



01/15/25 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Parisa () Case Discussants: Sharmin(@), Austin(@)

CC: Fever in a returning traveler

HPI:

75 yo male w/ no significant PMH presenting to his PCP for fever and cough. He is a pilot and returned from Congo a few days ago. his friend and girlfriend first noted that the patient had a dry cough. The cough progressive to fevers, body aches, and chills throughout the week. The patient scheduled a visit with his primary care doctor. They sent COVID FLU which was negative. Xray which was normal. Started on azithromycin

2 days later he became altered.

Vitals: T: 38.1 BP:163/99 RR: HR: Sat: 94 on 2L

Exam: Gen: AOx1

HEENT: CV:

Pulm: Decreased breath sounds in LLL

Neuro: Moving all extremities. No nystagmus

Notable Labs & Imaging:

Hematology:

WBC: 10,9 75% neutro Hgb: 14.2 Plt:302 MCV:83

VBG 7.37 /CO2 39

Chemistry

Na: 141 K: 4.6 Cr:1.1 Glu:90 Lactate: 4

AST nl ALT nl ALP nl P

HIV/serum malaria/ legionella neg

Imaging:

CT head normal

CXR: Interstitial coarsening in the left lung base may represent small aspiration or early developing pneumonia.

Brain MRI no acute intracranial findings

LP 2 WBCs, Protein 57 (Normal 0-45), Glucose 65 (normal)

CSF west nile/crypto/VZV/HSV neg

Respiratory panel negative for COVID/FLU/RSV, respiratory panel + for mycoplasma pneumoniae

Abx narrowed to levofloxacin

Serum dengue/mononucleosis neg UDS neg

Patient's mentation improved back to baseline at day 3, residual expressive aphasia

CSF mycoplasma serology + IgM IgG

Dx Mycoplasma associated meningoencephalitis

Problem Representation:

75M w/ no sig PMH p/w fever & cough x 1 week after recent travel to Congo, found to have decreased alertness & lung findings c/f pneumonia.

Teaching Points (Dan):

Initial Framework for Fever of Unknown Origin

IMADE: Infection, Malignancy, Autoimmune, Drug-Induced, Everything Else

Altered Mental Status Framework

- MIST: Metabolic, Infectious, Structural, Toxin

- Work-up: CXR, UA, Blood Cx

Timeline of Symptoms

Timing is key. Where did they travel? How long did they stay? Was prophylaxis taken? Is this a red herring?

- Must not miss: Malaria

< 10 days: typhoid fever, dengue fever, bacterial

1-3 weeks: malaria, typhoid, leptospirosis

> 3 weeks: TB

Approaching Lactic Acidosis

Type A (impairment of tissue oxygenation) vs Type B Lactic Acidosis (non-hypoxemia related). Do not forget seizures!

Approach to Symptoms

In critical illness, start broad w/ work-up & antibiotics

- Cell Count, Protein, CBC w/ diff, LP, ID consult

- CSF pleocytosis is *not required* for diagnosing encephalitis

- Consider Brain MRI (correlation between symptoms & imaging)

Deep Dive into Mycoplasma

Remember the common things remain common!

Non-respiratory tract manifestations can present with or in the absence of respiratory symptoms (carditis, GI symptoms, CNS -> most common)

Levofloxacin > Azithromycin for Mycoplasma-associated encephalitis

PMH:
None

Fam Hx:

Soc Hx:

Health-Related Behaviors:

Allergies:

Meds:
None