04/8/21 Morning Report with @CPSolvers

***Case Presenter**: Ann Marie Kumfer (@AnnKumfer) **Case Discussants**: Dhruv Srinivasachar (@TheRealDSrini) & Kirtan Patolia (@KirtanPatolia)*

CC: Nausea/vomiting and tachycardia

HPI: A 61-yo F p/w nausea, vomiting, and tachycardia. 2 months ago she had a partial resection of her toe in mexico from osteo. Worsening of this infection, led to a wound vac. Completed 5 days of abx and discharged. Had intermittent n/v during the hospitalization thought to be from metro but it persisted. Developed SOB, fatigue and dizziness. Some pain at the surgical site, no discharge from the wound site. No abd pain or fevers or rigors. Having normal BMs w/o blood. No diarrhea. No urinary symptoms. Further questioning notes the N/V started 2 months prior to the presentation and prior to the surgery. Lost 5 kg in the last few months

PMH: Type II DM (8.6%), PAD, HTN (not on meds), Osteoarthritis
Meds: Sliding scale insulin only (metformin was stopped). Atorvastatin, reglan, PEG, prn zofran and apap. Was was cefepime, flagyl, ertapenam. cilostazol

Fam Hx:

Soc Hx: Denies tobacco, drugs, etoh. Splits time between Mexico and US

Health-Related Behaviors:

Allergies:

Vitals: **T**: 36.8 C **HR**: 116-140 (110s post 2 L) **BP**: 121/65 **RR**: 18 **SpO_2**: 97%
Exam:
Gen: Comfortable in NAD
HEENT: No icterus, PEERLA
CV: tachy, no murmurs, JVP normal
Pulm: faint crackles in lower lung fields
Abd: Soft, no masses, no HSM, no rebound or guarding.
Neuro: no neuro deficits
Extremities/Skin: no edema in LE, amputation site had a good wound bed without purulence.

Notable Labs & Imaging:
Hematology:
WBC: 5.0 (diff of 45% neut, 32 % lymph, 14% eos) Hgb: 10 Plt: 328
Chemistry:
Na: 138 K: 3.4 Cl: 109 CO2: 27 BUN: 3 Cr: 0.51 glucose: 120 Ca: 8.8 Phos: Mag: 1.1
AST: Nml ALT: Nml Alk-P: Nml T. Bili: Nml Albumin: 3.4
CRP: 25 ESR 35 UA: SG 1.010 COVID and flu negative.
TSH nml: Trop neg x 2 Blood cultures: negative
AM cortisol at 330am: 1.2 : Cosyntropin 7.5 after test ACTH: mildly elevated. FSH/LH/IGF: WNL
Imaging:
CXR: Mild pulm edema, no infiltrates
CTA chest: Mild pulm edema, no PE
RUQ: Fatty infiltration of the liver
TTE: normal EF without valvular lesions
Was taking an OTC med (Ardosons) that she obtained in mexico that had betamethasone in it for arthritis (6.7 mg of prednisone eq for a few years)

Problem Representation: A 61F w/ T2DM, PAD, HTN, arthritis previously tx for osteomyelitis, p/w 2 mon of n/v, dyspnea, tachycardia only mildly responsive to fluids, labs notable for picture of AI given high eos, low cortisol, abnormal cosyntropin test, and mildly elevated ACTH

Teaching Points (Priyanka):

- **N/V/Tachy-** nonspecific Sx. Look for assoc. Sx to localize pathology. Consider: GI infx, chemo, COVID, endocrinopathies, structural abnl (obstruction, optho dz- acute angle glaucoma). IF isolated- consider severity (constant v fluctuating)
- **Layering on PMH, Exam, Labs:**
  - Hx of osteomyelitis→ consider spread of systemic infection to lungs, heart (endocarditis) + context of DM2 (gastroparesis, gastropathy)
  - **Eosinophilia**: fungal (Histo, aspergillus, cocci), parasitic, malignancy, adrenal insufficiency (note- DM2 can hide many of the presenting lyte abnl), vasculitis (EGPA, Churg Strauss)
- **Adrenal Insufficiency:**
  - **Primary**: low adrenal hormone; lesion localizes to adrenal gland
  - **Secondary**: low ACTH, and adrenal hormone. Localizes to pituitary → almost always accompanied by other pit abnl (low FSH, TSH, LH, GH)
  - **Tertiary:** AI from withdrawal of excess intake of steroid → most common, highest base rate of dz
  - **Dx:** screen with AM cortisol; diagnostic test: Cosyntropin test