5/12/20 Morning Report with @CPSolvers

***Case Presenter**: Rachel Kasimer **Case Discussants**: Justin Charles & Avi Sonnenschein*

CC: Fever and sore throat

HPI:
56 woman with h/o seroneg arthritis and HLD who p/w fevers + sore throat x 1 week
Sx's began 1 week prior to presentation with sore throat. Her fever reached 103F.
She went to Urgent care w/neg rapid strep and Cx (after some amox).
2 days later, nausea/NBNB emesis and abd px

ROS:
+Mild cough, Fatigue
No dysuria, HA or CP
No recent dental procedures, no recent travels
Represented with Fevers and RASH

PMH:
Seroneg arthritis (clinical Dx based on exam)
HLD

Meds:
Sulfasalazine
Atorva
APAP

NKDA

Fam Hx:
non contributory

Soc Hx:

Health-Related Behaviors:
No tob
No etoh or drugs

Allergies:

Vitals: **T**: 101.9 **HR**: 85 **BP**: 110/57 **SpO_2**: 96%
Exam:
Gen: well appearing
HEENT: non erythematous no exudates, no cervical LAD, + small mobile nontender axillary LN
CV: RRR no MRG
LUNG: CTAB
Abd: Soft, tender upper quadrants, no CVAT
Extremities/Skin: no rashes → represented with rash

Notable Labs & Imaging:
Hematology:
WBC: 21.9 (40% PMN, 50% Lymp, 4% Mono, 5% eos, 1% baso)
Hgb: 12.1 Plt: 276
Chemistry:
Na: 131 K: 3.9 CO2: 27 BUN: 10 Cr: 0.85 glucose: 99, AG10
AST: 210 ALT: 242 Alk-P: 542 T. Bili:2.0 (1.4) Albumin: 3.6
Prot 6.0 Ca/Phos WNL LDH 852 Ferritin 1000
UA WNL
Smear: Nl WBC , no blasts
CT chest bulky ax and mediastinal LNs , + Pleural effusions (small, bilateral)
Clinical update: in shock!
HIV/EBV/HSV/HHV/CMV/Heps -- neg
Histo/blasto neg
O&P neg
LP 22 WBC (92%L) 3 RBC, Prot 39 Gluc 96, + HHV-6
BCx and Sputum neg
LN (core) - no malignancy
BMB - normocellular, no blasts
Skin Bx - AoC spongiotic dermatitis c/w DRESS/DiHS!!!

Problem Representation:
Middle age woman p/w subacute fever, sore throat, and rash found to have leukocytosis with eosinophilia, mixed liver injury, and mediastinal lymphadenopathy diagnosed with DiHS likely 2/2 sulfasalazine with potential contribution from HHV-6 infection

Teaching Points (Anna):
Infection ddx pharyngitis:
- "Routine" bugs: viral (influenza, EBV) >>> bacterial (group A strep, group C strep)
- STIs: acute HIV, syphilis, gonorrhea, chlamydia
- Fungal: Candida, endemic mycoses

Faget sign: pulse-temp dissociation
- Infectious etiologies: Typhoid fever, Tularemia, Brucellosis, Legionella, Mycoplasma PNA

CBC Evaluation in Inflamed Patient:
- Most often expect demarginalization of PMNs (PMN predominant, with eosinopenia)
- Lymphocytic predominance suggests viral infection, hematologic malignancy, drug hypersensitivity reactions

Generalized LAD if serologic infectious workup negative: malignancy (liquid>solid) >>> autoimmune

DIHS: drug-induced hypersensitivity reaction
- Clinical manifestations: fever, malaise, rash, LAD
- AKA DRESS, but ~30% don't have eosinophilia!
- Labs: eosinophilia, lymphocytosis, elevated LFTs
- Drug exposure usually 2-6 weeks prior
- Associated with reactivation of HHV-6