# ACP Southeastern Regional Meeting

Drexel University College of Medicine—Queen Lane Campus  
October 15, 2016

*(NOTE: times may be adjusted depending on the flow of events)*

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>8:00-8:30am</td>
<td>Registration/Breakfast <em>(Student Activity Center)</em></td>
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<tr>
<td>8:30-9:45am</td>
<td>Poster Judging – <em>(SAC)</em></td>
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<tr>
<td>9:00am</td>
<td>Medical Jeopardy Round 1</td>
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<td>10:00am</td>
<td>Medical Jeopardy Round 2</td>
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<tr>
<td>11:00am</td>
<td>Final Medical Jeopardy – <em>(SAC)</em></td>
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<tr>
<td>12:00pm</td>
<td>Awards ceremony – <em>(SAC)</em></td>
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<tr>
<td></td>
<td>- Poster winners</td>
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<tr>
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<td>- Medical Jeopardy winners</td>
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<td>- Professionalism Awards</td>
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<tr>
<td>12:30pm</td>
<td>Adjourn</td>
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</table>
We thank our outstanding Program Committee for a job well done!

Planning Committee:

Chair: David Aizenberg, MD
Past Chair: Allison Ferris, MD
Medical Jeopardy Co-chair: Dave Bernstein, MD, FACP
Professionalism Co-chair: Emily Stewart, MD FACP
ACP SE Regional Governor: Greg Kane, MD, FACP

Special thanks to some super helpful people who were invaluable in making this meeting occur! I appreciate all the time and effort you put into this event.

Cicely Elliott, Executive Director, PA-ACP
Sharon Fahrer, Meeting Manager, PA-ACP
Jessica Winger, Meeting Manager, PA-ACP
A big **THANK YOU** to all our poster judges and abstract reviewers! This event could not succeed without you!

**ABSTRACT REVIEWERS:**
- Renee Amori
- Amy Baranoski
- Nadia Bennett
- Matthew Burday
- Nidhi Chaudhry
- Kevin D'Mello
- Gretchen Diemer
- John Donnelly
- Jonathan Doroshow
- Kevin Fleming
- Jason Fodeman
- Eric Green
- Keith Hamilton
- David Hares
- John Hippen
- Cathy Kuntz
- Iris Lee
- Florence Momplaisir
- Jason Ojeda
- Eric Palecek
- Sarah Perloff
- Aliza Rabinowitz
- Rachel Ramirez
- Manzoor Rather
- Manny Rosenberg
- Vinah Shah
- Corrie Stankiewicz
- Bizath Taqui
- Kshitij Thakur
- Jill Zavodnick

**POSTER JUDGES:**
- Renee Amori
- Lisa Bellini
- Marissa Blum
- Matthew Burday
- Antonette Climaco
- Kevin D'Mello
- Charlene Deng
- Imara Dissanayake
- Jonathan Doroshow
- Allison Ferris
- Bill Ford
- Jeffrey Gerbino
- Eric Green
- Arif Jan
- Ritu Khurana
- Jason Maley
- Dennis Policastro
- Rachel Ramirez
- Manzoor Rather
- Stefani Russo
- Jason Stankiewicz
- Emily Stewart
- Bill Surkis
- Dava Szalda
- Ellen Tedaldi
- Kshitij Thakur
- Susan Truong
Professionalism Award Recipients

Wajahat Humayun, MD
Abington Memorial Hospital

Katherine Melhado, DO
Albert Einstein Medical Center

Jason Stankiewicz, MD
Christiana Care

David Roofeh, MD
Christiana Med-Peds

Marijeta Pekez, MD
Crozer-Chester Medical Center

Hasan Ehsan, MD
Drexel University College of Medicine

Elizabeth Williams, DO
Lankenau Medical Center

Ana Maheshwari, MD
Mercy Catholic

Ifeanyichukwu Anidi, MD
University of Pennsylvania Medical Center

Stephanie Smith, MD
Penn Med-Peds Program

Amanda Podolski, MD
Temple University Hospital

Solomon Dawson, MD
Thomas Jefferson University Hospital
2016 ACP JEOPARDY COMPETITION
“DOCTOR’S DILEMMA”

EINSTEIN MEDICAL CENTER
Advisors: Glenn Eiger, Jean Bustamante Alvarez
Muhammad Masab
Nellow Candelario
Zurab Azmaiparashvili
Kevin Lo

LANKENAU MEDICAL CENTER
Advisor: David Cohen
William Johnson
Hasan Fadlallah
Khalil Anouti
Isaac Tea

ABINGTON-JEFFERSON HEALTH
Advisor: Zulifqar Arif
Wajahat Humayun
Purujit Thacker
Ali Ghani
Mohsin Hamid
Bilal Lashari

JEFFERSON UNIVERSITY
Advisors: Jill Zavodnick, Aaron Martin
Sarah Rosenberg
Juergen (Jay) Kloo
Rajiv Kabadi

UPENN
Advisors: David Aizenberg, Jason Maley
Chris Reilly
Hari Shankar
Mike Ayers
Christopher Jensen
Shaz Iqbal

TEMPLE
Advisor: Sheetal Koul
Shekar Eswarakrishnan
Janice Yackoski
Lauren Freid
Ziad Dimachkie

CROZER-CHESTER MEDICAL CENTER
Advisor: Yvette Wang
Omar Zaman
Karandeep Bumrah
Naveed Jan
Ali Mohammad Usman

MERCY HEALTH
Advisor: Dhruvan Patel
Yubraj Sedhai
Asim Ruhela
Abdul Asif Hameed
Reshma Golamari

DREXEL
Advisors: Andrew Gangemi, David Bernstein
Jared Chowdhury
Ideen Amirjazil
Payam (Paul) Pourhassani
Jen Schwartz

