable Labs & Imaging:**  
**Hematology:**  
 WBC: 5 Hgb: 10 Plt: 120 MCV:77, Diff: NL  
**Chemistry:**  
 Na: 126 -> 128 K: 4.4 Cl: 93 HCO3: 21, AG: 12 Cr: 0.83 -0.4, BUN: 9  
 Glucose: 96 AST: 162 ALT: 130 Alk-P: T.Bili: 2 Albumin: 2.8 Total Protein:6.3, ESR:100 CRP: LDH: 900 (<280), CK: 950  
 Iron panel: nl, haptoglobin: nl, TSH: normal.  
 Alcohol, salicylic acid, U tox: Negative. Anaplasma, Ehrlichiosis, lymes: Neg  
 Hep B: NR, Hep C antibody: reactive, HCV RNA: High.  
 CT head: No acute intracranial findings > nonspecific hypodensity on posterior limb of internal capsule. No bleed or midline shift. MRI recommended. ( Addendum)  
 Neuro consult: Psychogenic mutism vs seizures. EEG pending at this point.  
 MRI brain: Multifocal infarcts likely in the setting of cryptococcus.  
 LP: Cell count: 10, 70% neutrophils, glucose: low, Protein: high, opening pressure: not measured. Yeast found on CSF staining. CSF PCR: positive for Cryptococcus. Serum cryptococcus: Negative.  
 HIV: **Reactive**; serum CD4 count: **60**

**Dx:** Cryptococcal meningitis in the setting of advanced AIDS/HIV & active hepatitis C

**Problem Representation:** 32Y/M with unknown PMH presented with **AMS who is somnolent, found to high LDH, hypoalbuminemia**, hepatocellular pattern of liver injury, noted to have hypodense lesion on internal capsule with LP suggestive of **cryptococcus meningitis.**

**Teaching Points (Ramaswamy)**  
Approach to Altered mental status - Brain or body? - MIST - decide based on clinical picture - current case -> some metabolic derangement s/o M; Also consider psychiatric comorbidities; **do not anchor - young patient - alcohol Disproportionate brain conditions** - s/o toxins -> Endogenous vs exogenous **Why does AMS matter?** Acute alteration -> may lead to long term consequences;  
**Precautions in AMS - Lung -> aspiration, Seizures and treatable meningitis (hemodynamic profile + Neutrophilic leukocytosis) - likely to scar patients; + focal symptoms -> consequence has set in**  
Liver disease ->

- Elevated liver enzymes + low albumin + high bili + low platelets -> raises suspicion for chronic liver pathology
- AST>ALT s/o possible muscular pathology;
- Direct bilirubin - specific for liver disease**
- Check for ammonia -> requires immediate Rx

**Focal lesion in the internal capsule not s/o encephalopathy**  
**Low creatinine -> possible malnutrition -> s/o chronicity in illness**  
**Somnolence + no speech + nl reflexes and spontaneous movements** requires change in problem representation -> localize psychogenic vs seizures  
**Elevated CK -> trauma; seizures**  
**Elevated LDH -> cell death -> how to identify which cell -> trend of CK and LDH helps differentiate; in the context of elevated CK -> seizures is possible**  
**Cryptococcus infection -> potential immunocompromise -> worth getting HIV and checking for cirrhosis -> can cause stroke - multifocal infarcts; can raise ICP**  
**Cryptococcus gattii - immunocompetent -> non hectic severe immunodeficiency syndromes**  
**HIV testing - logistical barriers exist; threshold to test HIV should be low to prevent delay**