BREAKOUT
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CV 181 - 190
A Surprising Case Of Painful Lymphadenopathy
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Introduction; Lymphadenopathy is a well understood, but poorly studied physical exam finding. Clinically, generalized lymphadenopathy is described as lymph nodes >1 cm in two or more noncontinuous areas and a concerning finding but without specificity for specific pathologic processes. Generalized lymphadenopathy must therefore be identified in clinical context. Four key points should be discussed. First, localizing symptoms including site specific infection or neoplasm. Second, constitutional symptoms including weight loss, fatigue and night sweats. Third, epidemiologic clues such as occupational exposures or risk-taking behaviors and fourth, iatrogenic exposures.

Case; As 58-year-old man without prior medical history presented with bilateral inguinal pain, unintentional 100lb weight loss, repetitive falls and multiple episodes of presyncope. Although initial chest x-ray was unrevealing, computerized tomography scan of the chest abdomen and pelvis with contrast revealed pathologic inguinal lymphadenopathy with the largest nodes measuring 3.7x1.7x1.8cm. Cranial magnetic resonance imaging was unremarkable except for parotid lymphadenopathy. Infectious testing revealed HIV 1 with AIDS defining lymphadenopathy and pneumonia. Initial CD4/ was 32 cells (2%) and HIV viral load was remarkable at 847,000 copies. Right inguinal lymph node biopsy revealed necrosis and acute inflammation with polyclonal plasma cells, negative HHV-8, and positive for Epstein-Barr HHV-4. Subsequently the patient was diagnosed with HIV and Epstein-Barr lymphadenitis and improved after empiric antibiotics, HAART and supportive care.

Discussion; Generalized lymphadenopathy is a critically important physical exam finding; however context remains crucial. Lymphatic pain is often due to rapid expansion of the lymph node, but may also result from hemorrhage or necrosis at the lymph node center. Lymphatic pain or lack thereof does not reliably differentiate between malignant and nonmalignant processes. Supraclavicular lymphadenopathy has the highest malignancy risk, with >90% malignancy sensitivity in patients over 40 years old. Encouraging Valsalva maneuver enhances palpation of the supraclavicular fossae. Of note the left supraclavicular node receives input from the thorax and abdomen and the right from the mediastinum, lungs and esophagus. Generalized lymphadenopathy is deserving of a detailed history and physical exam to assess for systemic sources of illness.

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ABSTRACT FORM: Must be at least 10-point font. A sharp typeface will help reproduction. Be sure to single-space and STAY WITHIN THE BORDERS!
A Rare Case of Lupus Cerebritis in a 59-year-old Patient
Dena H. Tran, MD, Suryanarayana R. Challa, MD, Victor Okoro, MS, MBA, Aseem Sood, MD

**Introduction:** Systemic Lupus Erythematosus (SLE) is an autoimmune, connective-tissue disorder that commonly affects women of reproductive age and can affect all body tissues. Lupus cerebritis is an often misdiagnosed, fatal neurologic complication of SLE. The symptoms are often misleading and nonspecific, and a delay in treatment can be fatal. **Case:** A 59-year-old woman presented with a two-day history of an acute change in mental status. Her medical history was significant for SLE, type 2 diabetes mellitus, hyperlipidemia, and hypertension. She was diagnosed with SLE one year prior, but did not follow-up. On admission, the patient was confused and agitated. As per the patient’s family, she had a cough that progressed to lethargy and somnolence over the course of one day. She became aphasic. Blood was present on her blankets and clots in the toilet. Vitals signs on admission were the following: 95.9°F, 154/92 mmHg, 93 bpm, 12 breaths/min, and 100% saturation on room air. The patient was able to move all extremities without difficulty and her pupils were round and reactive to light. She was nonverbal, but responsive to stimuli. There was dried blood in her nostrils. No rashes or pedal edema were appreciated. There was a grade 3/6 systolic murmur at the left upper sternal border. Laboratory tests were significant for lactate 4.2, AST 274, ALT 140, INR 1.47, WBC 3.9, hemoglobin 8.2, and platelet 53. CT head was negative for acute intracranial processes. She was started on broad-spectrum antibiotics and high-dose dexamethasone. Lumbar puncture was deferred due to thrombocytopenia and elevated INR. Further investigation revealed ANA 1:2560, low C3 and C4, double stranded DNA antibody titer of 1:10,240, and the presumptive diagnosis of lupus cerebritis was made given her rapid clinical improvement within one day. MRI head and brain were also consistent with vasculitis. The patient was continued on steroids, and her mentation returned to baseline. Given her history of SLE and preceding infection, this may have triggered an inflammatory response affecting multiple organ systems, resulting in pancytopenia, elevated INR, and abnormal liver function tests, all of which improved with steroids.

