

November 17th, 2009

Clinicopathologic Conference – 48 yo Caucasian woman who presents with fever, confusion, and hypoxemia.

Chief Complaint:

Shortness of breath and altered mentation.

History of Present Illness:

Ms. P is a 48 yo Caucasian woman with a PMH significant for a recurrent anaplastic pleomorphic xanthoastrocytoma, on chemotherapy, who is transferred from the PM&R ward service to the MICU for further management of fever, confusion, and increasing FiO₂ requirements. The HPI is limited as the patient is somnolent.

Ten days prior to this deterioration Ms. P was admitted to the Neurosurgical service with a two month history of severe right upper extremity pain. The pain was initially mild, intermittent, and localized to the upper arm. However, the symptoms progressively worsened to a severe, constant and debilitating pain extending from the right shoulder to the hand. The neurology consult service ultimately diagnosed the patient with a thalamic pain syndrome, which was thought to be secondary to her infiltrating brain tumor. Ms. P was initiated on Lyrica and Fentanyl with symptomatic improvement. Of note, no CXR was obtained during the admission.

The patient was subsequently transferred to the PM&R service for treatment of her deconditioned state. On arrival to the PM&R ward, the patient was noted to be "conversant but occasionally confused". Within 24 hours, this occasional confusion progressed to somnolence. She became febrile with increasing oxygen requirements and a decision was made to transfer the patient to the MICU.

Additional information was obtained from family members. The patient had no previous complaints of cough or SOB and never required supplemental oxygen. No recent travel or exposure to animals. No history of fever, chills, or night sweats. No weight loss.

Review of Systems:

Limited by somnolence.

Past Medical/Surgical History:

Recurrent Anaplastic Pleomorphic Xanthoastrocytoma: This tumor is considered to be a high grade glioma but has a different natural history than GBM. Diagnosis made in 1999. Status post four resections, radiation therapy, and multiple rounds of chemotherapy. Her most recent chemo

infusion was 17 days prior to admission (Avastin and Irinotecan). Steroids, occasionally in high doses, were a central component of her treatment. Most recently, the patient had been prescribed dexamethasone 6mg daily for a duration of 3 months. At baseline, Ms. P has near normal neurocognitive status with mild word-finding difficulties. She is independent with ADLs. The patient was prophylactically placed on Keppra after her most recent resection in 2/2008.

Allergies:

Topamax: Unknown Reaction
Acetazolamide: Unknown Reaction

Current Medications:

Diazepam 5 mg po BID
Decadron 4mg PO QAM/ 2mg PO QPM
Hydrochlorothiazide 25mg PO Qdaily
Keppra 1500mg PO BID
Depakote ER 500mg PO Qdaily
Klor-con 20 meq PO Qdaily
Lyrica 50mg PO BID
Fentanyl 50mcg topical Q72 hours
Hydrocodone 5/500 2 tabs PO q4hrs PRN arm pain

Family History:

Mother: CAD
Father: Stroke

Social History:

Tobacco: Former heavy smoker. Quit 12 years ago.
ETOH: None
IVDA: None
Lives at home with husband and three children.

Physical Exam: obtained on transfer to the MICU

T: 38.3 **P:** 120 **R:** 35 **BP:** 131/81 **S_pO₂:** 90% **3L**

Gen: Cachectic. Somnolent but arousable. Oriented to Person and place (with coaching).

HEENT: Dry Mucous Membranes. Non icteric sclera. PERRLA with EOMI. No oropharyngeal erythema or exudates. Normal dentition

Neck: Supple. No LAD. No thyromegaly. No JVD

Pulm: Tachypnic but not labored. Decreased breath sounds in the right lower lobe (post>ant).

CV: PMI appropriately located. Tachycardic with a regular rhythm. Normal s1 and s2. No s3/s4. No Murmurs/Rubs

Abd/GU: Decreased, but present, bowel sounds. Diffuse mild tenderness to palpation. No guarding or rebound. No hepatosplenomegaly. No ascites.

Extremities: Warm without C/C/E. 2+ pulses X 4 extremities. Mild pain to palpation of the RUE.

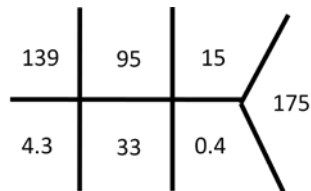
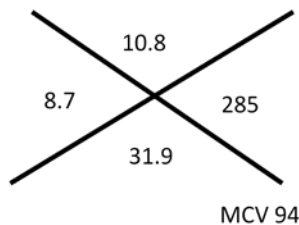
Skin: Stage 2 decubitus ulcer. Otherwise unremarkable.

Musculoskeletal: 5/5 strength x 4 extremities. No hot or tender joints

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

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

Labs:



97% Neut
30% Segs
43% Bands
16% Meta
8% Myelo
2% Mono
1% Lymph

Ca	9.2
Mg	
Phos	
Albumin	2.8
T Protein	5.7
AST	101
ALT	113
Alk Phos	207
Total Bili	0.9

PT	11.2
INR	1.1
PTT	26.8
Iron	13
TIBC	172
Ferritin	
Retic %	2.8
D-Dimer	10.8
Hapto	521

Stool Occult Blood	Neg
Troponin	<0.1
Ck	23
Ck-MB	0.3
BNP	68.3
Lipase	39

CSF: (Traumatic)	
Glucose	68 (138)
Protein	68
WBC	0
RBC	110

Pleural Fluid	
Appear	Cloudy
Color	Orange
RBC	198000
WBC	97260
N%	53
L%	1%
Meso%	45%
Mon/Mac	1%
PH	7.8
Glucose	24
Total Prot	3.2 (4.9)
LDH	14873
	(233)
TG	54

Urinalysis	
PH	7.0
SG	1.015
Protein	30
Nitrite	Neg
LE	Trace
WBC	10-25
RBC	3-5
Bacteria	1+

Blood culture x2:	Negative
Fungal BC:	Negative
CSF Culture:	Negative
CSF Fungal Smear:	Neg
CSF AFB Culture:	Negative
Urine culture:	Negative
Sputum Aerobic Culture:	Neg
Sputum AFB smear:	Neg x 2
BAL Culture:	Aerobic: Neg
	Fungal: Neg
	AFB: Neg
Bronch Brush:	Aerobic: neg
	Fungal: neg
	AFB: neg
Transbronch Bx:	ANerobic: Neg
	Fungal: Neg
	AFB: Neg
Pleural Fluid:	ANerobic: Neg
	Fungal: Neg
	AFB: Neg
AFB culture of gastric content:	Negative
Serum Histo Ag:	Neg
Serum CMV IgG IFA titer:	<1:10
ASPERGILLUS FUMIGATUS:	< 0.35 kU/L (negative)
Francisella Tularensis Ab:	Neg
