9/6/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter:*** *(Eric Marks@)* ***Case Discussants:*** *(Lourenco@) & (Kirtan@KirtanPatolia)*

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

Scribing (Noor):

CC: 23 yr F presents with mid pelvic discomfort, mild dysuria and mild chills. ED admitting diagnosis is PID

HPI: Pain started 2 days back, improved with cef and azithro, got tramadol.

ROS: past 3 to 4 weeks, fatigue and malaise, no nausea vomiting fever chills or shortness of breath

PMH:
none

Meds:
none

Fam Hx:
Non contributory

Social Hx:
Kern county-endemic Valley fever in the region, no travel

Health-Related Behaviors:
Tobacco use
IVDU, sexual exposure

Allergies: none

Vitals: T: 100 **HR**: **BP**: nl **RR**: nl **Sat**: nl **BMI**:23

Exam:

HEENT: mild maldentition
CV: 2/6 systolic murmur in parasternal S2 region
Pulm:nl BL breath sounds
Abd: soft, nontender
Neuro: AAox3, normal strength and sensations
Extremities/skin: no skin lesion, nail lesions or rashes

Notable Labs & Imaging:

Hematology:
WBC: 10,000,75% PMN Hgb:10.5 Plt: nl MCV: 85

Chemistry:
CMP- normal
Blood Cx- positive (6 sets)- Streptococcus mutans
HIV, Hep B, Hep C, syphilis :negative
Chlamydia, gonorrhea: neg
Beta hcg: neg

Imaging:
EKG:nl
CXR: nl
TTE: non diagnostic, thickening on the tricuspid valve
TEE: Perivalvular abscess on tricuspid valve, TR
Started on IV antibiotics, underwent open heart valve transplant, came back after 8 months, reinfected prosthetic valve, methadone clinic option discussed. Valve replacement done, came back third time, went into septic shock and HF.
Used to lick the needles before injecting and hence strep mutans

Diagnosis: Infective Endocarditis

Problem Representation: A young female with PMH of IVDU presents with constitutional symptoms, anemia and systolic murmur, found to have infective endocarditis from Streptococcus mutans.

Teaching Points (CPS Fan<3)

Approach to presenting complaints

- Reassess before anchoring to prior diagnosis like PID.
- Define what their GU symptoms are: Perception of what dysuria might mean to the patient vs what their symptoms really are (if UTI
- Never miss Dx: Pregnancy, STD (HIV), Autoimmune affecting GI/GU tract.

-PID has an acute dramatic presentation. Unusual for PID to have a subacute time course (3-4 weeks)

-Prudent to think **IE** when we see new murmur + fever

- Think exposures/ source of endovascular infection: Skin/soft tissue from intravenous drug abuse OR UTI
- Embolic phenomenon from underlying autoimmune conditions: Lupus (Libman Sacks)/ APLS/ MCTD

Renal infarct from the emboli can cause the dysuria.

- WORKUP Pearl: Get blood culture (Total 4 bottles from 2 sites at least) & get Chlamydia/ Gonorrhea from >1 mucosal site if GU source suspected!! TTE & TEE (delineates better) for valvular involvement. CT scan to see other potential organ involvement (Cavitary lung lesions). ***PET scan for prosthetic valve endocarditis (can be -ve in TEE).***

- Endocarditis suspected in pt without constitutional symptoms: Think hidden areas of infection: like *Aortic root with contained abscess* (presenting with non overt symptoms as the inflammation is walled off). Getting imaging is key here.

- If IE, think of complications:

- Get serial EKG to check for structural complications like heart blocks.
- Check vision and muscle strength in patients everyday! (from emboli to eyes and spinal cord respectively)

- IV drug abuse: Staphylococcus most of the time. H/O of Needle licking makes oral organisms likely cause.
- If PWID >50 years: Differentials of Gram -ve too: ESKAPE: Enterobacter, Stenotrophomonas, Klebsiella, Acinetobacter maltophilia, Pseudomonas.