CHRISTIANA CARE
Advisor: Matthew Burday
Stephanie Lewis
Robert DeGrazia Jr
Bryan Haimes
Jordan Assadi
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<th>Poster Number</th>
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<th>Program</th>
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<td>Osheen</td>
<td>Abramian</td>
<td>MD</td>
<td>Drexel University College of Medicine</td>
<td>Clinical Vignette</td>
<td>Intrapleural Fibrinolysis in Loculated Effusions</td>
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<td>2</td>
<td>Francisco</td>
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<td>Fever unmasking a syndrome in the EKG.</td>
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<td>divya</td>
<td>akella</td>
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<td>not all polyps are created equal: multiple myeloma in the gut</td>
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<td>Jad</td>
<td>Al Danaf</td>
<td>MD, Other MPH</td>
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<td>Quality Improvement/Patient Safety</td>
<td>Barriers to Anticoagulation in Atrial Fibrillation among Cardiologists, Internists and Family Physicians</td>
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<td>Rahul</td>
<td>Banerjee</td>
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<td>Daniela</td>
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<td>When epidemiology is the clue for a positive outcome: A case of Malaria during pregnancy.</td>
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<td>Courtney</td>
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<td>Has the pendulum swung too far? Evaluation of the appropriate use of VTE prophylaxis for medical inpatients.</td>
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<td>A case of rheumatoid arthritis developing after treatment with ipilimumab and nivolumab for non-small cell lung cancer</td>
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<td>Alan</td>
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<td>A Case Report of Hyperosmolar Hyperglycemic Nonketotic Syndrome Attributed to Olanzapine Use</td>
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<td>Goberdhan</td>
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<td>An Uncommon Presentation of Prostatitis: Multiple Organ Dysfunction Syndrome</td>
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<td>Spontaneous Pneumothorax in Patients Living with HIV without Infection or Trauma</td>
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<td>Synchrony in the Lung: A Tale of Two Cancers</td>
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<td>Warfarin use in a medical clinic: does a pharmacist driven protocol improve healthcare delivery?</td>
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<td>Mind the Oxygen Gap</td>
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<td>Making Unresectable Resectable: Complete remission following neoadjuvant chemoradiation and surgical resection in locally advanced pancreatic cancer</td>
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<td>Invasive liver abscess syndrome caused by Klebsiella pneumoniae K1 capsular serotype: An emerging entity in the United States</td>
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<td>Failed anticoagulation With Novel Anticoagulants Like Rivaroxaban in Patients’ on HAART (Efavirenz/Emtricitabine/Tenofovir).</td>
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<td>Understanding and Improving Patient Arrival Rates at an Urban Medical Resident Practice</td>
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<td>“An Unusual Case of Subacute Cutaneous Lupus Erythematosus”</td>
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<td>Ruptured gastroduodenal artery aneurysm- deadly complication of duodenal ulcers</td>
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<td>Sorafenib-Induced Pancreatitis: A Rare yet Serious Side Effect</td>
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<td>Oh My Boy-a, it’s Moyamoya!</td>
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<td>Incidence &amp; Impact of Contrast-Induced Nephropathy After Cardiac Catheterization; A Community Hospital Experience</td>
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<td>Right Ventricular Heart Failure Due to Isolated Calcific Pulmonic Stenosis in a Newly Diagnosed Acromegalic Patient</td>
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<td>To assess the clinical yield of inpatient renal ultrasound for evaluation of acute kidney injury.</td>
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<td>Systolic Anterior Motion of the Mitral Valve Unmasked by Combined Septic and Cardiogenic Shock</td>
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<td>Spontaneous Pneumothorax Affecting Three Generations: Is there a Unifying Hypothesis?</td>
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<td>Can Polymerase Chain Reaction Cycle Threshold values be used in determining the Severity of Clostridium difficile infections?</td>
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<td>When Back Pain Goes Wrong: Escherichia coli Native Vertebral Osteomyelitis Secondary to Urinary Tract Infection Leading to Quadriplegia</td>
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<td>Munveer</td>
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<td>MD</td>
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<td>A Rare Case of Parvovirus B19 Associated Myocarditis, Collapsing Glomerulopathy, and Acute Interstitial Nephritis.</td>
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<td>Sherry</td>
<td>Tsai</td>
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<td>The impact of reported penicillin allergy on patients with Streptococcus bacteremia at an urban community hospital</td>
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<td>A case of neurosarcoidosis exacerbation complicated by panhypopituitarism presented with visual and auditory hallucinations.</td>
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<td>Zaman</td>
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<td>Zambrotta</td>
<td>MD</td>
<td>Thomas Jefferson University</td>
<td>Clinical Vignette</td>
<td>Diagnosis of Brugada Syndrome in a Young Male Presenting with Spinal Cord Injury Secondary to Syncopal Episode.</td>
</tr>
<tr>
<td>60</td>
<td>Jinyu</td>
<td>Zhang</td>
<td>MD</td>
<td>Thomas Jefferson University</td>
<td>Research</td>
<td>The Prevalence of Binge Eating Disorder in Patients with Non-Alcoholic Fatty Liver Disease</td>
</tr>
</tbody>
</table>
INTRODUCTION: Complicated parapneumonic effusions are often unaffected by antimicrobials and can be loculated. Incomplete drainage increases the propensity towards thoracic empyema development. The fibrinous peel covering the visceral pleura in such cases renders the lung parenchyma unexpandable, reducing compliance and lung volume. Intrapleural fibrinolysis after two unsuccessful thoracostomies and its efficacy and safety is outlined in this report. In our case, reinserting a new chest tube to drain smaller loculations was unsuccessful as pleural pus clotted flow. Intrapleural tissue-plasminogen-activator/deoxyribonuclease augmented pleural fluid drainage.

CASE PRESENTATION: 61-year-old male with COPD transferred for VATS-decortication, after thoracentesis. CT revealed a loculated right-sided effusion and infiltrate. All cultures were negative. Pleural fluid analysis was: LDH-1758, 932-WBC, 73%-PMN, 2258-RBC. Chest tube inadequately drained and decortication was considered, which posed a high-risk of hemothorax due to the early fibrinous peel. Intrapleural fibrinolysis was initiated. Pleural output improved with a 25% drainage increase with fibrinolysis (200cc total prior to fibrinolysis and 250cc daily for almost 80 hours) and O2 requirements improved. Repeat CT showed near-complete resolution.

DISCUSSION: This case underscores the use of intrapleural fibrinolysis after unsuccessful drainage of a second chest tube for a loculated, non-communicating pleural effusion. Intrapleural fibrinolytics for early trapped lung is still in its formative years. Fibrinolytics can also be applied to intrapleural adhesions. There is little evidence indicating systemic side effects from intrapleural fibrinolysis (i.e. coagulopathy). Our case showed success after ineffective serial tube thoracostomies.

CONCLUSIONS: The re-expansion of a collapsed and possibly trapped lung was our aim in managing a fragile fibrinous peel. Our case highlights that chemical fibrinolysis has a vital role when decortication is high-risk.


**Fever unmasking a syndrome in the EKG.**

Brugada syndrome is an autosomal dominant disorder causing life-threatening ventricular arrhythmias and sudden cardiac death (SCD). ST segment elevation in this syndrome is thought to be caused by a shift in the ionic current balance that has been shown to be temperature dependent.

A 60-year-old Laotian monk, presented with 2 weeks of fever, chills and malaise. Upon admission patient denied headache, chest pain, shortness of breath, abdominal pain or joint pain. He was febrile (38.5 C), hypotensive and tachycardic, mental status was intact. Physical exam was normal. On admission was volume resuscitated and started on vasopressors, and covered with broad spectrum antibiotics. Complete blood count revealed leukocytosis (13.000/mm3), urinalysis and chest X ray were unremarkable, cultures were negative. Electrocardiogram (EKG) showed sinus tachycardia with incomplete right bundle branch block and coved 4mm ST segment elevation in V1-V2, with negative T waves, compatible with Type 1 Brugada Pattern. A repeated EKG when patient was afebrile showed sinus tachycardia without Brugada pattern. Further interrogation revealed family history of early unexplained cardiac death. Transthoracic echocardiogram revealed moderate diastolic dysfunction. Patient refused further cardiac evaluation, but agreed to follow up as outpatient for genetic testing and possible implantable cardiac defibrillator placement. His fever subsided and was discharged on medical therapy.

Identification of Brugada syndrome is crucial given its association with SCD. In some cases the EKG changes are not present and different triggers may develop the arrhythmia including bradycardia, fever, cocaine, alcohol intoxication, type I and type III antiarrhythmics.
not all polyps are created equal: multiple myeloma in the gut

Background: Multiple myeloma is a neoplastic proliferation of plasma cells producing a monoclonal immunoglobulin usually restricted to the bone marrow. Recent literature confirms increased extramedullary involvement of skin, liver and lymph nodes but gastrointestinal multiple myelomas remain rare.

Case: We report a case of 57-year-old female with a past medical history of progressive multiple myeloma IgA lambda on elotuzumab, lenalidomide and dexamethasone therapy, who presented with generalized weakness and black stools for approximately one week. Initial laboratory work demonstrated a hemoglobin of 6.7 grams per deciliter and heme positive stools consistent with anemia secondary to presumed gastrointestinal blood losses. Esophagogastrroduodenoscopy (EGD) was unremarkable. Colonoscopy revealed 6 colonic polyps scattered throughout the distal transverse, cecal and descending colon which were excised and sent for pathology. Pathology of the polyps showed plasma cell myeloma with anaplastic features. Immunohistochemistry demonstrated cells that were positive for CD-138 and negative for keratin staining, confirming plasma cell origin. Furthermore analysis was positive for lambda light chain, but negative for kappa light chain. The patient was managed with packed red cell transfusion with no further evidence of recurrent bleeding.