**Conclusion:** Lupus cerebritis is often difficult to diagnose because there is no “gold standard.” Lupus cerebritis can be presumed to be present in reproductive middle-aged women. However, this should be considered as a diagnosis of exclusion in elderly women who present with altered mental status and has a history of SLE.
ANOTHER GREAT MASQUERADE
Andrew L. Wescamp DO, Caleb B. Hudspath DO, Adam M. Tritsch MD

Chronic cough is defined as a cough lasting greater than 8 weeks and is among the most common complaints seen in the outpatient setting. The etiology of persistent cough is often benign, commonly attributed to three disorders: upper airway cough syndrome, asthma or gastroesophageal reflux disease. We present a case of intractable cough that was found to have an uncommon, unexpected underlying etiology.

A 71-year-old male with a history of asthma and GERD presented to the emergency department with a chief complaint of new-onset right-sided abdominal tenderness that he attributed to chronic cough. The patient endorsed a two-month history of persistent cough with sputum, white sputum production. Over this time he was treated as an outpatient with a proton pump inhibitor, leukotriene antagonist, and inhaled steroid. The cough progressively worsened despite these medical interventions. Upon review of systems, he noted losing 10 pounds since the symptoms began. During the workup, elevated liver associated enzymes were discovered, prompting ultrasound evaluation that revealed innumerable solid lesions in the liver. The CT chest/abdomen/pelvis showed a 1.9 cm x 6.1 cm mass in the esophagus concerning for malignancy. Subsequent esophagogastroduodenoscopy revealed a pigmented mass in the distal esophagus and biopsies demonstrated melanocytic proliferation. Additional biopsies from the liver revealed melanoma. Evaluations by dermatology and ophthalmology did not reveal primary lesion. The patient was diagnosed with T4bN3M1a BRAF negative metastatic melanoma of esophageal primary. He was treated with one cycle of checkpoint inhibitor therapy with ipilimumab and nivolumab, which was complicated by immune-mediated hepatitis necessitating hospitalization with steroid therapy. The patient declined additional chemotherapy and he transitioned to comfort care.

This case was unique both due to the rarity of the condition and the uncharacteristic chief complaint. Primary malignant melanoma of the esophagus is exceedingly rare, comprising only 0.1% of all esophageal tumors with less than 400 cases ever reported worldwide. While literature for esophageal melanoma is scant, typical esophageal malignancies present with symptom of dysphagia, which was absent in this case. Rarely patients may present with chronic cough as the sole symptom for esophageal malignancy. This highlights the importance of carrying a broad differential to seemingly benign problems if initial treatment failures occur.

References:

CV 183

BREAKOUT ROOM 19

ABSTRACT FORM: Must be at least 10-point font. A sharp typeface will help reproduction. Be sure to single-space and STAY WITHIN THE BORDERS!
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THE INDISPENSABILITY OF KIDNEY BIOPSY FOR THE EARLY DIAGNOSIS & TREATMENT OF LUPUS NEPHRITIS

Introduction: Lupus nephritis (LN) is an inflammatory kidney disease and a major complication of systemic lupus erythematosus (SLE). SLE is more common in Hispanics/Latinos and two-three times more prevalent in African and Asian Americans compared to Caucasians. While SLE is more prevalent in women, studies that suggest that LN affects a higher proportion of men. Patients with LN may remain asymptomatic or develop peripheral edema, hypertension, hematuria, and proteinuria. About 10 to 30% of LN cases progress to ESRD, requiring RRT or kidney transplantation. Early definitive diagnosis via kidney biopsy, which facilitates classification & treatment, is imperative to preserve renal function and improve prognosis.

