NYU Intercity Infectious Disease Rounds: References
May 9, 2016

Case #1

- Diagnosis, Treatment, and Long-Term Management of Kawasaki Disease. AHA, 2004

Case #2


Case #3

Case # 4

Case # 5

Case # 6
CASE #1: Dr. Sanchez

Presentation: A 9 y/o female, previously well, admitted for fever and rash. 4 days PTA, mother noted rash, macular, on the cheek without any other associated symptoms. 2 days PTA, patient had fever (Tmax: 104) associated with sore throat, odynophagia and small, tender left cervical lymphadenopathy (< 1 cm). She was brought to PMD who did a rapid strep, which was negative. Throat culture was sent and she was empirically started on Cefadroxil. At home, she continued to be febrile and mother noted spread of the rash to the face, trunk, and extremities. The next day, she was still febrile associated with worsening of the rash and 4 episodes of non-bilious, non-bloody vomiting so she was brought to the ER.

PMH: none
Allergies: Omnicef (hives)
FH: rheumatologic disease (SLE) in 2 maternal aunts, cousin with Addison’s disease
SH: lives with parents and 7 siblings in Brooklyn; in the Catskills 10 days ago; no sick contacts

Physical Exam:
Awake, uncomfortable, not in respiratory distress
NCAT, bilateral eyelid edema/erythema, pink conjunctiva with clear-yellow discharge, dry red cracked lips, diffuse facial swelling, (-) oral ulcerations, ears with desquamation and redness; 4 cm, tender cervical LAD
Good air entry, bilateral, (-) rales/wheezeing
Normal S1, S2, tachycardic, (-) murmur
Soft, flat abdomen, (-) masses/tenderness
Labial erythema; Full and equal pulses, (-) edema/cyanosis, (-) joint pain/swelling
Diffuse, discrete papular/plaque lesions 0.5-2 cm in diameter, even on palms and soles, some coalescing on forehead/arms > legs

Initial labs and imaging
11.8>40<223 N88 L6 M5 Bs1
CRP 157  ESR 24  Procatacticin 18.85
ASO: 800
AST 27, ALT 29, AP 116, TP 5.3, Alb 2.6
U/A: normal
CXR: mild bronchial wall thickening
Neck US: Left cervical lymphadenitis, with associated cellulitis and myositis of the sternocleidomandibulost muscle

A Procedure was performed!
CASE #2: Dr. Slawek

Presentation: persistent dysuria x1 year
39 yo M initially sent to urology for hematuria, found to have significant stone burden on imaging.
Cystoscopy performed with no abnormalities found. Was scheduled for ureteroscopy and lithotripsy, but patient was lost to follow up x1 year. Returned to urology one year later, for further workup and treatment.

PMH: none
SH: Works as an Uber driver. Lives with his wife in Brooklyn. No alcohol, smoking, or history of IV drug use.

Physical Exam: VS: 98.7, P 77, R 14, BP 135/70
Gen: alert & oriented x3, NAD, Abd: s/nt/nd, Back: no CVA tenderness bilaterally, GU: circumcised phallus, patent meatus, testes descended bilaterally

Initial Labs: CBC: 7.4>14.7/45.2<338 Neutrophils 58.9%
BMP: 139/4.8 | 101/28 | 24/1.2<75
UA: glu neg, bili neg, ketones neg, spec grav 1.026, blood moderate (2+), pH 6.5, protein 100 (2+), nitrite neg, leukest large (3+), WBC 50-100, RBC 5-10, Epithelial cells 1-10, Bacteria few, Crystals calcium oxalate (1-5)
Urine culture: no growth

CT abd/pel w/o: markedly dilated L anterior lower pole calyx containing multiple heavily calcified stones, with associated severe thinning of the overlying cortex and circumferential thickening of the adjacent infundibulum, presumably related to sequela of chronic calyceal obstruction from the patient’s stone disease. L proximal ureteral calculus, and punctate stone or stone fragments in the distal ureter with associated mild upstream dilation of the L ureter and of the remaining L- sided calyces. Extensive, smooth, circumferential thickening of nearly the entire left ureter and of the L renal pelvis in addition to the lower pole infundibulum described above, related to sequela of chronic stone disease.

Cystoscopy and retrograde pyelogram: to the R and L of the bladder dome, approximately 2-3 cm patches of weepy erythematous mucosa that was consistent with inflammation and cystitis. Significant alternating, narrowing and dilatation of the ureter. Moderate hydronephrosis. Beaded appearance of the ureter with alternating narrowing and dilation

Pathology and culture sent!
Case #3: Dr. Bontempo

Presentation: DOE for 1 week
45 y/o man with HIV, CD4 290 (21%), VL undetectable, presented with 1 month of DOE, intermittent dry cough, and with R chest pain. Denies fever, chills, night sweats, weight loss. Seen by PCP as outpatient after 10 days of symptoms. Azithromycin was prescribed and CXR ordered that showed some abnormalities non the right hilum and right middle lobe.

Bacterial PNA in 2014, h/o Bell’s palsy zoster, syphilis

Allergies: anaphylaxis to Bactrim
Meds: TDF/FTC/ETG/Cobi
SH: Born in Puerto Rico. Lived in NY for many years. Denies any drug use/ EtOH/ tobacco
FH: Father died from esophageal cancer.