Conclusion: Gastrointestinal multiple myeloma are rare, but as our case demonstrates, they must be considered in the differential diagnosis of patients with gastrointestinal bleeding, particularly those with multiple myeloma. The endoscopic appearance of multiple myeloma polyps may be similar to other more common conditions, making pathological and immunohistochemical analysis of biopsies essential for making a correct diagnosis.
Barriers to Anticoagulation in Atrial Fibrillation among Cardiologists, Internists and Family Physicians

**Background:** Stroke is the most common complication of atrial fibrillation (AF). Despite clinical guidelines recommending oral anticoagulation (AC) for stroke prevention in patients with AF at moderate-high risk for stroke, the literature still shows underutilization of AC irrespective of the type of practice.

**Methods:** The rates of AC for patients with non-valvular AF and a CHADS2VASc score >2 for Cardiologists (76%) and Internists and Family Physicians (71%) were obtained from our electronic health record (EHR). A 12-question survey was shared with Cardiologists (N=34), Internists (N=27) and Family Physicians (N=66) with 62%, 78% and 59% response rates respectively. Frequency analysis is used for data analysis. Our aim is to improve rates of AC in each department to at least 80% as part of their quality metrics and to ensure more patients with Atrial fibrillation are on oral AC agents whenever indicated.

**Results:** The rate of AC among cardiologists in patients with AF increased by 5% comparing years 2014-2016 to 2012-2014, with stable rates among internists and family physicians. This increase is mainly attributed to an increase in prescribing direct acting oral anticoagulants from 36% to 49%. There is also a noticed unanimous decrease in adopting warfarin as the preferred AC agent in AF since 2014. As for the survey results, the below table summarizes some of the results.

<table>
<thead>
<tr>
<th>Practice</th>
<th>Cardiology (N=21)</th>
<th>Internal Medicine (N=21)</th>
<th>Family Medicine (N=39)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response rate</td>
<td>62%</td>
<td>78%</td>
<td>59%</td>
</tr>
<tr>
<td>Use of CHA2DS2-VASc</td>
<td>95%</td>
<td>52%</td>
<td>69%</td>
</tr>
<tr>
<td>Calculate the bleeding risk of AC</td>
<td>81%</td>
<td>67%</td>
<td>49%</td>
</tr>
<tr>
<td>Possible reasons for no AC</td>
<td>-Previous ICH (95%) -Hospice (86%) -Falls risk (71%)</td>
<td>-Falls risk (76%) -Hospice (62%) -Previous ICH (62%)</td>
<td>-Previous ICH (62%) -Patient preference (69%) -Hospice (67%)</td>
</tr>
<tr>
<td>Most common reason for no AC</td>
<td>Falls risk (48%)</td>
<td>Falls risk (48%)</td>
<td>Falls risk (51%)</td>
</tr>
<tr>
<td>Most common AC prescribed</td>
<td>Apixaban (52%)</td>
<td>Warfarin (43%)</td>
<td>Warfarin (67%)</td>
</tr>
<tr>
<td>Lectures or webinars about AC are helpful</td>
<td>43%</td>
<td>67%</td>
<td>85%</td>
</tr>
</tbody>
</table>
Conclusions:

• Extraction of EHR data and formation of dashboards facilitate quality monitoring for AC in patients with AF.
• Physicians’ perception of barriers to AC differs by specialty.
• Cardiologists calculate stroke and bleeding risks more often.
• There was an increasing trend of increased DOAC adoption among all specialties, and increase in AC rates -even before any intervention- for Cardiologists.
• Shared decision-making is more common among cardiologists.

In order to improve AC rates, we will create individualized performance reports for providers indexed to their peers and include information regarding bleeding risk in patients who are at high risk for falls or have a history of ICH. For Family physicians and Internists, we also plan to summarize evidence about novel agents. We will also provide dashboards with ongoing AC rates.
INTRODUCTION: Unnecessary ordering of daily morning labwork for hospitalized patients is a recognized cause of hospital waste, patient distress from phlebotomy, and iatrogenic anemia. The reduction of unnecessary lab testing has been incorporated into “Choosing Wisely” campaigns for hospitalized patients; however, housestaff physicians-in-training may not receive sufficient guidance and education to be judicious when ordering labwork. At our institution, poor communication between housestaff and attending physicians has been identified as a major driver of unnecessary lab ordering. In February 2016, we piloted a novel intervention aimed at addressing this barrier with the goal of ultimately decreasing labwork on our general-medicine service.

METHODS: Our intervention targeted six general-medicine teams at our hospital over a three-month period. Housestaff received instructions to document ‘#labs’ as an inpatient problem for their patients, similar to how diets and thromboembolism prophylaxis are mentioned at the end of all notes. Specifically, housestaff were instructed to use this field to decide what morning labs (if any) their patients required and additionally to discuss morning labwork on rounds each day. Attending physicians were encouraged to use their residents’ mentions of ‘#labs’ as a starting point to lead discussions about high-value, cost-conscious labwork ordering. Our primary study outcome was the aggregate number of times any common test (basic metabolic panel, magnesium, complete blood count, coagulation panel, type/screen, liver function test, or troponin) was ordered per patient-day. Our secondary study outcome was resident perceptions of unnecessary labwork ordering before and after their inpatient rotations.

RESULTS: Over our three-month study period, as compared to the preceding three months, the mean number of common tests ordered per patient-day decreased significantly from 2.77 to 2.50 ($p < 0.01$, students’ $t$ test). Specifically, this metric fell as low as 1.90 one month after study initiation, constituting special-cause variation using Shewhart control-chart analysis. However, by the three-month mark, labwork ordering began to regress toward the mean. The percentage of residents reporting daily unnecessary labwork ordering fell from 35% pre-rotation to 11% post-rotation, although this trend did not reach statistical significance ($p = 0.07$, chi-squared analysis).

CONCLUSIONS: Our ‘#labs’ pilot significantly decreased morning labwork ordering by housestaff, with a nadir almost a third lower than the pre-intervention mean. Our intervention also led to a reduction in the percentage of residents reporting unnecessary labwork, suggesting a possible culture change regarding labwork-ordering practices. Study limitations include the fact that we did not assess the clinical necessity of any labwork; additionally, our pilot’s efficacy appeared to diminish as time progressed. Nevertheless, our intervention suggests that including ‘#labs’ in progress notes may be a simple step to help housestaff improve their labwork-ordering practices to bring about high-value care for their patients.
Mycobacterium chelonae Infection in the Immunocompromised

Patients with systemic lupus erythematosus (SLE) on immunosuppressive therapy are susceptible to nontuberculous mycobacterial infections such as Mycobacterium chelonae, which can present as skin and soft tissue nodules. A 54-year-old female with SLE and on treatment with prednisone, mycophenolate, and cyclosporine presented after an excisional skin biopsy stained positive for acid-fast-bacilli (AFB). About 1.5 months prior, she developed a small palpable subcutaneous nodule adjacent to her elbow. Two subcutaneous lesions subsequently developed around her right wrist and became painful, pruritic, and erythematous without overlying warmth or drainage. The patient denied trauma, traveling, sick contacts, exposure to fish or fresh/brackish water, or gardening. During her hospitalization, she has an incisional wedge skin biopsy performed to acquire a larger sample for AFB culture, which grew M. chelonae 20 days after specimen collection. She also reported worsening dyspnea on exertion and a dry cough that was concerning for a disseminated infection. A bronchoalveolar lavage of a lobar consolidation, and an arthrocentesis of a knee effusion were performed - both samples were negative for AFB staining. Once concerns of disseminated infection were eliminated, patient was discharged home with infectious disease follow up.

This case illustrates the potential for nontuberculous mycobacterial infection such as M. chelonae in the immunocompromised patient. The clinical presentation of skin nodules should raise suspicion for this type of infection and should warrant tissue biopsy and AFB culture to make a definitive diagnosis and to guide management.
Pheochromocytoma is an important reversible cause of secondary hypertension. Failure to diagnose or properly manage pheochromocytoma can have life-threatening consequences.