Case: A 29-year-old African American male with a past medical history of hypertension, diabetes mellitus, thrombotic thrombocytopenic purpura (TTP), and questionable diagnoses of SLE, presented with a chief complaint of positional chest pain. Of note, TTP was originally diagnosed in 2014, with reported supressed ADAM-TS13 activity level. He received several rounds of plasmapheresis and resolution was achieved only after rituximab therapy. At that time, he was repeatedly diagnosed with SLE and treated solely with corticosteroids, never requiring mycophenolate or cyclophosphamide. However, three years ago, he was re-evaluated by rheumatology and informed that he did not have SLE. Workup revealed pericarditis with pericardial effusion evident on the echocardiogram. He was also found to have asymptomatic microscopic hematuria. The patient had a creatinine of 0.71 mg/dL with a corresponding GFR of >120 mL/min/1.73m². Further work-up demonstrated low complement levels, nephritic proteinuria and a positive ANA antibody in 2017. Given the patient’s history and high suspicion for lupus, a kidney biopsy was performed. On light microscopy, there was mesangial expansion with increased cellularity, and endocapillary proliferation. Immunofluorescence revealed a “full house” pattern and electron microscopy showed subepithelial deposits. These findings supported the diagnosis of membranous and focal proliferative LN. He was started on prednisone & mycophenolate and received out-patient follow-up. Thus far, his renal function has remained stable, with increasing complement levels and decreasing proteinuria.

Discussion/Conclusion: It is important to maintain a high level of suspicion for lupus nephritis in patients with suspected SLE. Diagnosis based on clinical features and serological markers has been shown to be unreliable. A low threshold for kidney biopsy for definitive histological diagnosis, classification & early treatment with immuno suppressive agents can significantly improve patient outcomes.

Indicate your participation in research process (4 sentences or less): I was involved in the management of the patient. I researched relevant literature.

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ABSTRACT FORM: Must be at least 10-point font. A sharp typeface will help reproduction. Be sure to single-space and STAY WITHIN THE BORDERS!
Title: A case of inflammatory uncertainty in acute myositis

Introduction: Inflammatory myopathies share characteristics of immune-mediated muscle injury for which the mechanism is not well defined. The subset of necrotizing myopathies are often associated with malignancy, drugs, or may otherwise be idiopathic.

Case Description: A 28-year-old woman with a history of erythema migrans presented with acute progressive left chest wall and shoulder pain after recent travel to the Philippines. She had no history of trauma, rash, weakness, or arthralgia. She had no abdominal pain, nausea, vomiting, or diarrhea. She had been treated conservatively for a suspected muscle sprain as an outpatient with no improvement. On exam, she was afebrile and had significant tenderness to palpation over the left chest wall and shoulder with visible swelling but no erythema. She had point tenderness over the left sternoclavicular joint. Her labs showed no leukocytosis or eosinophilia but elevated CRP 10.2 and ESR 109. A CT of the chest revealed inflammation of the left sternocleidomastoid and pectoralis major with fat stranding and prominent left supraclavicular lymph nodes. Evaluation for bacterial, viral, fungal, parasitic, and tick-borne etiologies were negative. Additionally, ANA, Smith, dsDNA, Ro, La, C3/C4, RNP, CCP, CK, and aldolase were normal. A biopsy of the left pectoralis muscle showed necrotizing myopathy with prominent perivascular and endomyosial CD68+ infiltrates consistent with idiopathic inflammatory myopathy. She was evaluated for occult malignancy with a negative CT scan of her chest, abdomen, and pelvis. She was diagnosed with idiopathic focal myositis and was discharged on high dose steroids with Rheumatology follow up.

