Intercity Infectious Diseases Rounds
New York Medical College—3/14/16

Case # 1

HPI: A 59 y/o old woman with history of morbid obesity underwent a sleeve gastrectomy (8/2014), complicated by intractable nausea and epigastric pain that led to multiple subsequent intra-abdominal procedures including laparoscopic cholecystectomy, multiple upper endoscopies with dilations, hiatal hernia repair and jejunostomy tube placement (initially placed in 03/2015, exchanged in OR in 6/2015 and subsequently removed ~2months prior to presentation) The patient presented to the ER in 12/2015 complaining of pain with erythema and drainage in her left lower quadrant at the site of the recently removed jejunostomy tube. Pt had I&D of Left lower quadrant/jejunostomy site abscess 12/9/15 and was sent home on cephalexin. Her left lower quadrant pain and drainage continued to worsen for the next six days so patient decided to go to ER.

Past Medical History: Rheumatoid arthritis (last immunomodulatory therapy/steroids in 2014), asthma, depression/ anxiety, h/o latent TB s/p Rx (at 19yrs old); **Past Surgical History:** tubal ligation; **Home Medications:** multivitamins, calcium carbonate, ferrous sulfate, acetaminophen, ondasetron,pantoprazole,vitaminD3. **Social History:** lives with grand-daughter and daughter in law in LHV of NY. Never married. Born in Costa Rica, moved to US 1969, no other travel outside US since then. No ETOH/ no smoking/ no illicit drug use. Animal exposure: pet dog.

Vitals: T: 98.7 – BP: 110/77 - HR: 86 – O2 Saturation: 100% on Room Air General: obese, comfortable, not in respiratory distress; HEENT: No pallor or icterus, pupils equally reactive to light, throat clear; Neck: supple; Lungs: bilateral clear to auscultation; Heart: S1 S2 normal, no murmur

Abdomen: soft, no organomegaly. Lt abdomen abscess with purulent drainage and surrounding erythema.

CNS: normal cranial nerve, motor and sensory function; Skin: Rt Leg tattoo

Laboratory Data: WBC = 5000 cells/mm3 (N: 63.6%, L: 23.4 %, M: 10.8 %, E: 1.4%), Hgb: 10.2 g/dL; HCT: 34.1%; Platelet count: 339,000 cells/mm3. BUN: 12 mg/dL; Creatinine: 0.62 mg/dL; LFTs: WNL; ESR: 15; UA negative. **Imaging:** CT abdomen/pelvis: Patient is s/p recent gastrectomy. At the site of the previous jejunostomy tube entrance site there is now an open defect along the skin surface with indwelling material, overall measuring approximately 5.8 x 2.9 cm. There is also an elongated rim-enhancing focus measuring 2.2 x 1.1 cm abutting the fascial planes of the left anterior pelvic wall (series 4 image 186). This is located along the prior jejunostomy tube tract and likely represents an abscess. There is no definite communication with bowel and no definite enterocutaneous fistula is identified. Misty appearance of the mesentery with associated lymph nodes. Interval enlargement of left-sided iliac chain lymph nodes.

Your Dx is?

Case #2

HPI: A 64 year old Caucasian man was transferred to our hospital in June for management of headache and abnormal Magnetic Resonance Imaging (MRI) of his brain. He was in his usual state of health until three days PTA, when he developed a severe bi-frontal headache with mild nausea. The next day he developed double vision along with fever and chills. At another hospital he was given IV vancomycin and ceftriaxone prior to transfer. The patient recalled removing a tick from his left buttock three weeks prior to his current illness.

Past medical history: Lyme disease five years prior (erythema migrans); No home medications or drug allergies

Social history: He lived in Westchester county, NY with his wife and was a truck driver by profession. He smoked half a pack of cigarettes every day, but denied alcohol consumption or recreational drug use. He had a healthy pet dog and did not report any recent travel outside the state.

Physical examination

T 102.3 F, HR 72, BP 116/64, SpO2 94% on room air.
General: Appeared comfortable
HEENT :No pallor or icterus
Mobile, non-tender lymph nodes in the cervical, axillary and inguinal regions
Lungs: clear to auscultation
Heart: S1 S2 normal, soft systolic murmur at the left lower sternal border
Abdomen: soft, without organomegaly.
Skin: Faint morbilliform rash on his trunk and a small, scabbed lesion on his left buttock at the site of previous tick bite.
CNS: normal cranial nerve, motor and sensory function. No visual field deficits/ meningeal signs

Laboratory data

WBC 11,500 cells/mm3 (no differential done); Hgb 12.5 g/dL; Platelets 206,000 cells/mm3
Creat 0.72mg/dL.; BUN 12mg/dL; Na 137mEq/L, K 3.7mEq/L, Cl 106mEq/L, HCO3 24mEq/L,
Glucose 106 mg/dL; AST 17 u/L; ALT 7 u/L; ALK Phos 49 u/L; Bilirubin 0.5mg/dL; total protein 6g/dL,;
Albumin 3.5g/dL. UA: negative for nitrites and leukocyte esterase
CSF: WBC count 109 cells/mm3 with 26% polymorphs, 64% lymphocytes, RBC count 310 cells/mm3, protein 76 mg/dL, glucose 62 mg/dL; Gram's stain negative

Imaging

MRI Brain, orbits and paranasal sinuses C+/C- revealed bilateral white matter signal abnormalities which were felt to be non-specific, as well as a 2mm left internal carotid artery aneurysm
CXR: calcified pleural plaques bilaterally and right lung nodule (middle lobe)

Your dx is?

