4/14/20 Morning Report with @CPSolvers

Case Presenter: *Fernand (@fernandbteich)* ***Case Discussants:*** *Jamal B, Tony K*

CC: productive cough, fevers, chest pain

HPI: ~50M p/w 1 mo yellow sputum, fever > 102F, pleuritic chest pain during last week. Tx for CAP w/ amoxicillin-clavulanate+azithro presenting to ED w/ tachypnea, high fevers.

PMH: none

Meds: none

Fam Hx: unknown

Soc Hx: former smoker, drinks 14 cans of beer/week, no drugs, sexually active, lives in St. Louis with no recent travel

Vitals: T: 104F HR: 101 BP: 100/50 RR: 40 SpO_2: 99% w/ O2 supplementation

Exam:
Gen: very sick, intubated/sedated
CV: RRR, no murmurs
Pulm: bilateral rhonchi
Abd: soft, non-tender
Neuro: intact prior to sedation
Extremities/Skin: no peripheral edema, rashes, ulcers

Notable Labs & Imaging:
CBC: Hg 9.5, WBC 9.4, Plt 41
CMP: Na 128, K 4.4, Cl 100, HCO3 17, BUN 23, Cr 1.6, gluc 155, Alb 1.5, TP 5.9, LFTs normal, INR 1.1, BNP 14, Troponin neg, CK 35, *Procal .88*, lactate: 4.2
ABG: 7.39/203/31/18
Imaging:
CXR: ⅔ of lungs are involved with opacities
CT chest: bilateral dense consolidations
Negative studies: BCx/UCx, rapid flu, urine legionella, pneumococcus, viral PCR, blasto/histo/coccidio, crypto, IGRA, Sputum Cx: candida
LDH: 581, HIV positive, blood CMV PCR 116,000
BAL: 64 WBC, PJP: positive PCR & IF, no e/o CMV in lung

Problem Representation: Middle aged HIV+ man p/w septic shock and hypoxic respiratory failure, found to have bicytopenia, CMV viremia, and bilateral dense consolidation on CT imaging diagnosed with severe PJP pneumonia.

Teaching Points:
Inflammation + Lung is not always Comm. Acq. PNA
Pulmonary embolism, Autoimmune disease, Pericarditis, Malignancy, and fungal or mycobacterial infections also warrant consideration.
Radiographic findings of chronic lung infxns
Consolidations, cavities, nodules, bronchiectasis, each with its own DDx.
New/Acute Anemia + Thrombocytopenia: Evaluate for destructive processes: MAHA (DIC, TTP, HUS), AIHA, ITP. Then consider a bone marrow etiology.
2 key questions in HIV + Suspected infection: What is the viral load, and what is the CD4 count?
In an **immunocompromised host**, the **DDx does not *shift*, it *expands*.**
CMV sites of infection: Lung, liver, GI tract, bone, skin
Indications for steroids in PJP: PaO2 < 70, A-a gradient > 35, Room air SaO2 < 92%
In a patient with **untreated HIV,** always **send a serum CrAg and consider the possibility of crypto meningitis before starting ART.** Crypto meningitis warrants a delay in ART due to the potential for life-threatening IRIS in the CNS.