

October 29th, 2009

Clinicopathologic Conference – 48 y/o African American woman with ESRD presents with hypotension, altered mental status, and new pulmonary infiltrates.

Chief Complaint:

Altered Mental Status

History of Present Illness:

Ms. U is a 48 y/o African American woman with a PMH significant for controlled DM2, HTN, severe lower extremity PAD, and ESRD on peritoneal dialysis who is transferred from the Physical Medicine & Rehabilitation (PM&R) ward to the MICU with hypotension, increasing FiO2 requirements, and altered mentation. The HPI is limited as the patient is noncommunicative.

Twelve days prior to this decompensation Ms. U was admitted with bilateral necrotic gangrenous toes. There was no conversion to wet gangrene noted. She subsequently underwent an uncomplicated bilateral above the knee amputation. The patient had an unremarkable post operative course and was transferred to the PM&R service.

Throughout the hospitalization the renal consult service managed the peritoneal dialysis. As a result of the leukocytosis noted on presentation, the peritoneal fluid was sent for culture. Conservative management was selected and the patient was not started on antibiotics. Cultures were negative to date.

Additional information was obtained from family members. Ms. U had a 3-4 month history of chronic, dry cough, without fever or weight loss. Approximately 2 months ago the patient was admitted to an OSH hospital for the treatment of a "pneumonia". Limited records substantiated these verbal reports with a CXR that showed bibasilar and right middle lobe infiltrates. She was treated with a total of three different antibiotics without symptomatic or radiographic improvement. Family members report that the patient had not complained of SOB and never required oxygen. There was no recent travel or exposure to animals. The patient continues to smoke less than 1 pack per day.

Review of Systems:

Unable to obtain secondary to altered mentation.

Past Medical/Surgical History:

1. End-stage renal disease. Attributed to uncontrolled HTN. Never biopsied. On dialysis x 7 years. Multiple unsuccessful AV fistulas. Has required multiple permacaths. Has been on

peritoneal dialysis x 4 years. Recent Staph Epi peritonitis infection, requiring parenteral Vancomycin.
2. Secondary hyperparathyroidism: Underwent parathyroidectomy on the September 18th 2008.
3. Peripheral artery disease: Diagnosed 8 years prior. Experienced rest pain and ischemic ulcerations leading to bilateral gangrenous toes. Failed right femoral to anterior tibial bypass. Had been managed by the pain clinic for chronic ischemia-associated pain.
3. Hypertension
4. Diabetes mellitus type 2

Allergies:

No Known Drug Allergies.

Current Medications:

1. aspirin 81 mg p.o. daily
2. calcitriol 0.5 mg p.o. q.12 hours
3. PhosLo 667 mg p.o. t.i.d.
4. gabapentin 300 mg p.o. at bedtime
5. heparin 5000 units SQ t.i.d.
6. Dilaudid 0.4 mg IV q.4 hours
7. Megace 800 mg p.o. daily
8. Renagel 800 mg p.o. t.i.d.
9. Epogen 10,000 units subcu every Sunday
10. Lopressor 12.5 mg p.o. b.i.d.

Family History:

Hypertension: Mother and father
CAD: Sister and brother. Age of onset unknown

Social History:

Tobacco: 15 pk yr history. Continues to smoke.
ETOH: None
IVDA: None
The patient lives with a family member, but is independent with ADLs.

Physical Exam: obtained on transfer to the MICU

T: 95.9 **P:** 117 **R:** 18 **BP:** 79/49 **S_pO₂:** 89% **RA**
Gen: Well developed. Somnolent but arousable. Oriented only to person. Unable to effectively communicate.
HEENT: Non icteric sclera. PERRLA with EOMI. Dry mucous membranes. No oropharyngeal erythema or exudates
Neck: Supple. No LAD. No thyromegaly. No JVD
Pulm: Tachypnic but not labored. Bibasilar rales; peripheral>central; R>L. No wheezes. No egophony. No clubbing or cyanosis
CV: PMI appropriately located. Tachycardic with regular rhythm. Ns1 and s2. No s3/s4. No Murmurs/Rubs

Abd/GU: Normal bowel sounds. Non-tender/Non-distended. No hepatosplenomegaly

Extremities: Bilateral AKA. Stumps w/o signs of infection.

Skin: Firm, indurated, tender plaques localized to the bilateral flanks with associated superficial erosions. No ulcerations or necrotic eschar noted.

Lymphatics: No appreciable cervical, supraclavicular, axillary, or inguinal LAD.

Neuro: (limited) Somnolent but arousable. Responsive to noxious stimuli. Primitive reflexes intact. Moving all four extremities purposefully. Normal reflexes. No meningismus. Equivocal Babinski. No clonus

Labs:

Admission Labs:

15	9.3	140	101	42	183
29	MCV 76	3.3	23	7.7	

79.6% Neutrophils
11% Lymphs
7.7% Mono

Ca	6.4
I Ca	3.9
Mg	1.3
Phos	7.7
Intact PTH	17.4
Iron	<10
Ferritin	721
TIBC	Not calculable

Blood Culture: neg

Paracentesis Fluid:
Colorless fluid
WBC: 11
Cytology: neg
Culture: neg

Labs on the day of decomensation:

35	11.5	MCV 76	134	90	56	150
37.3			3.9	21	6.4	

Diff: 81% PMN / 6% Mono / 3% Lymphs / 7% Bands / 3% Meta

Ca	11.4
I Ca	5.3
Mg	2.1
Phos	6.1

BNP	129
AM Cortisol	36
Ammonia	44
CK	146
CRP	28.6

Blood cultures:
No growth X4

Sputum Culture:
No Growth

Albumin	2.5	ESR	94
T Protein	7.0	C-ANCA	neg
AST	10	P-ANCA	neg
ALT	5	Rheum Factor	<5
Alk Phos	121	ACE	50 (8-53)
Total Bili	0.3		
PT	11.7		
INR	1.1		
PTT	36.6		
4 days later:			
Phos	5.8		
Ca	9.1		
I Ca	4.8		
PTH	10.8		
25-hydroxy Vit D	12		

BAL and Bronchial wash Cultures:
Aerobic: NG
AFB S/C: NG
Fungal: NG
PCP DFA: Negx2
Viral DFA: Neg

Peritoneal Fluid: No growth X2

C-Diff x2

HIV Ab: NR

ABG: 7.34/38.9/59/88% RA

Studies:

ECG: Not Available

CXR (2/6/09): Bilateral lower lobe and right middle lobe consolidations are seen, new since 12/01/2008

Admission CXR: Borderline heart size with arteriosclerosis of the aorta. Bilateral pulmonary infiltrates more pronounced at the bases and on the right. These infiltrates are more extensive than they were on 2/6/2009. The lung fields were clear on 12/1/2008.

Decompensation CXR: Interval worsening of the pulmonary infiltrates which appear confluent in the right lung base.

CT Chest with contrast: Diffuse pulmonary infiltrates with the right basilar predominance. These infiltrates appear most confluent in the subpleural regions of the lungs. The mediastinal and hilar structures are remarkable for nonspecific right pretracheal and AP window lymph nodes. There is diffuse circumferential thickening of the esophagus. There are extensive atherosclerotic calcifications of the aorta and coronary arteries.

Bronchoscopy description:

The vocal cords were normal and moved symmetrically with phonation and breathing. The subglottic space is normal. The trachea is normal in caliber; however, the color of the trachea was very pale with white to yellow hue. The carina was sharp. Left airway inspection revealed