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Case # 3

HPI: 20 y/o woman with no pmh was admitted with a rash on her right palm. She had taken valacyclovir for seven days as treatment for shingles with no improvement. During this time the rash had become larger and confluent (pictures will be shown). Because of the worsening her PMD then prescribed doxycycline (took for two days) and a topical steroid, but there was still no improvement. On day 9 of rx she was hospitalized. Pt complained of severe pain in the right hand. Pt recalled being bitten by one of her domesticated rats (pet) on her right index finger (5 weeks prior). Pt sought no treatment at that time and cleaned the site with hydrogen peroxide (not soap and water).

Past medical history: None

Social history: no toxic habits; works as a taxidermist x 3 yrs; usually works with tanned, treated skins, mostly foxes and some coyotes, had worked with some untreated fox skins (from Iowa) one month PTA. Some skins were treated with a new dye (Cowboy Magic Yellow Out). Lives in LHV. Has a dog, two cats, domesticated rats, a leopard gecko, and a ball python. Had a recent tattoo at certified parlor; sexually active with her girlfriend of one year.

Physical examination

T : 98.0 , HR : 77 bpm , BP : 99/55 mmhg
General: Appeared comfortable
HEENT :No pallor or icterus
Lungs: clear to auscultation
Heart: S1 S2 normal
Abdomen: soft, without organomegaly.
Hand : right palm confluent skin lesion with raised skin, and surrounding erythema
CNS: normal cranial nerve, motor and sensory function. No visual field deficits/ meningeal signs
LN : no regional LN palpable

Laboratory data

WBC : 8.4 (**N %** 62.9 **L %** 25.7 **M %** 8.0 **E 3.**0 %), HGB : 10.6, BUN : 4 , Creatinine : 0.53

Your dx is?

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Case #4

HPI

A 44 year old Caucasian man presented in August with a 4 week history of fatigue and generalized weakness. He also had 2 bouts of fever with chills and myalgias lasting for ~ 3 days each; the first at the end of July, and the second occurred 3 weeks later (resolved 2 days prior to presentation). He recalled at least 6 tick bites over the month preceding the onset of his illness. He felt that the ticks had been attached no more than a few hours prior to removal on each occasion. He had not seen a physician regarding his current complaints and had not received any antibiotics. He had been unable to work over the past month due to persistent fatigue

Past medical history: none
No home medications or drug allergies.

Social history: He lived in Westchester County, NY and was a massage therapist by occupation. He denied smoking or illicit drug use. He drank alcohol in moderation. No pets/ animal contact or recent travel outside the tristate area.

Physical examination

T 97.4 F, BP 120/80, HR 77, SpO2 98% on room air
HEENT: no pallor/ icterus
No lymphadenopathy
Lungs: Clear
Heart: S1 S2 normal, no murmur/ rubs
Abdomen: soft, non-tender, no organomegaly
CNS: no focal deficits
Skin: no rash

Laboratory data

WBC 6,200 cells/ mm3 (N 36.9, L 40.2, M 17.3, E 4.8) , Hgb 15.6 g/dL , Platelets 140,000 cells/mm3, Creat 0.81mg/dL, BUN 16 mg/dL, Na 136mEq/L, K 4mEq/L, Cl 100mEq/L, HCO3 25mEq/L, Glucose 86mg/dL, AST 23 u/L, ALT 38 u/L, ALK phos 60 u/L:, Bilirubin 0.7mg/dL, Protein 7.4g/dL, Albumin 4.3g/dL liver enzymes and bilirubin were unremarkable.

No imaging

Your Dx is?

Case # 5

HPI: A 75 y/o male with a h/o HCV cirrhosis s/p liver transplant, lymphoma s/p radiation therapy to neck region (1970) complicated later by carotid stenosis, s/p carotid endarterectomy (2008) presented to the hospital on 12/2015 c/o Rt neck wound drainage for 2months. Pt noted bluish discoloration and swelling on Rt side of neck since 7/2015, he had I&D twice after that with outpatient antibiotics (Clindamycin and Augmentin). Neck wound drainage started ~2months prior to presentation (~10/2015), in 11/2015 pt had Carotid Endarterectomy patch repair in outside hospital. Pt noted persistent purulent drainage from surgical wound and went to ID specialist who advised to go to ER. **Past Medical History:** Hypertension, bipolar disorder, peripheral artery disease, hypothyroidism; **Home Medications:** tacrolimus (2mg BID), metroprolol, clopidogrel, levothyroxine, venlafaxine, quetiapine, alprazolam prn

Social History: Lives in Hopewell, NY. Ex smoker (quit 1975), ex IVDA (1970's), +ETOH. Animal exposure: cats. No recent travel.

