12/31/24 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter:*** *Teymour Sadrieh* ***Case Discussants:*** *Aye Thant (@AyeThant94), Dr. Aaron Berkowitz (@AaronLBerkowitz)*

CC: 55M presenting with lower abdominal pain and vomiting for 1 day.

HPI: febrile, hypertensive and tachycardic, with diffuse abdominal pain on palpation and distended bladder, all since 1 day. Remained in fetal position throughout exam.

9 hrs after admission, responding to questions in groans. Uncooperative with testing. Able to stand up at bedside to urinate.

ROS: unremarkable

PMH: depression, anxiety, substance use disorder, left craniofacial trauma secondary to self-inflicted gunshot

Meds: seroquel (quetiapine), trazodone

Fam Hx: -

Soc Hx: substance use disorder (benzos, cocaine, THC)

Health-Related Behaviors:

Allergies:

Vitals: T: febrile **BP: RR: HR**: tachycardia **Sat:**
Exam: Gen: restless in fetal position. Eyes closed at baseline.
HEENT: pupils equal and reactive to light
CV: tachycardia **Pulm:** clear
Abd: no guardian or rebound tenderness. Bladder palpable at level of umbilicus
Neuro: somnolent. Moving spontaneously + when asked. Reduced grip strength bilaterally
MSK: tenderness at L3 upon spine palpation
Skin: no rashes or track marks

Notable Labs & Imaging:
Hematology: WBC: 30.5 > 18.6 Hgb: Plt: Hct: MCV:
Chemistry Albumin 3.3 Na 135 Ca 8.2 CO2 13, Lactic acid 3.9 > 1.4
Tox screen positive for benzos, THC, cocaine
Blood cultures positive for Strep pneumo
UA unremarkable. Respiratory panel negative

Imaging:
CXR: small consolidation in the right upper lobe
CT chest: unremarkable
CTAP: bilateral hydroureter, distension of bladder, moderate volume of stool.

Started on Vancomycin, Pip-tazo, doxycycline empirically. Foley catheter placed to decompress the bladder.

CT head: new complete opacification of left tympanic and mastoid cavities.
No mastoid tenderness, erythema or warmth on exam. Left ear canal surgically closed after previous surgery.
TTE: EF 65% with mild aortic regurgitation. No vegetations.
MRI head and spine: signs of spinal meningitis and arachnoiditis
Lumbar puncture: Pneumococcal meningitis. IV ceftriaxone begun.

Dx Pneumococcal spinal meningitis.

On chart review, patient had been receiving low back injections for pain.
Course: The patient had persistent left lower extremity weakness which improved with PT.

Problem Representation: 55M p/w 1 day of fever, bladder distention and AMS. Physical exam is remarkable for tenderness at L3. Blood cultures were positive for Strep pneumo and MRI spine showed spinal meningitis and arachnoiditis.

Teaching Points:

Neurological causes of

- Abdominal pain: abdominal migraine, neuropathic pain.
- Vomiting: Increased ICP (mass, cerebellum - area postrema, meningitis)

Distended bladder: Spine and cauda equina (C2-C4 / parasympathetic fibers).

- In the acute setting spinal shock can present with LMN signs ex. Flaccid.
- Medications: anticholinergics, serotoninergics.
- Serotonin syndrome: fever, hypertension, rigidity, hyperreflexia.

AMS: MIST - Metabolic, Infection, Structural, Toxic.
Relapse heroin myelopathy: posterior to a period of abstinence people that use heroin again can develop myelopathy.
Austrian syndrome: Strep pneumo endocarditis, meningitis and consolidation.