# 06/05/21 Morning Report with @CPSolvers

***Case Discussants**: CPSolvers Family*

**CASE 1 -** Maria Aleman (@mariamjaleman)

**Problem Representation:**
ESP: Paciente femenina de 60a en dia 10 de hospitalización, ingresada por CAD y NASS inicia con somnolencia y status epileptico no convulsivo en EEG.
ENG: 60YF on hospitalization day 10, previously treated for DKA and recently diagnosed with CKD and HAP has increased somnolence and NCSE in EEG.

**CC and HPI:** 60y female with increased somnolence on 10th Hospital day. Admitted for ketoacidosis triggered by UTI and appropriately Tx . Dx with CKD. Day 7: developed Fever, cough, leukocytosis, and Dx with HAP. H/o DM (poorly controlled), HTN, Neuropathy
Meds- Insulin, Metformin, Gabapentin, Enalapril, Atorvastatin, Zosyn, Cefepime, Vanco

**Findings from exam:** Neuro- Increased somnolence. Couldn't raise arms and legs against gravity. Doesn't respond to commands, stuporous. Pupils isocoric and reactive to light, CN, Gag reflex normal, and other reflexes normal. No meningeal signs.
Pulmonary-Rales at lung bases b/l GI -Normal

**Labs/imaging:** WBC- 22k-->18k, Cr-4.5-->2.7-->2.5, BMP: normal. Alb-3, EKG-Normal
-CT non contrast and MRI- Normal, LP-Normal,
- EEG-Non convulsive status epilepticus (NCSE)

**Final Dx- Cefepime Encephalopathy with NCSE**

**Teaching points (Gabi F. Pucci - @gabifpucci):**
**- "Brain problem" + normal MRI**: MI(S)T (Metabolic, infection, and toxin). Diseases: autoimmune encephalitis, seizures, and psychiatric diseases.
-Increased somnolence in elderly hospitalized patients: look for infections, use of drugs (sedatives, opioids, ATBs). Watch for: wrong first diagnosis? Neurological disorder associated (secondary to hospitalization or prior diagnosis ?);
-CKD with increased kidney size: check for amyloidosis and diabetes;
-*Clostridium difficile* diarrhea: when diarrhea improves - look for toxic megacolon!
**Cefepime: can induce seizure, specially in CKD patients. ATB- induced encephalopathy: Type 1: seizure (penicillin, cefepime), type 2: psychosis (quinolones, macrolides), type 3: late-onset, seizure and psychosis, metronidazole use**

**CASE 2 -** Kushal Vaishnani (@k_vaishnani)

**Problem Representation:** PT: homem de 50 anos se apresenta com retenção urinária aguda e sintomas urinários há 2 meses (noctúria, aumento da frequência e dificuldade em iniciar urina), bem como quadro crônico de perda de peso e um episódio de pneumonia prévia. Ao exame: próstata aumentada e multinodular e lesões cutâneas.
ENG- 50 Y male from Kentucky with 2mo h/o LUTS with weight loss and eschar w/enlarged nodular prostate on exam.

**CC and HPI:** 50 Y male with h/o Urinary retention presents with nocturia, increased frequency & difficulty in initiating stream since 2 months
5-6 mo ago Dx pneumonia (3 ER visits - Tx w/ multiple abx w/ some improvement), reports weakness, weight loss 18 Lb. Admitted twice for urinary retention. Tx by PCP for cutaneous Staph Aureus infection .
Lives in Kentucky. Hunting and camping. Non-smoker, no illicit drug use or alcohol consumption

**Findings from exam:** Rash leading to eschar formation on anterior aspect of knee.
DRE- Moderately enlarged, fixed nodular prostate suggestive of Prostate CA

-**Labs/imaging:** UA- 1+ bacteria, 13-20 WBCs, 3-5 RBC, Ucx negative. Normal BMP, CBC
-CT- Hypoattenuation of prostate suggestive of Prostatic Abscess.
Culture and biopsy showed broad based budding yeast.

**Final Dx: Blastomycosis -** ***what a blasto!***

-**Teaching points (Gabi F. Pucci - @gabifpucci):**
**- How to approach urinary retention?** Muscle weakness -> due to neuropathy, autonomic system compromised/ Obstruction / Secondary to medications / Infections (abscess)
If neuro: check for other symptoms/exam findings like lower limb weakness, loss of pain/temp
-Granulomatous prostatitis: blasto, cocci, crypto. Melioidosis - can be a cause (male/Australia are risk factors).
**Blastomycosis: previous pneumonia + skin lesion (similar to squamous cell carcinoma) + bone lesions + urinary tract symptoms. Geography: great lakes. Can be common in immunocompetent patient.**