A 51-year-old female with no past medical history presented to an outside hospital with severe headache, vision changes, and nausea. History elucidated episodic chest palpitations, diaphoresis, anxiety, nausea, and vomiting that began 12 months earlier. The patient was prescribed propranolol for migraine prophylaxis two weeks prior to admission, but subsequently experienced worsening of symptoms. On arrival to our hospital she appeared anxious and uncomfortable, with color vision changes, intractable nausea and vomiting, tachycardia, and blood pressure of 255/140 mmHg. Ophthalmologic exam revealed bilateral macular edema, flame hemorrhages, and central scotoma with color vision loss on the right. Initial work-up included negative CT scans of the head and chest except for an incidental 10 cm x 12 cm left upper quadrant abdominal mass arising from the adrenal gland. Laboratory evaluation of 24 hours of urine metanephrines and normetanephrines revealed elevations of 85,247 mcg (ref: 30-180) and 91,463 mcg (ref: 128-484), respectively. Subsequent iodine-123 metaiodobenzylguanidine scintigraphy confirmed massive unilateral adrenal uptake while excluding extra-adrenal foci. The patient was stabilized, completed a 14-day course of oral non-reversible alpha blockade, phenoxybenzamine, and underwent successful resection of her pheochromocytoma and resolution of her symptoms.

Although rare, pheochromocytoma is a dangerous cause of hypertensive emergency and resistant hypertension. Isolated beta blockade may precipitate hypertensive emergency due to unopposed alpha-1 stimulation. Additionally, lack of alpha blockade prior to surgery may result in hypertensive crisis.
Reduced communication between the amygdala and cortical regions in intermittent explosive disorder

Intermittent explosive disorder (IED), defined as the presence of recurrent behavioral outbursts due to a failure to control aggressive impulses, is estimated to affect up to 7% of adults in their lifetime. Studies have shown inconclusive evidence as to the etiology of IED, with suggestions for both genetic and environmental factors cuing the progression of the disorder. As IED is often comorbid with major psychiatric illnesses such as depression and anxiety and is also found in violent criminals, we sought to determine whether individuals with IED have altered resting state brain connectivity that predisposes them to such behavior, and if so, whether early detection and intervention can modify such destructive behaviors and prevent damages to individuals and society. A total of nearly fifty IED subjects and fifty matched controls received MRI resting network connectivity scans over a two-year period. At the conclusion of the study, differences in connectivity between the two populations were analyzed using SPM’s Connectivity Toolbox. As compared to matched controls, IED individuals demonstrated reduced resting state connectivity between the left amygdala and its connections to the frontal medial cortex, posterior cingulate cortex, and posterior cingulate gyrus (p < 0.05). These results indicate that when an IED individual gets initially aggravated there is reduced communication between their emotional hubs in the amygdala and their cortical centers for reason and taking action, and thus, they are less likely to be able to process and reason out their emotional aggravation and instead channel it into immediate bursts of violence. These results lend evidence to the idea that there are organic brain differences in individuals with IED and suggest that detection of these differences early on could be used as a screening tool to promote better behavioral outcomes in these individuals.
Octreotide-induced hypoglycemia in a cirrhotic patient

Hepatorenal syndrome is a complication of cirrhosis that is treated with a combination of midodrine, albumin, and octreotide. Although octreotide is a somatostain analog, it can have the paradoxical effect of causing hypoglycemia in patients.

A 44-year-old man with a history of Roux-en-Y gastric bypass and alcoholic cirrhosis complicated by ascites and esophageal varices was transferred from an outside hospital for management of hepatic encephalopathy, which clinically improved with lactulose. He was recently diagnosed with acute kidney injury from presumed type 2 hepatorenal syndrome, and started on octreotide. His hospital course was complicated by persistent symptomatic hypoglycemia that required him to be on a continuous dextrose-50 infusion. The initial suspicion for an occult insulinoma was ruled out after an extensive work-up that included abdominal ultrasounds, octreotide scans, abdominal magnetic resonance imaging studies, and intra-arterial calcium stimulation with hepatic venous sampling. All of these studies were unrevealing for evidence of a neuroendocrine tumor. There was no appreciable improvement in the patient’s blood sugars until the octreotide was discontinued and high-dose steroids was initiated. The patient was weaned off the dextrose-50 infusion about 3 weeks after he last received octreotide, and was subsequently discharged home one week later on low-dose steroids. As an out-patient, the steroids were slowly tapered while closely monitoring his blood sugars to ensure normoglycemia.

This case illustrates the first reported case of the paradoxical effect of octreotide in a cirrhotic patient being treated for hepatorenal syndrome.
When epidemiology is the clue for a positive outcome: A case of Malaria during pregnancy.

Daniela de Lima MD 1, Antonette Climaco MD2, Andres Mora MD1 1Department of Medicine, Einstein Medical Center, Philadelphia, Pennsylvania, USA. 2Department of Infectious Diseases. Einstein Medical Center, Philadelphia, Pennsylvania, USA.

A 29 year-old female G1P0 at 37 weeks of gestation, with no medical problems, presented for prenatal care complaining of fever, chills, and generalized body aches. She was living in Malawi for a year and was on atovaquone/proguanil prophylaxis, until she was found to be pregnant. Prophylaxis was changed to mefloquine and discontinued upon her return to the US. She traveled emergently to Malawi six weeks prior to presentation, where she stayed for 1 month without prophylaxis. On admission, vital signs were normal. She had no lymphadenopathy or jaundice. Given the presentation and epidemiologic findings, malaria smear was performed which showed 4% parasitemia, all ring forms. She was treated with mefloquine two doses eight hours apart as per current guidelines. This was later identified as \textit{Plasmodium falciparum}. Two days after treatment, she again presented with fever, chills and myalgia. Malaria smear showed <0.01% parasitemia, with 2 ring forms. Serologies for dengue, chikungunya, leptospira, and blood cultures were negative. These symptoms were deemed secondary to recrudescence of malaria. Was treated with quinine sulfate for 3 days and clindamycin for 7 days. Patient delivered at full term without complication. Pregnant women are more susceptible to severe forms of malaria. \textit{P. falciparum} infected red blood cells can get sequestered in the placenta causing infarct and subsequent intrauterine growth retardation, low birth weight, and increase risk of abortion. High index of suspicion and careful evaluation of epidemiologic factors are clue in early identification of malaria, in order to start early treatment and prevent deleterious outcomes.
Has the pendulum swung too far? Evaluation of the appropriate use of VTE prophylaxis for medical inpatients.

**Introduction:** Venous thromboembolism (VTE) is the most common cause of hospital death. Pharmacologic intervention has become the standard of care in the prevention of VTE in hospitalized patients. However, studies have not been able to show a consistent benefit of VTE prophylaxis on mortality in hospitalized medical patients. Medical inpatients are a very heterogenous group; not all of them need VTE prophylaxis. Current guidelines recommend the use of heparin or related drugs as VTE prophylaxis in medical inpatients at increased risk of thrombosis, and recommends against pharmacologic VTE prophylaxis in patients at low risk. Several risk assessment modules including the Padua Prediction Score, attempt to identify patients at high-risk for thromboembolism. The goal of the study was to evaluate if risk is assessed and defined by clinicians prior to prescribing VTE prophylaxis.

**Methods**
A retrospective chart analysis was performed for patients admitted to the medicine service from January 2015 to June 2015. The initial arrival orders as well as the history and physical documented by the admitting physician were reviewed to determine if the risk of VTE was recorded and if VTE prophylaxis was prescribed. Patients were stratified as either admission or observation and the type of anticoagulation was recorded. If the admitting physician did not perform a VTE risk assessment, risk of VTE was calculated using the Padua Prediction Score.

**Results:** Data was collected on a total of 648 patients. 314 (48%) patients met admission criteria and 334 (52%) patients met observation criteria. Chemical VTE prophylaxis was prescribed for 262 of the 314 (83%) admissions and 215 of the 334 (64%) observation patients. Of the 262 admissions that received chemical VTE prophylaxis, 240 (92%) of these patients were considered low-risk based on the Padua Prediction Score (Figure 1). 201 of the 215 (93%) observation patients that received chemical VTE prophylaxis were calculated to be low-risk (Figure 2). Adverse events were found to occur in 7 of the 648 (1.1%) patients that received chemical VTE prophylaxis.

