



04/15/25 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Marcela (@marcelaas) Case Discussants: Yousef (@saklawiMD) and David (@davserantes)

Scribing (Noah)
CC: 33 yo F w/ 1 week of low back pain, right leg pain, chills, and fatigue

HPI: Flu-like symptoms - body aches, cough, sinus congestion, dyspnea.
Syncope episode 1 day PTA - woke up on the floor.
Urinary urgency and incontinence (thought to be due to low back pain) but no dysuria and increased frequency.
Tamiflu with no improvement.
Menses late for a month.

PMH:
Asthma
Bipolar
HIV
HTN

Meds:
Biktarvy
Albuterol

Fam Hx:
None relevant

Soc Hx:
Health-care worker
No EtOH, smoking, drugs
Lives at home with husband and kids, independent at baseline

Allergies:
NKDA

Vitals: T: 98.6 BP: 104/61 RR: 18 HR: 117 Sat: 96% RA BMI: 60
Exam: Gen: WDOWN, NAD
HEENT: wnl **CV:** wnl **Pulm:** wnl **Neuro:** wnl
Abd: Diffuse tenderness, no guarding.
MSK: 1+ BLE edema

Notable Labs & Imaging:

Hematology:
WBC: 23 (neutrophil) Hgb: 9.7 Plt: 78 k

Chemistry
Na: 136 K: 3.9 Cr: 2.1 (bl 0.9) BUN: 62 Cl: 103 HCO3: 24
LDH: mild elevation AST: 24 ALT: 14 ALP: 282 Bili: 3.1

UA with 1+ protein, 1+ bilirubin, 3+ blood, 4.0 urobilinogen, 3+ LE, > 50 Wbc, 11-20 RBC, 6-10 epithelial cells, 4+ bacteria, 3+ amorphous crystals.
Urine HCG negative.
VL not detected, CD4 564/36% RPP negative
BCx negative

Imaging:
CT AP wo contrast ordered and showed small L-sided bartholin gland cyst, cholelithiasis to cholecystitis, moderate hepatomegaly, and mild hepatic steatosis.
Ortho eval - no pocket - XR hip and knee OA
Creatinine improving
GC/CT negative
CT with contrast with signs of bilateral pyelonephritis, bilateral kidney abscesses
ID consulted - plan to treat for a prolonged course

Dx: Pyelonephritis with abscesses

Problem Representation: 33 year-old female with controlled HIV presents with acute inflammatory abdominal pain associated with urinary urgency and incontinence, found to have neutrophilia -> pyelonephritis and renal abscesses

Teaching Points(Minahil):

-**Approach to low back vs leg pain** by distinguishing common msk causes from red flags like cancer, immunosuppression, or IV drug use -spinal infection(epidural abscess,osteomyelitis) or metastasis.

Start with **CT** if concern for bony pathology/trauma,**MRI** preferred for evaluating soft tissue,inflammatory/infectious etiology

-**Leg pain with radicular features** suggest nerve root involvement ,consider deeper structure or infectious etiologies if systemic signs are present.

-**Syncope** episode(hypoperfusion to brain)-evaluate whether its localizing or marker of severity of disease

-**Urinary urgency/ incontinence** -in absence of infectious signs raises concern for neuropathic involvement/ spinal cord pathology or external compression of urinary tract

-HIV:

- Assess source(IV/sexually)
- immunosuppression from low T cells count predispose more frequent and severe infection,esp from intracellular organism.
- Full body exam is essential,though often less sensitive in AIDS patient-imaging will be required
- Higher viral load lower will be platelets

-**Culture negative infections:** organism not found in blood-chlamydia,gonorrhea,trepnema,zoonotic tick born infection or pathogens sequestered in walled off abscess

-**Contrast enhanced CT** typically required when evaluating abdominal or mediastinal pathology,and in brain when goal is to rule out non hemorrhagic causes.

