12/23/23 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter:Yuki(@) Case Discussants:Rabih (@rabihmgeha) and Ximena(@ximechm16)

CC: 70 yr old female with PMH of DM presenting with sudden vision loss in left eye.

HPI: 3 days prior to presentation,patient complains of fatigue,fever and anorexia.On the day of admission patient had sudden difficulty seeing through left eye. Loss of appetite ,vision loss left eye ROS unremarkable.

PMH: Poorly controlled DM

Meds: Linagliptin 5 mg

Fam Hx: N/a

Soc Hx: No recent travel Drinks Beer ,past smoker

Health-Related Behaviors: **N/a**

Allergies: N/a

Vitals: T: 38.4**HR:** 96/min **BP:170/100 RR:** 20/min,spo2 99%RA
Exam: Gen: tired and confused
HEENT: no pallor,no hemorrhage, redness in left eye,no LAD, blackness around left nasolabial fold,some dental caries
CV: normal,no murmur ,no jvp
Pulm: clear b/l breath sounds
Abd: soft and flat.
Neuro: confused,oriented to place and person,normal eye movt,left nasal hemianopia,,truncal ataxia,,difficulty sitting still,unable to perform finger nose test,(both sides,)
Extremities/skin: no rash n o edema,

Notable Labs & Imaging:
Hematology:
WBC: 22K(90% neutrophils),Hgb: 15,Plt: 111K
Chemistry:
Na:134 ,K:4.5, Cl: 95,
BUN: 30, Cr:0.9, glucose:480 ,Ca: 8.5,CRP-25
AST: 33 ALT: 60 Alk-P: 380,Total Bilirubin- 1.1,Albumin: 3.2
LDH-250, HBAIC-10
Imaging:
EKG: normal
CXR: normal
CT chest with contrast- Rt lung lower lobe consolidation and liver cyst
Head Ct - rule out stroke, shows high density fluid filled lesions in b/l ventricles.
DM Retinopathy rule out by ophthalmologist.
Lumbar puncture - cloudy, WBC count 0f 10k, neutrophil predominant,protein- 400,glucose- 60,LDH- 180
Patient is suspected of bacterial meningitis with endophthalmitis and ventriculitis suspected.
Blood cultures shows klebsiella pneumoniae .

Final Dx: Invasive klebsiella Infection.

Problem Representation: 70 year old female with PMH of DM with complains of sudden U/L vision loss with redness in left eye and truncal ataxia.

Teaching Points (Shreyas Nandyal**)**:
1/ Sudden vision loss: Time course and localization are crucial -. Unilateral v/s bilateral; Vision loss v/s visual field deficits are important considerations.
2/ **Ocular sudden visual loss**: Glaucoma (hard, red eye), Ischemia/thrombosis to the vasculature(CRAO, CRVO), optic neuritis, tumor, retinal detachment, vitreous hemorrhage. **Anterior** (keratitis, angle closure glaucoma) v/s **Posterior** (Retina/Optic N/Vitreous)
3/ **Diabetes and vision loss**: MC cause of mono-ocular vision loss in DM - **atherosclerotic** ; 2nd most common- hemorrhage (2º to neovascularization -> **vitreous hemorrhage**). Fever + vision loss prioritizes vascular and infectious etiologies
4/ ≥ 50 + sudden vision loss - always important to consider TGA!
5/ Chronic uncontrolled disease - HPI accuracy comes into question (the patient could have a chronic underlying process and what we might be dealing with might be delayed presentation/ acute on chronic process)
6/ **HTN + ocular manifestations** tend to localize to the **retina**; dilated fundoscopy becomes crucial. **Red eye + visual loss** -help us localize to the **cornea, conjunctiva, sclera**
7/ **Red eye + fever- endophthalmitis** becomes an important Dx to consider; it is important to also look for disease in the sinus especially in the setting of eye pain and fever
8/ **Elevated ALP** - important to think of **bone destruction** (painful) and **cholestatic liver disease** ; elevated GGT can clue us into a hepatic pathology.
9/ In the context of **sepsis, liver abscess, lung consolidation**, **endophthalmitis, meningitis, uncontrolled DM and SE Asia demographic** - infection, especially **Klebsiella invasive syndrome** was the leading hypothesis and final Dx. Rx - Empiric Carbapenem therapy.