**Conclusion:** Inappropriate use of chemical VTE prophylaxis was observed in a majority of medical inpatients.

**Discussion:** Routine use of VTE prophylaxis is not recommended. Current guidelines advise practitioners to evaluate all hospitalized patients for risk of VTE and bleeding prior to the initiation of VTE prophylaxis. Risk assessment tools such as the Padua Prediction Score help discriminate those patients at high risk of VTE and bleeding. However, this study shows that most clinicians do not perform a proper risk assessment for thromboembolism and bleeding prior to the initiation of VTE prophylaxis. Significant bleeding and thrombocytopenia were the most common complications identified in patients who received pharmacologic intervention. Although the rate of complications was low, further studies are needed to address additional negative consequences from the overuse of anticoagulation such as cost, nursing time and patient discomfort.
Figure 1. VTE risk assessment of anticoagulated patients who met admission criteria
Figure 2. VTE risk assessment of anticoagulated patients who met observation criteria
Title: A case of rheumatoid arthritis developing after treatment with ipilimumab and nivolumab for non-small cell lung cancer

Authors: Alexis Zavitsanos, MD, Lauren Freid, MD, Roberto Caricchio, MD

Introduction:

The general concept behind cancer immunotherapy involves development of antibodies that target lymphocyte receptors or their ligands in order to enhance endogenous anti-tumor activity (1). Both CTLA-4 and PD-1 are important molecules in the inhibitory check point pathway of T-lymphocytes. However, it is thought that blocking these inhibitory pathways with agents such as ipilimumab and nivolumab, induce a tolerance break against the tumor but also predisposes the patient to immune-related adverse events (irAEs) (2). We present a case of rheumatoid arthritis developing shortly after treatment with ipilimumab and nivolumab.

Case:

Our patient is a 75 year old African American female with a past medical history of hypertension, chronic kidney disease, and stage IV non-small cell lung cancer diagnosed in July 2014. In September 2014, she was started on ipilimumab and nivolumab. She was referred to rheumatology clinic in October 2015 for progressive bilateral wrist and hand pain associated with 2-3 hours of morning stiffness. Physical exam was consistent with synovitis of her bilateral wrists and metacarpal phalangeal (MCP) joints bilaterally. Lab work showed positive ANA 1:1280 nucleolar, negative RF and CCP, and elevated ESR and CRP. Radiographs of the hands and wrists were pertinent for marginal erosions of the wrists and MCPs consistent with rheumatoid arthritis. She was treated with methotrexate 10mg weekly, folic acid 1mg daily, and prednisone 5mg daily with improvement of her symptoms.

Discussion:

Immune-related adverse events have been reported in up to 72% of patients receiving ipilimumab (1). There have been a variety of irAEs reported. However, to our knowledge this is the first reported case of rheumatoid arthritis developing after treatment with ipilimumab and nivolumab documented in the literature.

References:

A Case Report of Hyperosmolar Hyperglycemic Nonketotic Syndrome Attributed to Olanzapine Use

Introduction:
Second generation antipsychotics are often prescribed for the treatment of psychotic disorders, but are associated with side effects requiring monitoring. Olanzapine is notorious for its propensity for metabolic effects. Our case is a severe manifestation of metabolic derangement, presenting with Hyperosmolar Hyperglycemic Nonketotic Syndrome (HHNS) and significant rise in hemoglobin A1c four months after initiation of olanzapine.

Case:
A 70 year old man with history of dementia, unspecified psychotic disorder, and diet controlled diabetes mellitus presented to the emergency department with five days of altered mental status, polyuria, and polydipsia. Physical exam revealed tachycardia, dry mucous membranes, poor insight and attention. Laboratory data revealed blood glucose of 552, negative urine protein, and trace ketones. Infectious work up, toxicology screen, CSF RPR, TSH, EKG, vitamin B12, and folate were all within normal limits or negative. The patient’s hemoglobin A1c was 11.1%, an increase from 7.1% just four months prior, at olanzapine initiation. He was diagnosed with HHNS and worsening diabetes secondary to olanzapine. He was given intravenous fluids, insulin drip, and transitioned to subcutaneous insulin. After discussion with his psychiatrist, he was transitioned to lurasidone.

Discussion
This case illustrates an extreme example of a well-known adverse effect of second-generation antipsychotics. Though there are case reports of hospitalizations from hyperglycemia due to olanzapine, they are rare. Interestingly, some studies state most of the derangements can be reversed with withdrawal of the offending agent. This case highlights the importance of communication between mental health and primary care in monitoring and selecting psychiatric medications.
An Uncommon Presentation of Prostatitis: Multiple Organ Dysfunction Syndrome

INTRODUCTION: Acute bacterial prostatitis (ABP) is commonly caused by Chlamydia trachomatis, Neisseria gonorrhoea and Escherichia coli. It presents with fever, chills, pain in the lower back, rectum and perineum. In severe cases, it can present as sepsis. We report a case of septic shock with multi organ dysfunction syndrome (MODS) from ABP.

CASE: 47-year-old male presented with fever, dysuria and constipation for 2 days. Past medical history was significant for atrial fibrillation and hypertension. Medications included flecainide and metoprolol. Sexual history was unremarkable. Physical exam revealed supra pubic tenderness, with a normal digital rectal exam (DRE). WBC count was 28,900 and urinalysis with >100 WBC/hpf. Patient was initially treated with Ciprofloxacin. CT scan revealed inflammatory fat strands surrounding the urinary bladder, enlarged prostate and seminal vesicles. Prostate specific antigen (PSA) was 89.29 ng/ml. On day 2, patient became hypotensive and developed acute respiratory failure. Over the next four days he developed MODS. Urine culture was positive for Escherichia Coli (pan sensitiv and blood cultures remained negative throughout. A repeat PSA prior to discharge was 19.8 ng/ml.

DISCUSSION: ABP generally presents with a positive DRE. Our case is unique as the patient presented with urinary symptoms, elevated PSA and normal DRE. The radiological diagnosis of prostatitis and resolution of PSA to normal levels helped secure diagnosis in this case.

CONCLUSIONS: We conclude that prostatitis should be among the differentials for septic shock with MODS in healthy male patients and a low threshold to consider prostate as the primary infection focus.
A Case of Rheumatoid Pachymeningitis

Introduction:
Rheumatoid arthritis (RA) is primarily an inflammatory arthritis; however systemic complications frequently occur. Common neurologic manifestations of RA include articular subluxation and external compression of peripheral or central nerves by synovitis or pannus. Vasculitis and meningitis are rarely seen and portend a poor prognosis.

Case Description:
A 71-year-old woman with Stage III, Class IV RA on methotrexate presented with subacute onset of tonic-clonic seizures and cognitive decline. Serological markers revealed elevated rheumatoid factor (RF), erythrocyte sedimentation rate and high sensitivity C-reactive protein. Cerebrospinal fluid (CSF) studies revealed pleocytosis, elevated protein, RF, and IgG index. Brain magnetic resonance imaging (MRI) revealed increased T2 signal in the right frontal and parietal leptomeninges accompanied by sulcal FLAIR signal abnormality. Computed tomographic angiography of the head and neck excluded vasculitis. Left frontal lobe biopsy revealed necrotizing lymphoplasmacytic leptomeningitis with giant cells and rheumatoid nodules. Serum, CSF, and histological testing was negative for infection or malignancy. Initiation of prednisone and azathioprine resulted in significant improvement in mental status and suppression of seizures.