Physical Examination: VSS, afebrile, NAD, no respiratory distress, No skin findings, No lymphadenopathy, RRR s1 s2 ok no m/g/r, Abdomen is soft NT ND BS+, AOX3, CNS WNL

Initial Labs: WBC 5.4, Hb 12.4, CMP wnl (Alk Phos 144), VL undetectable, CD4 count 290 (21%)

CT Chest: Consolidation on right middle lobe. Soft tissue density right laterally adjacent to the esophagus measuring 2 x 2.9 cm, extending to the right superior mediastinal region. Suspect mild extension of the mass into the right posterior wall of the trachea. Right hilum lymph node measuring 1.2 cm x 1.8 cm. Few other sub centimeter mediastinal lymph nodes are noted, nonspecific.
Conclusion: Suspicion of esophageal neoplasm (from esophageal or tracheal origin)

Further imaging study and biopsy was performed!
Case #4: Dr. Parajuli

**Presentation:** fevers and muscle aches x 6 days
18 y/o woman c/o low-grade fevers and muscle aches x 6 days. Associated symptoms of right chest, neck, and left back pain x 4 days. Also withnausea/vomiting. No travel. Found to be Influenza positive and given Tamiflu by PMD prior to admission.

**PMH:** GERD, eczema
**PSH:** EGD showing esophagitis
**Allergies:** NKDA
**Meds:** Pantoprazole
**SH:** lives in Brooklyn, NY. Orthodox Jewish family. No toxic habits.
**FH:** IBD in extended family

**Physical Examination:** Febrile (T102.4), HR 109, drowsy, no LAD, L-sided neck pain. Diminished breath sounds bilateral bases, mild RUQ abd tenderness without rebound.

**Initial Labs:** WBC 13.8 (N88%), CMP wnl, CRP 270, ESR 67, Lactate 1.7, HIV negative

**CT Chest:** Diffuse confluent mediastinal adenopathy as well as diffuse thickening surrounding the esophagus with infiltration of the surrounding mediastinal fat. Diffuse esophagitis versus marked mediastinitis. Small/moderate R and tiny L pleural effusions w/patchy airspace disease at R lung base (atelectasis vs. PNA).

**Diagnostic procedure was performed!**
Case #5: Dr. Epstein

**Presentation:** fevers and cough x 4 days
58 y/o woman with h/o esophageal cancer s/p esophagectomy/XRT 2011 presented complaining of productive cough associated with chest pain and SOB. Symptoms similar to recent pneumonia which was treated with antibiotics but never fully recovered. Reports multiple pneumonias since her surgery.

**PMH:** esophageal adenocarcinoma s/p esophagectomy/XRT, DVT/PE, GERD, obesity s/p gastric bypass
**Allergies:** PCN (unknown childhood reaction)
**Meds:** umeclidinium, fluticasone-salmeterol, tiotropium, quetiapine, duloxetine, gabapentin, pantoprazole, cyclobenzaprine
**SH:** chronic former smoker, quit 6 yrs ago
**FH:** mother with liver cancer, father with colon cancer

**Physical Examination:** Febrile (T102.8), O2 90-96% RA, chronic ill appearing, nontoxic, decreased breath sounds bilateral bases, bibasilar crackles R>L

**Labs:** WBC 12.5 (N83%), CMP wnl, HIV negative

**CT Chest:** Findings compatible with worsening multifocal pneumonia, right greater than left. Likely some component of CHF with asymmetric edema, greater on the right. Increased small bibasilar pleural effusions. Prior partial esophagectomy and gastric pull-up. Borderline and mildly enlarged mediastinal nodes, some of which are increased. These may be reactive and should be re-assessed on follow-up.

**Diagnostic procedure was performed!**
Case #6: Dr. Kupferman

**Presentation:** left index finger pain and swelling x 3 wks
84 y/o woman with ESRD on HD c/o progressive index finger swelling/pain. Started as a small black lesion with proximal spread. Given antibiotics for cellulitis without improvement. After admission started on empiric antibiotics without improvement.

**PMH/PSH:** ESRD on HD, COPD, Stage 2 colon cancer s/p hemicolecetomy, Prostate cancer s/p TURP
**Allergies:** NKDA
**SH:** lives in NYC, h/o extensive travel worldwide in past, gardens for hobby
**FH:** IBD in extended family

**Physical Examination:** Vitals normal/stable, well-appearing, NAD, no LAD, 3/6 holosystolic murmur, bibasilar pulmonary crackles, LUE AVF with thrill, left first digit with erythema extending proximally to elbow with lymphagitis.

**Diagnostic culture performed!**


HSV1 on hand


Atypical mycobacterial infection and abdominal surgery


Pasteurella multocida wound infection


REFERENCES

Powassan/Deer tick virus


Borrelia miyamotoi


Adenovirus


[Article in Russian]
Marenunikova SS, Zhukova OA, Manenkova GM, Ianova NN.
Abstract
The present work describes a case of human disease resulting from the bite of a white rat and caused by a biological variant of cowpox virus. The isolates obtained from the sick man and the white rats which had been the source of this infection proved to be identical and did not differ from the biological variants of cowpox virus, isolated earlier from white rats and carnivorous animals of the family Felidae. Thus, the possibility of ratpox (cowpox) transmission from sick rodents to man was established.
PMID: 3176779 [PubMed - indexed for MEDLINE]