12/21/24 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Norwalk Hospital (@NHIMresidents) **Case Discussants**: Rahul (@RahulPottabath1), Mengyu (@zhoumy07) and Anmol (@anugrewal19)*

CC: **Cough and SOB on exertion** for **1 month**

HPI:
48yM p/w cough & SOB for 1 month
He was in his usual state of health until he developed coughing spells and exertional SOB. The cough was episodic, dry, intermittent, 5-6x times per day for 10-15 min, prevents him to sleep. Due to SOB he had difficulty breathing while walking or walking up stairs, progressed for 3 weeks.
He was prescribed Azithromycin for bronchitis, but did not respond → then diagnosed w/ pneumonia and got prescribed Cefpodoxime+Azithromycin, got worse and pneumonia was a/w fainting episodes related to paroxysmal coughing episodes
ROS: diaphoresis 3 days, discomfort while passing stool, unintentional weight loss for 6 mo (…..kg), fatigue, weakness. No orthopnea,
Traveled to Bermuda 1 week prior to his symptoms.

PMH:
Asthma
EBV infection
Questionable history of Rheumatoid arthritis

Meds:
Gabapentin
Trazodone

Soc Hx:
Working in plastic industry

Health-Related Behaviors:
Travel to Bermuda 1 week prior to start of symptoms;
Vaping stopped 8 months ago; stopped smoking 2020

Vitals: T: 36.6°C **BP:** 124/76 **RR:** 22 **HR**: 106 **Sat: 94% RA**
Exam:
HEENT: periorbital ecchymosis 2/2 coughing episodes
CV: RRR rhythm, no murmurs **Pulm:** clear to auscultation **Abd:** nontender
MSK: no edema, no clubbing

Notable Labs & Imaging:
Hematology:
WBC: 15.1 Hgb: 13.5 Plt: 483
BNP <50, Ferritin 640
Imaging:
EKG: sinus tachycardia
CXR: diffuse lung consolidations
CT: multifocal b/l consolidations, pleural effusion, no GGOs
Multifocal PNA → Cefepime+Vanc → progressive SOB with SpO2 85% RA → 4L nasal cannula → SpO2 89% → tachypnea, tachycardia with HR of 140, BP dropped, b/l crackles, pH 7.32, pO2 60, PCO2 32, 8L high flow (100% IO2) → ICU for intubation
XRay: concern for ARDS
LA 1.3, BP 100/60 (not on vasopressors) → ID: adding Azithromycin, high dose Prednisone
ID workup: negative (HIV, MRSA PCR, Strep pneumo, Influenza, RSV, Covid, Legionella, Resp viral panel, lower resp panel, Aspergillus+PJP neg, Strongy neg); AFB stain neg, ESR 90, Bronchoscopy: gram stain neg, few PMNs
Improved with high dose steroids. UA: hyaline cast
Autoimmune panel: ANA 1:320 +, C3, C4 nl, ANCA neg, RF neg, CCP neg, anti-dsDNA neg, anti-Jo1 neg, Chromatin-ab neg, RNP ab neg
Bactrim prophylaxis for PJP. Extubated 6 days later. CT: multifocal airspace dz → consolidation RML, EF 62%, mild pulm HTN,
Discharged with 4L oxygen. Again pleural effusion. Underwent CT Abd: Carcinomatosis, osteolytic lesions in femur + thoracolumbar spine, thickening on sigmoid, thoracocentesis: mixed cloudy effusion.

Dx: Presumed metastatic sigmoid cancer

Problem Representation:
48yM w/ a PMH of Asthma and questionable h/o RA p/w dry, intermittent, episodic cough and SOB on exertion for 1 month and unintentional weight loss for 6 months.. Patient traveled to Bermuda 1 week prior to start of symptoms. Treated for PNA but got worse. Developed tachypnea, tachycardia, drop in BP and hypoxemia. Imaging concerning for ARDS.

Teaching Points (Ethan):
SOB: cardiopulmonary system, with cough being severe here we should zoom in in respiratory tract. Also would like to rule out cardiac causes with the hx of fainting spells. Consider pneumonia mimics with nonresponse to abx.
Asthma hx -> consider EGPA, ABPA; RA -> consider CTD-ILD; Vaping exposure -> consider hypersensitivity pneumonitis
Leukocytosis and thrombocytosis -> currently explained by under inflammatory syndrome; For CXR, need HRCT to characterize the opacifications

***With rapid progressive hemodynamic instability -> hemodynamic support (consider intubation early, calculate P/F ratio), check lactate**
***Consider adding doxycycline and other macrolides to cover other causes atypical pneumonia; consider bronchoscopy for further infectious survey**

Bilateral multifocal consolidation: infectious causes (S. aureus, legionella, strep pneumo, TB, etc), vascular (GPA, septic emboli), neoplasm (BAC, lymphoma, metastases), eosinophilic pneumonia, lipoid pneumonia, organizing pneumonia

*After thorough evaluation of ruling out infections -> consider empiric high dose steroid

Migratory infiltrates: consider COP, eosinophilic pneumonia, BOOP, etc.