Discussion:
Rheumatoid pachymeningitis is an exceedingly rare phenomenon characterized by chronic articular disease, subacute meningeal symptoms and histopathology with rheumatoid nodules, meningeal inflammation, and vasculitis. For our patient, consistent with case reports, it was a diagnosis of exclusion aided by specific histopathologic findings of rheumatoid nodules. Evidence for corticosteroids and immunosuppressive agents is limited to several case reports with poor success. Future studies linking inflammatory cytokines responsible for the pathogenesis of RA and central nervous system complications may result in therapeutic targets.
A 30-year-old male patient presented from an outside hospital where he was found to have a left-sided spontaneous pneumothorax and multiple bilateral pulmonary cysts in the basilar medial regions on high-resolution CT. The patient underwent video-assisted thoroscopic surgery (VATS) and pleurodesis. We saw the patient in pulmonology clinic after hospital discharge.

Upon reviewing the patient’s family history, it was discovered that the patient’s sister, mother and maternal grandmother all suffered from repeated spontaneous pneumothoraxes and approximately twelve aunts, uncles and cousins suffered from renal cell carcinomas, skin lesions and pneumothoraxes. These clinical manifestations within a family are consistent with an autosomal dominant genetic disease called Birt-Hogg-Dubé syndrome (BHD) which is characterized by follicular hamartomas, pulmonary cysts, spontaneous pneumothoraxes and kidney neoplasms. [1]

BHD syndrome is caused by a germline mutation in the folliculin gene (FLCN) which is thought to act as a tumor suppressor gene. [2] The incidence of BHD syndrome is unknown but there are approximately 200 families in the world that have been identified. [3] Pulmonary cysts are reported in 80% of affected members of BHDS families but only 24% of affected members suffer from spontaneous pneumothoraxes. [2] Our patient’s immediate family history which demonstrates three generations with spontaneous pneumothoraxes is unique and suggests a more complicated interfamilial pattern of inheritance of the FLCN mutation, especially because of the different predominant manifestations in distant relatives. Upon learning this family history, all members were encouraged to get screened for renal neoplasms and to undergo genetic testing for BHD syndrome.
Fulminant Levamisole Induced Vasculitis with Devastating Outcomes

A 61-year-old African-American male with a history of hepatitis C virus, syphilis, and substance use disorder who presented with a 1-day history of painful, blue discoloration of toes, ears, and nose associated with exquisitely tender, hyper-pigmented, and edematous distal upper and lower extremities. The patient’s urine drug screen was positive for cocaine. The location of the lesions was consistent with levamisole induced vasculitis and the patient was positive for p-ANCA antibodies. After appropriate workup, the patient was administered a 5 day course of prednisone as well as a low dose ACE-inhibitor for associated acute kidney injury with subsequent improvement of renal functioning and was discharged to a nursing facility. The patient subsequently returned 3 weeks later with sepsis secondary to osteomyelitis requiring emergent right guillotine below-the-knee amputation, left 2nd and 3rd toe amputations with debridement, as well as bilateral upper extremity distal digit amputations. Wound cultures were positive for MRSA and Group-B-Streptococci and the patient was placed on IV vancomycin. The patient further developed biventricular systolic heart failure as evidenced by an echocardiogram revealing an ejection fraction of less than 10% and a cardiac catheterization revealing no evidence of coronary artery disease.

This case illustrates the potentially fulminant progression of an increasingly reported disease, first described in 1970. Leukocytoclastic vasculitis without evidence of thrombosis secondary to ingestion of this anti-helminthic agent, which was found in 69% of seized cocaine by the U.S. Drug Enforcement Agency in 2009, can indubitably lead to devastating outcomes.
Synchrony in the Lung: A Tale of Two Cancers

Although lung cancer is the most common malignancy diagnosed in men, pulmonary nodules are commonly representative of a metastatic process. Multiple pulmonary nodules are typically the same histologic pattern. Rarely, multiple pulmonary nodules may represent synchronous presentation of two or more malignancies. We recently encountered a case of a pleural nodule and lung mass as a presenting sign of metastatic prostate and colon cancer.

Case
An 80-year-old male with history of colon cancer and an elevated outpatient PSA presented with dyspnea for several weeks. A CT chest demonstrated multiple pleural nodules, right lung mass, large right pleural effusion, and multiple boney lesions concerning for metastatic disease. Data included PSA of 843 and CEA of 4.5.

A thoracentesis demonstrated an exudative effusion without malignant cells. Thorascopic pleural biopsy and iliac bone biopsy were consistent with metastatic prostatic carcinoma. He received bicalutamide and leuprolide. PSA decreased to 1.9. Follow up CT chest demonstrated a persistent large right lung mass. A biopsy of the lung mass was indicative of colorectal adenocarcinoma. The patient is now undergoing radiation therapy.

Discussion
Lung metastases are usually representative of colon, breast, renal, testicular or sarcoma as primary malignancy. Lung metastasis of prostate cancer is rare and has been described in a few case reports. Synchronous pulmonary metastases are unusual and can be a diagnostic and therapeutic challenge. Our case highlights the importance of close surveillance in the setting of multiple lung nodules. Unfortunately for our patient, treatment strategies are starkly different for prostate cancer versus colon cancer.
Warfarin use in a medical clinic: does a pharmacist driven protocol improve healthcare delivery?

Warfarin use for stroke prevention in atrial fibrillation or for treatment of thromboembolic events continues to be widespread. Monitoring INR levels is crucial to assuring appropriate dosage, as warfarin has a narrow therapeutic range (therapeutic range 2.0 to 3.0). Elevated INR levels have been associated with increased risk of intracranial hemorrhage, gastrointestinal hemorrhage and death. Subtherapeutic INR levels can place a patient at risk for stroke or other thromboembolic event. The frequency of INR monitoring depends on the stability of the patient’s INR.

**Primary objective:** to decrease time outside the therapeutic INR range through implementation of a pharmacist-driven protocol with resident oversight.

**Secondary objective:** to decrease cost associated with INR monitoring in patients treated with warfarin in our clinic population.

**Methods:** The study included patients >18 years of age taking warfarin who were cared for at the clinic between November 2013 and April 2014. Patients without two or more consecutive INRs within the study period were excluded. Data was collected retrospectively for the pre-intervention period (11/1/2013 to 2/1/2014) and for the post-intervention period (2/1/2014 to 4/1/2014). Pre-intervention and post-intervention data were compared. The therapeutic INR range was considered between 2 and 3. Statistical analysis was conducted using t-test and chi-squared test for continuous and categorical data, respectively.

**Results:** During the study period, 54 patients were included who were treated with warfarin and who had repeated INR results. The median age of the cohort was 55 years; 52% (n = 28) of the cohort was male. The mean INR within the pre-intervention cohort as compared to the post-intervention cohort was 2.4 versus 2.1 (p < 0.001). There was no statistically significant difference of overall time spent within therapeutic range between the pre-intervention and post-intervention cohort (49.7% versus 50.3%, respectively). The pre-intervention cohort had 10 INR levels greater than 4; the post-intervention cohort had no INR levels greater than 4. The total number of INR tests performed in the pre-intervention and post-intervention cohorts was 392 and 193, respectively. This equates to approximately $2352 healthcare dollars versus $1158 healthcare dollars respectively, with a net overall savings of $88 per patient per year.

**Conclusion:** Prior to the implementation of our pharmacist-driven protocol, INR monitoring was entirely resident-driven with attending supervision. After implementation of the protocol, there was no significant difference in the overall time spent within the therapeutic window; however, the pharmacist driven protocol led to a decrease in the number of supratherapeutic INR levels and a decrease in the number of INR tests completed. The greatest impact of implementing this protocol was economic. If extrapolated to our current warfarin clinic population, this protocol has saved the clinic a total of $4752 per year, a savings that benefits both the clinic and the patients.
Rasburicase is commonly used to enhance uric acid secretion in patients with hyperuricemia secondary to tumor lysis syndrome (TLS). Rasburicase-induced methemoglobinemia has been reported throughout the literature; few cases have been reported in patients without G6PD deficiency.

