



7/29/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Tansu (@drtansue) Case Discussants: Ravi (@rav7ks) and AMK (@annkumfer)



<p>Scribing (Lera) CC: 40M with body aches, chills and headaches HPI: Sx started 4 d ago while was at work, progressive during the day -> fever of 103.4 (39.6). Slept all day. Next day developed bitemporal headache 6/10, pulsatile, associated with photo/phonophobia. Responsive to Tylenol, but temporarily.</p> <p>Had similar episode 10 y ago: was hospitalized for disseminated amebiasis (liver & lung).</p> <p>ROS (-): blurry vision, dizziness, CP, SOB, cough, N/V, loose stool, urinary Sx, abdominal pain. Endorses discomfort of the neck.</p>	<p>Vitals: T: 39.3 BP: 110/70 HR: 95-112 Sat: 96% on RA Exam: Gen: in acute distress, irritated by light HEENT: PERRLA, EOM intact, throat clear, no LAD, no neck stiffness, no Brudzinski / Kernig signs CV: tachycardia, otherwise nl Pulm: nl, no accessory muscle use Abd: soft, non tender Neuro: nl, AO x 3 MSK: skin warm, no rashes, no jaundice, tenderness on palpation in bilateral calves, ROM nl, strength nl</p>	<p>Problem Representation: A 40 y/o gentleman with exposure to mice presented with acute systemic inflammatory Sx and new headache. On exam was found to have bl calf tenderness. Labs remarkable for anemia, thrombocytopenia, AKI, muscle breakdown. Lung imaging showed bl GGOs. Serologies positive for Leptospira.</p>	
<p>PMH: No Hx of migraines PreDM (A1c 5.8%) ADHD Anxiety Asthma Allergic rhinitis</p> <p>Meds: Fexofenadine Propranolol Lisdexamfetamine Trazodone</p>	<p>Social Hx: Lives w/ cats and wife. Recent travel -> Northeast, Midwest, Mountainwest. No water exposure or tick bites. Mold exposure in conditioning, mouses.</p> <p>Health-Related Behaviors: No sick contacts. For past 10 y smoked marijuana and electronic cigarettes, 3-4 beers / week.</p> <p>Allergies: pollen</p>	<p>Notable Labs & Imaging: -> + <i>SIRS criteria</i> -> received ABx before BCx CBC: WBC: 7.4 (<i>neutrophilic</i>) Hgb: 11.8 Plt: 90 (<i>bl 252 3 mo ago</i>) MCV: 92 VBG: pH 7.43, CO2 37, HCO3 25, lactate 0.8</p> <p>Chemistry: Na: 136 K: 3.9 Cr: 1.73 (<i>bl 0.9</i>) GFR: 51 BUN: 15 Ca: 8.5 Ph: 3.4 Mg: 2 LDH: 348 AST: 93 ALT: 73 ALP: 145 Bili: nl Total pr: 5.6 Alb: 3.1 CK: 817</p> <p>Respiratory viral panel: negative. HIV: neg UA: moderate blood, but <i>no RBCs</i> on microscopy</p> <p>EKG: nl sinus rhythm CXR: no acute pathology CT head: no mass / bleed CT A/P: non-specific LAD, no visualized acute abdominal / pelvic pathology, bl GGOs in lower lungs Haptoglobin: 260 (nl) PBS: no schistocytes Chest CT: bl diffuse air space opacities with some peribronchial distribution</p> <p>ID workup: Broad respiratory panel sent + HBV, HCV, tick borne & zoonotic diseases, Legionella urine Ag, Quant-GOLD, atypical pneumonia, Histo Ag, Cocci ABs, parasite smear, EBV ABs -> + Mycoplasma IgG & Leptospira IgM</p> <p>-> ABx switched to cefepime + doxycycline -> improvement -> discharged before results came back.</p> <p>Dx: Leptospirosis</p>	<p>Teaching Points (SEEME): Approach to body aches, chills and headache: -Multiple symptoms make us think about a systemic process. We can see who is our host is whether immunocompromised and asking about exposure history. Approach to bitemporal headache+photo/phonophobia: Headache could be a reflection of infectious process such as meningitis. Lack of AMS and focal deficits takes us away from encephalitis. Ruling out HIV and malignancy is also important. Tick borne and fungal infections are worth considering. LP can help us make progress. Approach to past medical history and exam findings: - Patient is febrile with relative bradycardia which makes us think about intracellular organisms such as anaplasmosis/ rocky mountain spotted fever. -When we have tenderness in the muscles we can have electrolyte abnormalities, creatinine levels and CK levels. It could be a manifestation of the infection - Patient has history of disseminated amebiasis history so patient might have a complication of this condition. -FOCUSED criteria is used for CT before LP-focal deficits, observed seizure,changed consciousness , unusual headache, signs of raised ICP, evidence of immunocompromise and definite or suspected hemorrhage. Approach to labs and imaging: -Normal WBC count does not eliminate infection.Tick borne diseases can cause thrombocytopenia.Thrombocytopenia could be due to bone marrow issue or sequestration. Normal bilirubin takes us away from hemolytic process. - Atypical lung syndromes can be sneaky. Lack of hyponatremia takes us away from legionella. Diffuse ground glass opacities can be seen in interstitial lung diseases. Mycoplasma/Covid/Legionella/rickettsia/Hantavirus/Tularemia/Leptospirosis are atypical organisms that can contribute to lung findings. . Marijuana and smoking history can contribute to lung findings. -When we have blood but not RBCs in urine, it can be secondary to rhabdomyolysis. - Tick borne infections are worth considering with response to doxycycline +thrombocytopenia and sometimes diagnosis is made by treatment response.</p>