09/9/21 Morning Report with @CPSolvers

***Case Presenter**: Kevin Grudzinski (@) **Case Discussants**: CPSolvers family*

CC: AMS plus fever

HPI: 29-year-old female (G5P1022) with AMS and fever of acute onset. Patient has been sleeping more than usual and feeling tired since morning.

PMH: HFrEF due to myocarditis, hypothyroidism

Meds: Levothyroxine

Fam Hx:

Soc Hx:

Health-Related Behaviors:

Allergies:

Vitals: **T**: 102.8 **HR**:88 **BP**: **101/72** **RR**:30 **SpO_2**:97 % on RA
Exam:
Gen: Lethargic
HEENT: nl
CV: nl
Pulm: nl
Abd: nl
Neuro: nl
Extremities/Skin: nl

Notable Labs & Imaging:
Hematology:
WBC: 3.8 Hgb: 5.7 (no evidence of bleeding or recent h/o bleeding)
Plt: 56k
Chemistry:
Na: 131 K: 5.9 Cr: 1.04 glucose: 90 AST: 158 ALT: 60 Alk-P: 202 HIV-negative
VBG - pH of 7.3, pCO2 28, normal lactate, UA- normal
CXR: left retrocardiac consolidation
LP- WBC- 20 (86% lymphocytes), 0 RBC, Glucose-46, Protein- 42.2, negative gram stain
Parainfluenza virus +, Blood cx- +gram positive cocci (coag - staph),
Low AM cortisol, TSH- 1.434, Free T4- 0.6, TPO abs negative, improvement in mental status with stress steroid dose.
ACTH- <1.5, LH-2, FSH-6, Estradiol - <10, Prolactin <1, ALdosterone <1, Renin <0.167, IGF-1- 3.6 Z-score, Somatomedin-43, Anti 21 alpha hydroxylase abs negative
MRI brain- partially empty sella---**Final dx- Sheehan syndrome**

Problem Representation: A 29-year-old female (G5P1022) presenting with acute onset of fever and AMS with labs revealing pancytopenia and panhypopituitarism.

Teaching Points (Vale):

- **AMS:** MIST, but change the order! Who is the patient?: Young prioritize intracranial process (look for focal signs), extracranial (toxins, metabolic).
- **Heart and Brain Venn Diagram:** Vascular or meds (Digoxin toxicity)
- **Fever=Inflammation** - 7 never miss: Viruses, Bacterias (respiratory, UTI, skin, enterocolitis, hepatobiliary, bacteremia w/o a source).
- **Faget Sign:** Bradycardia + Fever (Dengue, Chikungunya, Yellow fever, S. typhi, Legionella, Babesia, Malaria, Leptospirosis, C. burnetii, RMSF)
- **Hectic Pancitopenia:** In the setting of an acute presentation - prioritize destruction (infection-tick borne, autoimmune-LES, malignancy-CLL) or Aggressive bone marrow disorders (AML, Granulomatous)
- **Cellular toxicity** (hyperkalemia, >2:1 AST/ALT): RBCs, muscle cells or tumor cells. Ask for an LDH!
- **Contaminants on cultures**: Micro Qs (how long it take to grow? In how many cultures did it grow?) and Clinical Qs (Is the syndrome compatible? Is the kind of host we would expect this bug?)
- **Central Adrenal Insufficiency:** #1 Steroid use, Cancer (pituitary adenoma), autoimmune (2ry causes are more common than primary), Sheehan Syndrome.
- **Pituitary Apoplexy:** More common from pituitary adenoma.