



6/16/26 Morning Report with @CPSolvers

“One life, so many dreams” **Case Presenter:** Sudharshan(@) **Case Discussants:** Ravi(@rav7ks) & Khashayar(@)
<https://clinicalproblemsolving.com/present-a-case/>



Scribing (Lukas)
CC: 28 yo male presents to the ED with **Fever** and **generalized body pain** for 3 days (global localization: *India*)

HPI: 2 episodes of **Vomiting**, poor oral intake since his symptom onset, intermittent high fevers T-max 103 (self measured), no similar episodes in the past, took MCP and acetaminophen before presentation

ROS (-): SOB, dysuria, headache, cough, CP, rhinorrhea, diarrhea, neck stiffness

Vitals: T: 99 HR: 93 BP: 124/82 RR: 20 Sat: 99 on RA BMI: 25
Exam: Gen: appears weak and in mild distress, slightly lethargic
HEENT: signs of dehydration
CV: recap time 2 seconds
Pulm: -
Abd: mild, poorly localized right sided tenderness, no peritoneal signs
Neuro: no focal neural deficits
Extremities/skin: **blanchable macular rash over his abdomen**

Notable Labs & Imaging
CXR: wnl (normal cardiac silhouette, clear lungs)
Beside POCUS: mild hepatomegaly, trace right sided pleural effusion
EKG: wnl, SR
CBC:
WBC: 5,6 **Hb:** 14,2 **HK:** 49% **Plt:** 124k
Na: 140 **K:** 4,2 **Cl:** 101 **Bicarb:** 24 **pH:** 7,44 **Cr:** 1,2 **BUN:** 30 **Glucose:** 102 **Ca:** wnl **Ma:** wnl **AST:** 340 **ALT:** 232 **AlkP:** 104 **TBL:** 1,2 **directBili:** 1 **Albumin:** 3,4 **tProtein:** 7,4 **ESR:** 34 **CRP:** 2 **Lactate:** 2,8
 → **admitted to ICU:** started IV fluids, BC obtained; **Rx:** Ceftriaxon/Azythromycin

UA: wnl **repeat HK:** 54%
 → Urine output decreased; **PLT:** 89k , **lactate:** 3,2 **AST:** 2860 **ALT:** 1400
Coags: aPTT: 48,2 **PT:** 18 **INR:** 1,9 **LDH:** 450 **Fibrinogen:** 180 **Ferritin:** normal
Albumin: 3
US: ascites, bl PLE ri>le, hepatomegaly, gallbladder wall edema
CXR: bl PLE, no pulmonary edema or infiltrates
Respiratory viral panel: neg for COVID, RSV, Influenza
HIV: neg. **Hepatitis Panel:** neg. **EBV:** neg **CMV:** neg **NS1:** neg
Typhoid: neg **BC:** neg **ANA:** neg **Malaria:** neg **Leptospirosis:** neg scrub
typhoid: neg **Dengue Serology:** positive IgM IgG
Dx: Severe Dengue

Problem Representation: 28 yo initial hemodynamically stable male presents to the ED with an inflammatory Syndrome with blanchable macular rash developing acute liver injury with ascites and pleural effusions with serology eventually confirming Dengue.

Teaching Points (Julia Z)
Fever: inflammation/infection
 - “I MADE” mnemonic: Infection - Malignancy - Autoimmune - Drugs - Everything else
 Most common infections: respiratory, urinary, neurologic
 - Young patients tend to “hide” severe conditions because of compensation

Abdominal pain/tenderness: poor localization → bowel, colon
Rash: Nonblanchable (extravasation of blood under the skin → severe condition such as meningococcal) vs blanchable (infection, eczema)

Multi-system involvement (high lactate, LFTs): without an elevated WBC, think about viral infection (EBV, CMV). Rocky Mountain spotted fever, anaplasmosis
Liver injury: cholestatic injury pattern (AST > ALT) = dengue, leptospirosis
 - When the LFTs increase to thousand = toxins, acute viral infection (hepatitis), hemolysis, muscle (AST is not specific for liver injury)

Severe dengue: fluid extravasation, liver injury, low platelets, shock
 - Tropical disease
 - NS1 is a high sensitive test but maybe can come neg if too early or too late on the disease course

PMH:
 Major depressive disorder
 Eczema

Meds:
 Sertraline

Fam Hx:
 Eczema
 Allergic rhinitis (father)
 Nasal polyps (aunt)

Social Hx:
 Software engineer
 No sick contacts
 No recent travel hx

Health-Related Behaviors:
 Social drinking alcohol
 No i.v. drug abuse
 Not sexually active

Allergies: -