12/4/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Ravi* ***Case Discussants****: Rabih & Shriya*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Noah)

CC: 38 y/o M w/ AMS and SOB

HPI:

Not feeling well for 2 days. On second day, confused upon waking up. EMS called. Agitated, hypoxic, placed on NRB. POCT glucose 300.

PMH: Rheumatoid Arthritis, CKD, HTN, DM, Sarcoidosis, Polymyalgia Rheumatica

Meds: Prednisone 5 mg qd
Tocilizumab q1w
MTX q1w, Insulin

Fam Hx: None relevant

Social Hx: None relevant
No EtOH, tobacco, drug use

Allergies: NKDA

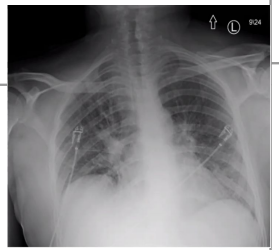
Vitals: T: 102.6 **HR**: 150 **BP**: 101/54 **RR**: 22 **Sat**: 80s RA - Upper 90s NRB

Exam: Gen: agitated, diaphoretic, alert but disoriented, resp distress

Pulm: Rhonchi RML RLL, accessory muscle use, resp distress

Abd: Diffusely tender

Neuro: Moving all extremities **Extremities/skin**: No rashes



Notable Labs & Imaging:

Hematology:

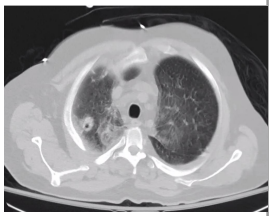
WBC: 9 Hgb: 8.1 Plt: 168

Chemistry:

Na: 138 K: 5.4 Cl: 104 HCO3: 12 Cr: 3.80 (close to bl) BUN: 46 Glucose: 304

Lactate: 7.4 HIV: negative A1c: 9.5% TSH: 0.4 (low) fT4: 3.4 (normal)

EtOH <10 UDS: negative



Imaging:

CXR: Perihilar opacities R, elevation of R hemidiaphragm

CT: cavitary lesion R w/ consolidation

CTh: negative for acute process

bMRI: focus of DWI R superior cerebellum

TTE: EF 40% global hypokinesis, no veg. seen

Fluids and abx given for suspected multifocal PNA.

Patient continued to worsen. Intubated.

BAL unrevealing initially - > **1 month later Cryptococcus**

Improved pulm, extubated. Still AMS.

LP: Opening pressure 30 mmHg. Glucose 81. Protein 418. VDRL neg. WBC 1100. PMN 22% L 72% Varicella, HSV, CMV negative.

CrAG positive serum and CSF

Dx: Disseminated Cryptococcus infection

Problem Representation: 38 y/o M immunosuppressed (toci, MTX, pred) p/w acute persistent AMS c/b resp failure found to have lung cavitation and meningoencephalitis.

Teaching Points (Glen)

-AMS, R/O life threatening causes like electrolyte imbalances. In this case elevated glucose levels.

-Hypoxemia a clue to the cause of AMS but they can be independent.

-Infection cause? PNA (tachycardic and tachypneic with low Sats). Could be immunocompromised or non-adherent to meds.

-Be careful with oxygen administration because of combination of hypoxemia and encephalopathy. Consider intubation.

-Consider possibility of Aspiration causing resp abnormalities and CNS findings being explained by something else like meningitis.

-ANAEMIA? Could be of chronic disease or actively bleeding. Acidosis caused by elevated lactate and lack of perfusion to tissues. Repeat lactate will be helpful after improving Sats. This could also explain tender abdomen in the form of ischemic bowel. Also backed up by PMH.

-CXR could be caused by atelectasis or an intrinsic disease.

-CXR good for pneumothorax, congestive HF or community acquired PNA in an immunocompetent host.

-CT scan (cavitary lesion): Infectious vs Ischemic (emboli). Explained by TB, fungal infections. Timeline of 2 days means a virulent organism is the cause (e.g S.aureus).

-CSF: Viral vs TB vs fungal. Glucose interpreted differently in the context of diabetes. Subacute because of lymphocytic predominance.

-Respiratory and CNS findings point to Tuberculosis.

-The stroke at the sup cerebellum could be explained by the meningoencephalitis. The cavitary lesion at the lungs could be infiltrating the meninges. And common organism to do that is Cryptococcus.