Discussion: This case illustrates the workup of an unexplained acute onset focal myositis without weakness in the context of significant travel history and without drug or medication exposures. The findings of idiopathic necrotizing inflammatory myopathy should prompt early screening for malignancy given their association. Symptoms often worsen with steroid tapering and additional immunosuppression can be required.
CONGRATULATIONS, YOU'RE HAVING AN ADRENAL CRISIS!
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Introduction: Hypopituitarism can represent an interesting diagnostic
dilemma with a wide range of clinical presentations, some of which are
life-threatening. This can be challenging as the initial symptoms can be
non-specific and the differential for the underlying etiology is wide. We
present here an unusual presentation of hypopituitarism in pregnancy.
Case: A 24 year old woman, G3P2002 at 17+2, with a history of beta
thalassemia minor and asthma was admitted to the hospital under the
OB/GYN service with intractable nausea/vomiting and weight loss
initially concerning for hyperemesis gravidarum. Initial vitals were
stable with labs revealing mild hyponatremia to the low 130s mEq/L.
Within 12 hours of admission she developed encephalopathy with
hypotension to the 70s/50s mmHg. Labs revealed worsening of her
hyponatremia to the 120s mEq/L and hypoglycemia to the 60s mg/dL.
Potassium remained normal. Random serum cortisol level returned low
at 0.5 mcg/dL, ACTH and FSH/LH were undetectable, prolactin was
inappropriately normal, free and total T4 were low and IGF-1 was
normal. She was started on stress dose IV hydrocortisone for treatment
of adrenal crisis with rapid hemodynamic improvement and resolution
of her lab abnormalities. Non-contrast MRI brain was obtained which
showed partially empty sella with flattened pituitary tissue though no
mass was seen. Hypothalamus and pituitary stalk were normal without
MR evidence of pituitary apoplexy. She was discharged on oral
hydrocortisone and synthroid. Further questioning revealed that this
patient had similar clinical presentations and hospitalizations during all
prior pregnancies with inability to lactate though no prior formal
diagnosis. When not pregnant, she has had normal menstrual cycles.
There had not been any prior blood transfusions, head trauma,
significant family history or infertility.
Discussion: This case represents the diagnostic challenge of diagnosing
the underlying cause of hypopituitarism, especially in select populations.
Adrenal insufficiency should be evaluated when pregnant patients
present with emesis, weight loss, hypoglycemia, and hypotension. Given
the unremarkable workup, the most likely underlying diagnosis is auto-
immune hypophysitis which is documented to occur in pregnant women,
however is most commonly documented in the postpartum period.
Further work up with contrasted MRI will be obtained after delivery.
UNUSUAL PRESENTATION OF DRESS

Introduction: DRESS (drug reaction with eosinophilia and systemic symptoms) is a rare hypersensitivity reaction induced by drugs which could be life threatening. It involves skin eruption, lymphadenopathy, hematologic abnormalities (eosinophilia, atypical lymphocytosis), multi-organ involvement (liver, kidney, lung). DRESS has usually two to eight week latency period between drug exposure and disease onset, however it can have onset after a week of exposure and does not always have eosinophilia.

Case description: A 34 year old female who was recently treated with seven day course of Bactrim and amoxicillin for nasal cellulitis who presented with rash that started on the upper extremities, spread to face, trunk then lower extremities, sparing hands and feet which started on 7th day of antibiotics. Additional symptoms included fever (100.7) and flu like symptoms (myalgias, fatigue and eye pain). No oral, genital, mucosal, conjunctival symptoms. Past history significant for hives reaction to antibiotic in past but unable to recall the name. Physical exam was notable for extensive symmetrical exanthematous eruption forming confluent blanching erythema involving over approximately 90% body surface area sparing hands, feet and distal extremities. No erosions, vesicles, bullae, target lesions were noted. Negative Nikolsky sign. Laboratory findings were notable for elevated creatinine, mildly elevated LFTs, low bicarbonate with elevated anion gap, leukopenia without eosinophilia or atypical lymphocytes and lactic acidosis.

