06/08/22 Morning Report with @CPSolvers

***Case Presenter**: Nikitha Crasta (@NikithaCrasta) **Case Discussants**: Jack Penner (@jackpenner) and Sharmin Shekarchian (@Sharminzi)*

CC: LOC & abnormal behaviour

HPI:

- 76yM brought by his neighbour
- Unconscious, his neighbour tried waking him waking up, the patient regained his consciousness
- At the ED: 2 episodes of emesis, vomitus clear; not oriented; had labored breathing

PMH:
HTN,
DMT2 since age of 40

Meds:
unknown

Fam Hx:

Soc Hx:
Previous farmer

Health-Related Behaviors:
Non-smoker - 40years
Alcohol in weekends

Allergies:

Vitals: **T**:38.9°C **HR**:140 **BP**:70/50 **RR**:40 **SpO_2**: 89% in RA
Exam:
Gen: poorly nourished
HEENT: not oriented, Pin-point pupils, bleeding gums, bloody vomiting
CV: wnll
Pulm: diffuse crackles
Abd: wnll
Neuro: couldn't perform neurological tests
Extremities/Skin: purpura in lower limbs b/l, patches in back, Swelling in L lower limb up to knee
GU: catheter w/o any output

Notable Labs & Imaging:
Hematology:
WBC:16200 Hgb: 6.5 Plt: 80000
INR and aPTT prolonged; ESR 20
Fibrinogen low
Chemistry:
Na: 135 K:6 Cl: 110 CO2:12 Serum-Urea: 213 AST: 727 ALT: 528 Alk-P 420
ABG: pH 7.32, pCO2 24, pO2 83
Serum Urea 213 Crea 8.9 Serum Uric acid: 7.2
Imaging:
EKG: ST-segment depressions in anterior chest leads
CXR: b/l patchy and diffuse opacities
CT brain: punctal hemorrhages in brain
Dorsum of food: bleeding lesion on foot due to snake bite
Final dx: **DIC due to snake bite** (venom induced)
- Russel's viper (hemotoxic) Anti snake venom is TOC; fluid resus; hemodialysis, blood transfusion)

Problem Representation: 76yoM farmer p/w transient loss of consciousness and snake bite, found to have bleeding gums, purpura, renal failure, anemia and thrombocytopenia c/f DIC.

Teaching Points (Madellena):
LOC/AMS: Ability to regain consciousness is key.
Transient LOC: syncope, seizure (post-ictal), stroke, substance, sugar, sleepiness: Rx > Dx: hypoglycemia
Labored breathing: consequence of what is driving LOC/AMS?
- Aspiration event? Metabolic (acidosis)?
PE: need to rule out life-threatening infection
Inflammation: think infection, malignancy, autoimmune
First need to rule out infection given how systemically ill
Infection localization: purpura > vasculopathy or coag abnormality
Infection + coagulopathy > think DIC
Hypotension biggest concern: think shock buckets
Distributive (sepsis), hypovolemic, obstructive, cardiogenic
Labs: First need to stabilize
CBC: leukocytosis > c/f inflammation/infection
thrombocytopenia > get smear for schistocytes to look for MAHA/DIC. DIC can be present even w/out schistocytes
Most causes of DIC are secondary
CMP: What is most urgent? TTP, HUS, infection > DIC
Which can cause renal failure? All
Plausible? DIC and MAHA
Bloodstream infection > DIC: meningococcemia, gram +/- bacter
Imaging: Ischemic changes can be driven by underlying preexisting CAD activated iso stress. Other etiology: result of intravascular coagulation process or embolic process
Opacities: can be infection, edema, hemorrhage
CT: primary driver or, more likely, *sequelae of event*