CASE PRESENTATION

HIV Clinicians Society Conference 2014

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CMJAH

29 July

- Mr JM is a 49 year old male admitted to CMAJH on 29/07/2014
- Emergency medical services responded to a call that he had collapsed at home
  - they arrived to find the patient fitting
  - he required heavy sedation to abort the fit and the decision was taken to intubate him

    (etomidate, succinylcholine, morphine, dormicum and lorazepam)
  - pupils initially pinpoint

29 July

- Arrived @ CMJAH in the afternoon
  - BP 238/163
  - sats 97%
  - pulse 125
  - healing rash over his trunk
  - Chest: coarse crackles on the right with an expiratory wheeze
  - CVS: normal heart sounds
  - Abdo: soft with 4cm hepar; spleen 1cm below costal margin
  - CNS: sedated and paralysed; pinpoint pupils
- Loaded with epilim
- Started labetalol infusion

29 July

- Point of care investigations
  - Hb 8.4
  - CRP < 4
  - glucose 10.9
  - U&E 146/3.5/113/19/11.6/226
  - CXR: wide mediastinum with a nodular infiltrate on the left (?miliary) and diffuse infiltrate on the right

- Discharge summary obtained from Tshepong Hospital
  - treated empirically for TB in 2012
  - newly diagnosed HIV+ with CD4 = 118
  - renal dysfunction on previous admission – assessed as probable HIVAN
  - not yet on ART

What are the possibilities?

1) Meningitis
2) Hypertensive emergency
3) Cerebrovascular accident
4) Toxin ingestion
5) Uraemia

29 July

- Mr JM commenced the following therapy in the emergency department
  - co-amoxiclav 1.2g IVI 8 hourly
  - azithromycin 500mg IVI daily
  - enoxaparin 40mg s/c daily
  - co-trimoxazole 4amps IVI 6 hourly
  - hydrocortisone 100mg IVI 8 hourly
  - clonazepam 1mg PRN
  - 5% D/W + 150ml $NaHCO_3$ @ 100ml/hr

29 July

Laboratory results

29th and 30th July

U&E	136/3.7/110/8/10.6/208		
FBC	6.72/8.6/47 red cells: rouleaux formation; moderate fragments; marked anisocytosis; round macrocytes; occasional normoblasts white cells: left shift; toxic granulation; Döhle bodies		
LFT	5/2/93/35/95/28/31/104		
CMP	2.06/0.89/1.8		
INR	1.02	CRP	<4
ProBNP	26 888		
CK	321	CKMB	5.6
βDG	349		
LP	glc 3.6; protein 1.93; ADA <1.0 PMN 0; lymphocytes 0 erythrocytes 3 no bacteria seen no growth; India Ink and latex negative		

29 July

Further investigations…

- CTB: multiple hypodense areas in the parietal and occipital lobes – old infarcts most likely secondary to emboli
- Echocardiogram: concentric LVH with goos systolic function – EF 69%; diastolic dysfunction; pericardial effusion <2cm

30 July

…admitted to ICU still intubated

Further Mx or Ix?

31 July – 5 August

Subsequent progress over 6 days

- creat: 208… 256… 318… 359
- Hb: 8.6… 7.2… 8.0… 5.8… 7.7
- platelets: 47… 53… 48… 33
- CRP <4… 125
- B/C negative
- sputum culture grew ESBL Klebsiella spp sensitive to ertapenem
- HIVVL 2 668 750
- DIC screen: PT 13.9 , PTT 35.2; thrombin time 16.4; INR 1.11 fibrinogen 4.9↑; D-dimer 3.3↑; anti-thrombin 112
- opening eyes to stimuli
- BP still uncontrolled
- developed diarrhoea
- started amlodipine and carvedilol
- started fluconazole and TB treatment
- started and stopped decadron

Further plan of action included

- Gastroscope
- MRI/MRA brain
- EEG
- Renal sonar
- Bone marrow

- Diagnosis of TTP suggested by the classic pentad:
  - neurological manifestations
  - fever
  - renal dysfunction
  - thrombocytopaenia
  - microangiopathic haemolytic anaemia

Treatment of choice?

1) Plasma infusion
2) Plasma exchange
3) Corticosteroids
4) Anti-CD20 monoclonal antibody
5) Intravenous immunoglobulins