Involvement of multi systems and classic morbilliform eruption after onset of antibiotics was suggestive of DRESS reaction. Dermatology agreed. Both Bactrim and amoxicillin have been attributed to DRESS reaction in the past, it was unclear which one or both were the culprit. Thus, she was treated with systemic steroids with slow taper to prevent recurrence. Her symptoms resolved with prednisone therapy.

Discussion/Conclusion: This case was unusual in the sense that latency period was short (1 week) and there was lack of eosinophilia. Although eosinophilia is one of the features of DRESS syndrome, it is nevertheless possible to have DRESS without eosinophilia. Per Kardaun et al. (2007) study, eosinophilia was absent in 10-50% of cases.

Eosinophilia may occur later in the course. Also, short latency period (~1d) have been previously reported by Wang et al. (2007). European registry of severe cutaneous adverse reactions have devised a scoring system (RegiSCAR) which can aid in diagnosis of DRESS. However the tool is more helpful in retrospective validation. Further tools need to be investigated to aid in earlier diagnosis.

Program Director's Name: Paul Foster, MD

CV 187
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ABSTRACT FORM: Must be at least 10-point font. A sharp typeface will help reproduction. Be sure to single-space and STAY WITHIN THE BORDERS!
GUILLAIN-BARRÉ SYNDROME FOLLOWING THE PNEUMOCOCCAL POLYSACCHARIDE 23 VALENT VACCINE

Sawan Vijay Rupani MD, Joseph Fuscaldo MD
Greater Baltimore Medical Center, Towson, Maryland

Introduction: Guillain-Barré Syndrome (GBS), a group of acute immune mediated polyneuropathies characterized by weakness, sensory abnormalities and dysautonomia, has been linked to vaccinations, most notably the influenza vaccine. The current evidence suggests that there is no evidence of an increased risk of GBS following vaccinations. However, this clinical vignette depicts a case of GBS following administration of the pneumococcal polysaccharide 23 valent (PPSV 23) vaccine.

Case: A 68-year-old male with a past medical history of hypertension, type 2 diabetes mellitus and depression presented with a 3-day history of generalized distal limb weakness and worsening upper extremity paresthesia. He received the PPSV 23 vaccine 12 days prior to this presentation, and during this period he presented twice to various emergency departments with complaints of diarrhea, weakness, confusion, chest pain and paresthesia in his hands, with all work up being unremarkable. Between these episodes, all symptoms except for the hand paresthesia had resolved. Exam revealed patchy weakness in his limbs, asymmetric sensory loss in his lower extremities and areflexia. Neuroimaging and CSF analysis were unremarkable, with a normal protein count, which is common early in GBS and does not exclude the diagnosis. His clinical presentation strongly suggested GBS, and he was managed with intravenous immunoglobulin (IVIG) and was then discharged to acute neurological rehabilitation. Following this, his strength improved, mainly in his lower extremities with only mild improvement in his upper extremities.

Discussion: GBS has long been linked to vaccinations, with the 1976 swine influenza vaccine being shown to be associated with an increased risk of GBS. However, other epidemiological studies since then demonstrate a low to negligible risk of GBS associated with the influenza vaccine. While there have been few other reports of GBS following the PPSV 23 vaccine in a safety study, its association with GBS has not been studied as extensively. This clinical vignette not only helps to monitor vaccine safety, but also asks further questions about the pathogenesis of GBS. It asks us to re-examine the association between GBS and vaccinations, particularly the PPSV 23 vaccine.
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( ) Quality/Safety
( ) Clinical Research

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PCSK9 Inhibitor induced Interstitial Lung Disease
Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors are medications used to treat hyperlipidemia. They have recently come under spotlight as their use is now recommended by American College of Cardiology in their 2018 guidelines for the management of drug resistant hyperlipidemia. They have been associated with Interstitial lung disease (ILD) but have not been studied in detail and ILD associated with their use remains a diagnosis of exclusion.

