04/19/24 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Amal Naji(@)* ***Case Discussants****: Reza (@DxRxEdu)*

CC: 60 y/o male AMS for 2 days

HPI: History for his partner, found in the floor of the shelter defecated on himself
The patient had been confused for the past 2 days.
Partner said that he had SOB, loss of appetite and had been acting different for the past few days.

PMH:
Alcohol use
Anxiety
HTN
Depression

Meds:
None

Fam Hx: HTN father
Mother heart disease

Soc Hx: Lives in a home shelter with his partner
Health-Related Behaviors:
Drinks 4 beers and shots of vodka everyday
Smokes cigarette
No drug use
Allergies: Denied

Vitals: T: 87.8F → 31C **HR:**82 **BP:**78/58 **RR:** 17 **SpO2** 95% → on 4 l then up to 14 liters (next morning)
Exam:
Gen: Chronic ill
CV: Irregular irregular, no murmur
Pulm: Diffuse crackles
Abd: Soft non tender no splenomegaly
Neuro: Oriented times 1, no focal deficit
Extremities/skin: Nonblanchable rash in the lower extremities

Notable Labs & Imaging:
Hematology: WBC: 13.900 Hgb:7.6 Plt: 54.000

Chemistry: Na:135, K:4, Cl:105, HCO3:18, BUN: 98, Cr:1.23 (baseline normal) glucose: 88, Ca: 8.4, Mag:2, AST: 63, ALT: 17, Alk-P:78, Albumin: 2.6, GFR 54, TSH normal.
UA: leukocyte esterase nitrate positive, **UC:** enterococcus faecalis and staph lugdunensis.
Blood culture: Staph lugdunensis, enterococcus.
Reticulocytes, LDH elevated Peripheral smear: schistocytes

Imaging:
EKG: Afib no acute myocardial infarction
CXR Admission: no acute cardiopulmonary disease, next day: asymmetric glass opacity, 5 days after: diffuse bilateral and alveolar opacities
Echocardiogram:EF 60-65%
Head CT: no acute intracranial abnormality
CT chest: bilateral pleural effusion; with passive bibasilar atelectasis; patchy GGO and consolidation through lungs
→ Treat with broad spectrum antibiotics, the patient denied intubation.

Dx: DIC, ARDS, Sepsis, bacteremia caused by Enterococcus

Problem Representation: 60 y/o pt with acute AMS with alcohol use disorder and SOB presenting with hypothermia and hypoxemia with findings of septic shock. ARDS and DIC due to enterococcus and staph lugdunensis bacteremia.

Teaching Points (Umbish): AMS

1. History is always the king!
2. Core foundations of a good diagnostic framework include 3L's: most **LIKELY, LETHAL, LEAST** likely
3. AMS> **MIST** mnemonic: **Metabolic**, Infectious, Structural(seizure), **Toxins**
4. Pt in acute encephalopathy with PMH of chronic alcohol use> Initial labs> **POC Glucose, Urine Tox., Alcohol levels, Sodium, Ca2+, BUN, CAT scan to rule out SDH b/c of head trauma**
5. Plausible causes for AMS and fecal incontinence: acute enceph., seizure post-ictal state, myelopathy…
6. Effects of alcohol: -**colonic infl.**> inc bowel movts.
   -**Hypothermia** (Dr. Ravi)
   -**pancytopenia** (Shreyas)
7. **Approach to hypothermia**: (Prof Rez.)
   Step 1 - Repeat temperature assessment to verify its accuracy
   Step 2 - Does degree of hypothermia correlate with clinical syndrome? If not, look for an alternative dx of clinical syndrome.
   Step 3 - Environmental exposure? Drug exposure?
   Step 4 - Infection, hypothyroidism, and hypocortisolism
   Step 5 - Other causes
8. Rewarm gradually> external vs internal
9. 3 most prominent causes of MAHAs: TTP,HUS,DIC
10. DDX: DIC, TTP, HUS