Case
A 46-year-old male with history of HIV on HAART presented with a large pleural effusion and mediastinal lymphadenopathy. Data included creatinine of 3.3, potassium of 5.1, uric acid of 19.2, LDH of 2201. Workup ruled out infection. Pleural fluid cytology was consistent with large cell lymphoma.

Due to evidence of TLS, rasburicase was administered. Three hours later, the patient was noted to have an oxygen saturation of 84% on non-rebreather. Arterial blood gas demonstrated pH of 7.38, pCO2 of 38, paO2 of 256, arterial oxyhemoglobin of 85.6%, methemoglobin of 12.6.

A peripheral smear revealed rare schistocytes without bite cells, making G6PD deficiency unlikely. Due to the patient’s clinical deterioration, methylene blue and ascorbic acid were administered. PRBCs were transfused. Methemoglobinemia percentage decreased and the patient stabilized.

Discussion
The saturation gap, a gap between paO2 and pulse oximetry, is an often-missed sign of methemoglobinemia. Rasburicase-induced methemoglobinemia has been described in patients with G6PD deficiency; however, our patient did not show signs of G6PD deficiency on microscopy and was later found to have a normal G6PD level. Clinicians should be wary of this increasingly used medication as a cause of a life-threatening outcome. If a patient, even without G6PD deficiency, deteriorates after receiving rasburicase, the diagnosis should be considered and the saturation gap measured.
Making Unresectable Resectable: Complete remission following neoadjuvant chemoradiation and surgical resection in locally advanced pancreatic cancer

The only chance for cure in pancreatic adenocarcinoma is surgery. In locally advanced pancreatic cancer (LAPC), The National Comprehensive Cancer Network (NCCN) suggests chemotherapy and possible radiation without repeat surgical evaluation. Here we present a rare case of LAPC with a complete histo-pathological remission after chemoradiation followed by resection.

A 54-year-old female presented to our clinic on December 2013 with complaints of abdominal pain and thirty pound weight loss. MRI showed a mass in the pancreatic body measuring 6.2 x 3.2 cm, biopsy positive for adenocarcinoma. Because of splenic vein, splenic artery, and celiac artery encasement she was deemed surgically unresectable. At the time, she started FOLFIRINOX therapy which was sequentially followed by radiation with adjuvant Capecitabine, FOLFIRI and finally XELIRI. Switches in chemotherapy were made due to persistent encasement of her vasculature. After 8 cycles of XELIRI completed in March 2015, restaging showed decrease in her tumor size with a PET scan showing no FGD avid uptake. However, there remained encasement of her splenic vein and artery. Despite this, she was re-evaluated by surgery and taken for resection April of 2015. Histopathologic specimens showed an R0 resection with no residual tumor found. She continues to follow at the clinic and has no evidence of recurrence about one year post resection.

This case illustrates the efficacy of neoadjuvant chemoradiation followed by surgical resection in LAPC. From our case and others, we suggest that surgical re-evaluation following chemoradiation is crucial in improving patient outcomes in this aggressive cancer.

FOLFIRINOX- Folinic Acid, 5-FU, Irinotecan. Oxaliplatin
FOLFIRI- Folinic Acid, 5-FU, Irinotecan
XELIRI- Irinotecan, Capecitabine
Disseminated Cryptococcosis in a patient with Idiopathic CD4 Lymphopenia (ICL)

ICL is a rare clinical syndrome defined by persistent CD4+ T cell lymphopenia in the absence of HIV infection or any other immunodeficiency. Patients usually present with opportunistic infections, malignancies, or autoimmune disorders.

A 50 year-old man presented with multiple skin lesions and generalized headaches of 2 month duration. The lesions were located on his chest and left arm. They measured 3-5mm in diameter and had an erythematous-vesicular appearance with central ulceration. Skin biopsy was diagnostic for cutaneous Cryptococcosis. At this point, the patient developed severe headaches, photophobia and neck stiffness for which he was admitted to hospital. Initial work-up showed CSF cultures positive for C.neoformans, CD4 count 2cells/mcl, CD8 count 20cells/mcl and negative HIV 1/2 serology. He was started on a course of Liposomal Amphotericin B and Flucytosine. His symptoms progressively improved and his skin lesions slowly resolve. Further work up was negative for HTLV,CMV, EBV, HHV-6, tuberculosis, influenza A/B, hepatitis B/C, and Toxoplasma. The patient had a monozygotic twin who underwent immune workup and showed normal CD4 and CD8 count. This suggested that our patient had likely an acquired immunodeficiency. He was diagnosed with ICL. He was later discharged on fluconazole and prophylactic antibiotics with referral to NIH. Follow up at 5 months revealed resolution of disseminated cryptococcosis but persistence of CD4 lymphopenia.

This case illustrates the importance of checking T-lymphocyte count and HIV serology on every patient who presents with cryptococcal infection. If the CD4+ count is low and HIV is negative, further work-up is needed to elucidate the cause of lymphopenia. If no etiology is found, then a diagnosis of ICL should be considered. Recognition of this rare syndrome is critical for initiation of treatment and appropriate referral to a specialist.
**Invasive liver abscess syndrome caused by Klebsiella pneumoniae K1 capsular serotype: An emerging entity in the United States**

The invasive liver abscess syndrome caused by Klebsiella Pneumoniae K1 capsular serotype has been especially prevalent in recent decades in Southeast Asia, but now is emerging in the United States.

86 year-old African American man with past medical history of type 2 diabetes presented with a four day history of fever, right upper quadrant abdominal pain and unilateral blurry vision. Physical exam notable for injected conjunctiva of the right eye with pus drainage. CBC revealed leukocytosis 12.2 THO/ul. CT scan of the abdomen showed a 6.6cm right hepatic lobe abscess. He underwent aspiration and drainage of abscess. He was started on broad IV antibiotics. The patient later developed tonic-clonic seizures, escalating to status epilepticus. Lumbar puncture was performed. CSF gram stain revealed Gram-negative rods. MRI of the head showed pus in the occipital horns, cavum septum pellucidum and left insula, as well as lateral ventriculitis. Blood, urine, CSF and hepatic abscess cultures were all positive for Klebsiella Pneumoniae K1 capsular serotype. His antibiotic regimen was readjusted based on sensitivity. Given the location and extent of the brain abscess as well as the presence of ventriculitis; it was decided to not pursue further neurosurgical intervention. Ultimately, the patient mental status continued to deteriorate and he died several days after his admission.

We hope that by presenting this case we can raise awareness of this emerging entity in the United States since early recognition of this syndrome is key for starting appropriate treatment and therefore improve prognosis.
Failed anticoagulation With Novel Anticoagulants Like Rivaroxaban in Patients’ on HAART (Efavirenz/Emtricitabine/Tenofovir).

Objective:
Human Immunodeficiency Virus (HIV) patients are at increased risk for venous thromboembolism (VTE). Anticoagulation in these is tricky and sometimes response can be very unpredictable. We are reporting a HIV patient who was on Efavirenz/Emtricitabine/Tenofovir combination, and failed anticoagulation with rivaroxaban.

Methods:
Our patient was a 44 year old male who had past medical history of HIV on HAART. He had developed a left lower extremity (LLE) deep vein thrombosis (DVT) and was started on rivaroxaban. A week later, he was admitted again with dyspnea and worsening lower extremity pain. His doppler LE was positive for extension of deep vein thrombosis. He was also found to have a small pulmonary embolism. Patient was compliant with his medications. He received catheter directed ablation for extensive DVT. He was later discharged on coumadin along with enoxaparin bridging.

Conclusion
The HAART (Especially Efavirenz) can cause decreased level of novel anticoagulants like rivaroxaban by affecting hepatic and intestinal enzyme CYP3A4 metabolism. This effect leads to increase clearance of above mentioned medication leading to inadequate anticoagulation and high risk of recurrent VTE.