Case
62 year old non-smoker female with a history of hypertension, hyperlipidemia, Osteoporosis and hypothyroidism presented to the clinic with shortness of breath and a dry, non-productive cough for the past 6 weeks. A Chest Xray showed bilateral interstitial infiltrates, CT chest with contrast showed scattered infiltrate/interstitial fibrosis predominantly in the bilateral lower lobes. ANA, ESR, CRP were negative and Rheumatoid Factor was mildly elevated at 16.9. Pulmonary function tests showed decreased DLCO and restrictive pattern. No significant occupational/ pet / drug exposure was reported except evolocumab that was started 7 months ago ago due to statin intolerance. She underwent Endobronchial Ultrasound with Bronchialalveolar lavage that was negative for infectious process/ malignancy. Jo1 antibody, myeloperoxidase, proteinase 3, C3 C4, ANCA, centromere, scl 70, SSA, SSB, Smith, aldolase, dsDNA, CCP, actin antibodies were all negative and the common culprits of ILD like Connective tissue disorders- such as scleroderma, Scleroderma arthritis, polymyositis/ dermatomyositis, vasculitis, sarcoidosis and SLE were excluded. Repeat CT showed worsening interstitial disease, and the patient was started on prednisone. Evolocumab was held and dyslipidemia was managed with ezetimibe. As the patient didn’t show much improvement on monotherapy, mycophenolate mofetil was added. Patient experienced significant hairloss and continued to have dyspnea so Mycophenolate was switched to azathioprine due to mycophenolate intolerance. Her DLCO and FEV1 and FVC improved in 4 months and azathioprine was held because absolute neutrophil count dropped to less than 1000, She was started on Bactrim prophyaxis and once the ANC counts were normal the patient was restarted on lower dose azathioprine with plans to taper prednisone. She reported symptomatic improvement and PFTs showed improved FVC and DLCo.

Discussion/ conclusion
A number of drugs have been associated with ILD, but the diagnosis of Drug induced- ILD rests upon the temporal association between exposure to the drug and development of pulmonary infiltrates. The histopathological features are not suggestive/ specific to the drug so diagnosis is usually made by exclusion of all other causes and drug removal produces significant improvement in symptoms.
VAPE-INDUCED LUNG INJURY (VILI) IN A HEALTHY
TEENAGE FEMALE. LaRosa R. MD, Kathari Y. MD. The
University of Maryland School of Medicine and VA Medical Center,
Baltimore, MD.

With vaping becoming more popular among
teenagers and adults, vape-induced lung injuries (VILI)
have been gaining increasingly more attention, though still
there is a vast amount to learn about this deadly condition.

A relatively healthy 19-year-old female with history
of exercise-induced asthma originally presented to an
outside hospital (OSH), with a productive cough and
progressively worsening dyspnea. She had a history of
vaping every day, for three years, originally with nicotine
pods, then with THC (THC cartridges and Dank vapes) for
approximately one month. She was diagnosed with
pneumonia and prescribed azithromycin. However, she
returned prior to completing antibiotics due to worsening
dyspnea and was admitted to the ICU due to hypoxic
respiratory failure, requiring BiPAP. Work up was
significant for a chest x-ray showing bilateral interstitial
infiltrates. She had negative ANA, streptococcus
pneumoniae urine antigen, legionella urine antigen and HIV.
D-Dimer, LDH and haptoglobin were elevated.

Transthoracic echocardiogram (TTE) showed left
ventricular ejection fraction (LVEF) 55%. BNP was
elevated to 3750 on admission increased to 16200 two days
later. She was transitioned to high-flow nasal cannula
(HFNC) due to hypoxemia. CT of her chest showed
extensive bilateral ground glass infiltrates with air
bronchograms, consistent with VILI. She was started on a
prednisone taper, and was eventually weaned off HFNC to
room air. Bronchoscopy was not performed to obtain a
biopsy given her tenuous respiratory status during her
hospitalization.

While vaping was considered a safer option than
smoking cigarettes, this case delineates the implications of
the severity of VILI, even in healthy patients.