# 12/19/22 Morning Report with @CPSolvers

***Case Presenter***: *Madellena Conte (@MadellenaC )* ***Case Discussants***: *Dr. Daniel Restrepo (@DrDanRestrepo)*

**CC:** diarrhea

**HPI:**
-43yo transgender female
-Acute on chronic non bloody diarrhea
-2 months ongoing, 5 loose stools a day for 2 months, acutely worsened, now going nearly every hour, which is why she presented in the ED
-Soft/liquid non bloody
-No trigger, at night and day, denies uncooked or spoiled food
-ROS: chills, diffuse abdominal pain, rectal pain
-Denies fever, weight loss, melena

**PMH:**
HIV/AIDS (CD4 24, VL 98k) - on Symtuza
H/o Cryptococcal meningitis, pul. Kaposi Sarcoma
Methamphetamine abuse disorder
HepC (Epcluza; undetectable

**Meds:**
Symtuza
Seroquel (Quetiapine)
Zyprexa (Olanzapine)

**Fam Hx:**
none

**Soc Hx:**
Currently un-housed in SF
One male partner

**Health-Related Behaviors:**
No Methamphetamine for 2 months, Alcohol 1-2 drinks a day
No recent travel, no noted sick contacts or animal contacts

**Vitals:** T: 37C HR: 119 BP: 108/76 RR: $SpO_2$: 100% in RA
Exam:
**Gen**: thin, no acute distress
**HEENT**: MMM, no thrush, no LAD
**CV**: RRR, no murmur, normal S1+S2
**Pulm**: clear to auscultation b/l
**Abd:** diffusely TTT through all 4 quadrants, hypoactive bowel sounds

**Notable Labs & Imaging:**
**Hematology:**
WBC: 5.1 Hgb: 12 Plt:276k
**Chemistry:**
Na: 143 K:3.6 Cl:107 CO2:26 BUN:11 Cr: 0.57 glucose: 109 Ca:8.5
Mag:1.8
AST: 39 ALT:25 Alk-P:81 T. Bili: 0.2 Albumin:3.7
Lipase wnl, TSH wnl
**Imaging:**
EKG: sinus tachycardia
CT abd pelvis w/ contrast: negative - no acute abnormality
Microbiology: C.diff PCR neg., Fecal leukocytes neg
Stool: O&P: did not grow any pathogenic organisms; did grow endolimax nana and few blastocystis hominis - non-pathogenic
Microsporidia stain neg.; AFB culture for MAC: no growth to date
STI testing: Syphilis negative (rectal swab)
CMV PCR negative
Stool cultures+Blood cultures: Shigella flexneri resistant to Ceftriaxone, fluoroquinolones, azithromycin. Susceptible to Unasyn

**Final Dx:** Diarrhea due to Shigella enteritis c/b shigella bacteremia

DDx: Colonoscopy for CMV/HIV colitis
Clinical course: IV Unasyn > transitioned to PO augmentin. 10d Metronidazole. ARV Symtuza + OI prophylaxis w/ TMP-SMX and fluconazole.

**Problem Representation:** A 43 transgender female w/ Acute on chronic diarrhea w/ a PMH of HIV/AIDS and opportunistic infx. Currently unhoused. Abdomen diffusely tender. CT abdomen and CMP negative.

**Teaching Points (Yazmin):**

**Approach to diarrhea:**

- Onset/Duration: <4 weeks = acute, >4 weeks is chronic
- Immunocompromised? (In this px, we have to consider a viral reactivation)
- Night symptoms: Is the px having nocturnal awakening > makes osmotic diarrhea less likely.
- The characteristics can help differentiate between: osmotic, inflammatory, infectious/non-infectious.
  - Secretory diarrhea is the rarest category of diarrhea > the volume is commonly higher (i.e. carcinoid sx.)
- Always interrogate about personal history: travel, animal contact, occupational exposure, sick contacts, etc.
- Dyschezia + proctitis can suggest proctocolitis > infections that can cause it are Chlamydia, HSV, Syphilis, CMV
- HIV/AIDS predisposes to Cryptosporidium infection and MAC (although dyschezia is not commonly seen)
- When interrogating: Make the difference between Rigors and "Chills"
- In diarrhea we must expect hypokalemia and nonanion gap metabolic acidosis
- Consider testing for fungal etiology, mycobacterium, C. Diff, syphilis (direct/indirect treponemal, chlamydia and gonorrhea test (urine and rectal swab) HSV and CMV PCR, cryptosporidium parvum, O&P stool test. Other screening tests: sigmoidoscopy.
- Shigella infection: causes bloody diarrhea, intense symptomatology