ROS: positive for fatigue, lethargy, malaise.

Vitals: Afebrile, T: 98.1 – BP: 147/90 - HR: 68 – RR: 16 – O2 Saturation: 98% on Room Air

General: Elderly male, appeared comfortable, not in respiratory distress; HEENT: No pallor or icterus

Neck: Positive for scar with purulent drainage from right lateral CEA wound with fibrinous exudate, mild local erythema. No Lymph node enlargement

Lungs: bilateral clear to auscultation; Heart: S1 S2 normal, no murmur;Abdomen: soft, without organomegaly. CNS: normal cranial nerve, motor and sensory function

Laboratory Data: WBC = 6.200 cells/mm3 (N: 47.9%, L: 32.8 %, M: 5.1 %, E: 3.7%), Hgb: 12.5 g/dL; HCT: 36.3%; Platelet count: 147,000 cells/mm3. Glucose: 105 mg/dL; Sodium: 136 mEq/L; Potassium: 3.8 mEq/L; BUN: 20 mg/dL; Creatinine: 1.08 mg/dL; Tacrolimus level: 17.9 (H), Liver function tests: WNL

Imaging: CXR : No focal consolidation, pneumothorax or pleural effusions.

CTA Head: No evidence of acute intracranial hemorrhage, mass effect or midline shift. Area of hypodensity involving the left frontal lobe, which may represent age indeterminate area of infarction. Cerebral atrophy and chronic ischemic white matter changes. Moderate-sized chronic appearing infarction in the right cerebellum. Circle of Willis: Occlusion of the intracranial internal carotid arteries bilaterally with partial segmental stenosis of the proximal right anterior cerebral artery; CTA Neck: complete occlusion of the right common carotid artery from its origin to the bifurcation point and complete occlusion of the right internal carotid artery. Stent graft material in the extracranial right common to internal carotid artery with occlusion of the vessel. Induration and soft tissue density in the region of the right carotid sheath, (postoperative change/ infectious process). 90 percent stenosis of the left internal carotid artery at the bifurcation.

Your Dx is?

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Case # 6

HPI/Course of Illness:

A 27 y/o man presented in September with a 4 day history of malaise, fevers, cough & worsening SOB. CXR showed a right sided consolidation. Aztreonam, vancomycin, and Levaquin were started. Patient continued to have fevers and with a further decline in his respiratory status, requiring high flow supplemental oxygen. Repeat imaging showed increased opacity in right lung field. 3 days later antibiotics changed to cefepime, vancomycin, azithromycin, and oseltamivir. Respiratory status continued to decline and patient placed on BiPAP.

Past medical history: none; penicillin drug allergy (diffuse rash)

Social history: active smoker: 10+ years; alcohol (2 beers per month); denies illicit drugs; daughter w/ ear infection same time as pts presentation; pet dogs for past 6 yrs; has visited sites such as nursing home and hospitals 4 months PTA and travelled to Florida 2014; Arizona and Las Vegas 2013; Mexico 2014; Bermuda 2012. No recent travel out of NY area

Physical examination

- BP:133/68 P: 102 RR: 24 Sat: 93% on 50% face mask Tmax: 103F
- HEENT: pharyngeal erythema, no exudates, no ulcers no sinus tenderness
- No lymphadenopathy
- CARD: tachycardia regular S1 S2 no murmurs or rubs

RESP: Dullness percussion to over right lung; decreased fremitus on right; right sided rales.

- ABD: soft, non-tender, no organomegally
- EXT: no edema, cyanosis, or clubbing
- SKIN: multiple tattoos, no rash, no lesions

Laboratory data

- WBC = 6.2 (N: 75% L: 13.6% M: 4.4% E: 0.6% B: 0.2%) ; HGB = 13.1 HCT = 38.4 PLT = 271
- Na: 135 K: 3.5 Cl: 101 CO2: 26 BUN: 11 Cr : 0.56 Glu: 90; AST = 40 ALT = 65 ALK PHOS = 58 T. Bili = 0.7 D. Bili= 0.4 PROTEIN = 6.2 ALB= 3.1; INR: 0.7 PT: 9.7 PTT: 30

ABG on 50% Fi02

- pH 7.46; PCO2 mmHg: 33.0; LPO2: mmHg 54.0 L

BiCarb mEq/L: 26.3 H O2 Sat :91%

Imaging:

CXR: Increased opacity in the right thorax involving most of the right thorax suggesting fluid and/or consolidation or atelectasis. There is also some increased left basilar opacity noted which could represent atelectasis and/or consolidation. Heart and mediastinum not adequately evaluated on this projection. There is no discernible pneumothorax noted.

Your dx is?