Our patient had clearly failed anticoagulation with rivaroxaban in scenario of being on Efavirenz. Efavirenz increases metabolism and clearance of rivaroxaban which leads to inadequate anticoagulation. We are reporting this case to keep this interaction in mind while anticoagulating such patients. Coumadin may be more reliable option in such patients.
Understanding and Improving Patient Arrival Rates at an Urban Medical Resident Clinic

Introduction
Missed appointments (cancelations and no-shows) have a negative impact on outpatient clinical practices. Patients suffer from delayed care and longer wait times for appointments due to wasted time slots. Practices and physicians experience lost time and revenue and, in the case of resident clinics, fewer training opportunities. The arrival rate at the Internal Medicine resident clinic at our institution over the previous two academic years (2013-2015) was 52-53%, with 23-25% no-shows and 22-25% cancelations. We explored factors that contribute to missed appointments at our practice and attempted to improve the arrival rate of patients by 10% over a 10-month period from July-April 2016 using a combination of live reminder calls and targeted clinical summaries from physicians.

Methods
At the beginning of our intervention period, we instituted a double call policy for all patient visits to our clinic (n = 7420) in which a live appointment reminder call was added to the existing automated call. Later, a targeted clinical summary intervention was added for patients in the Monday resident firm, in which providers wrote a summary card at each visit reminding patients of the date and reason for follow-up. Rates of arrival, no-show, and cancelation during the intervention period were compared to the prior two-year average using Student’s t-test. Survey data were gathered from patients who missed appointments (n = 193) to assess contributing factors. Residents were also surveyed on their perceptions for the reasons behind missed appointments (n = 55).

Results
We observed a statistically significant decrease in no-show rates (19%, p=0.0001) in the period following our interventions. However, this was associated with a concomitant rise in cancelations (27%, p=0.0019), leading to no significant change in arrival rates (54%, p=0.33). We found that patients’ and residents’ perceptions of the reasons behind missed appointments differed, with patients more likely to cite external factors and residents more likely to cite patient-specific factors.

Conclusions
Our interventions did not lead to the targeted increase in arrival rates. However, we noted a significant decrease in no-shows which led to more available appointment for acute and walk-in patients. Our results may be limited by incomplete resident adherence to the clinical summary intervention, insufficient length of follow-up, and lack of stratification (e.g. Mondays vs. all weekdays,
patients who received clinical summaries vs. all patients). Potential future interventions should be targeted at factors that patients perceive as modifiable causes of missed appointments (e.g. increased scheduling flexibility, better coordination with other providers).
Leiomyosarcoma with Rare Metastatic Site

Key Words: leiomyosarcoma, gastric metastases

Introduction:
Primary bone leiomyosarcoma (LMS) is an extremely rare malignancy. Our patient had successfully resected tibial LMS, subsequent reoccurrences, and presented with upper gastrointestinal bleed, found to have numerous metastatic gastric lesions, an exceedingly rare site of metastases.

Case Description:
47 year-old male who presented with confirmed high-grade leiomyosarcoma of left proximal tibia. He underwent resection with negative margins. He had multiple reoccurrences of boney lesions, requiring palliative XRT then chemotherapy. PET/CT showed increased gastric FDG avidity. He presented to our hospital with gastrointestinal bleeding; endoscopy revealed fourteen cratered gastric ulcers. Pathology revealed atypical spindle cells consistent with leiomyosarcoma. Follow-up PET scan showed a hypermetabolic mass in the gastric body. He re-presented with gastrointestinal bleeding; EGD revealed malignant gastric tumor in gastric fundus, three nodules in the stomach. PET scan demonstrated increasing gastric body metastases, with the largest mass approximately 5.1 by 3.5 cm. Given his declining functional status and lack of treatment response, he was transitioned to hospice care without further intervention.

Discussion:
Leiomyosarcoma most commonly arises from uterus or soft tissue. Long bones are preferentially affected in primary bone leiomyosarcoma. Lung is the most common site of metastases (1,2). Isolated case reports have identified small bowel metastasis and gastric metastases from soft tissue sarcomas, but gastric metastasis appears to be a very rare finding of a rare malignancy (2,3,4,5). Additionally, our case is unique for the finding of both gastric masses and multiple diffusely distributed lesions. In general, gastric metastases mark advanced disease with poor prognosis (6).

Bibliography
“An Unusual Case of Subacute Cutaneous Lupus Erythematous”

A 64 year-old man with a history of gastroesophageal reflux disease presented with a seven month history of widespread erythematous cutaneous lesions. The lesions were not pruritic or painful, but were worsening with time. He had never experienced this before. An outside provider prescribed plaquenil out of concern for systemic lupus erythematosus; however, his lesions continued to recur, at times accompanied by fevers and joint pains which prompted his referral to dermatology. Here, the patient was noted to be taking lansoprazole.

Physical examination was significant for extensive erythematous scaling and eroded papules on the face, trunk, and extremities, with blistering of the oral mucosa. Skin biopsies were consistent with subacute cutaneous lupus erythematosus (SCLE). Serum laboratory values included a negative anti-nuclear antibody (ANA) and SSA/SSB, and a normal complete blood count and urinalysis. Patient was initiated on 0.1% triamcinolone ointment and plaquenil (200 mg twice daily), and his lansoprazole was discontinued. He had complete resolution of his cutaneous lesions with this regimen, which notably recurred when his primary provider initiated esomeprazole.

Drug-induced subacute cutaneous lupus erythematosus is characterized by annular and/or papulosquamous eruptions, often in a photodistributed pattern. Although uncommon, it has been reported with proton pump inhibitor use, lansoprazole being the most common. Patients often have positive ANA and/or SSA antibody titers, though both may be negative. The wide range of commonly prescribed medications associated with this disorder highlight the didactic value of this case. Prompt recognition and removal of the offending agent are crucial to proper treatment.

**Photographs can be provided if the board would like**

References:

Post-Pericardiotomy Syndrome Disguised as Fever of Unknown Origin

Post-Pericardiotomy syndrome (PPS) is a clinical diagnosis characterized by fever, pericardial or pleural effusions, and a pericardial friction rub occurring over several days after cardiac surgery. The infrequency of PPS can cause delay in recognition and management, thus leading to significant morbidity.

We present a case of a 62 year-old Caucasian female who presented 10 days after Aortic Valve Replacement (AVR) with fever, weakness, night sweats, chills, and altered mentation. In the ED she was tachycardic with a WBC count of 14,000 without bands; she admitted to symptoms of chest pain with deep inspiration and dyspnea on exertion. A chest x-ray demonstrated both pleural and pericardial effusions. A urinalysis was unremarkable, two sets of blood cultures were sent immediately and the patient was started on empiric antibiotics.

On the second day of hospitalization, the patient had worsening dyspnea, tenderness to palpation of the chest wall. During her hospital stay, an ECHO and following TEE were found to be negative for vegetation, and a thoracentesis showed mild exudate, while culture data remained negative. She was started on non-steroidal anti-inflammatory medications, to which her leukocytosis and fever responded immediately.

Post-pericardiotomy syndrome is thought to occur secondary to mesothelial pericardial injury, release of cardiac antigens and subsequent immune response. This case showed the value of clinical diagnosis in a fever with unknown source. In the setting of a cardiac procedure, PPS should be considered as a potential cause of fever in the extended post-operative period.
Screening, diagnostic, and therapeutic actions are known to favorably affect health outcomes of patients with diabetes. Twenty one percent of Jefferson Hospital Ambulatory Practice’s (JHAP) total patient population has diabetes. Out of 378 total diabetic patients at JHAP, Thursday Clinic accounts for 20% (74 patients). Of those, only 3.3% had complete diabetic care as of November 2015. Additionally, only 75% of patients had annual HbA1c checked which was significantly below the average for the rest of the other JHAP clinics. There were virtually no documentations of ophthalmology or podiatry referral results. By April 2016, our AIM was to improve Complete Diabetic Care* of Thursday JHAP Clinic’s patients with diabetes by 50%.

Our interventions included: 1) Diabetic Visit Flow Chart – to guide providers in meeting all elements of best practice in an organized way, 2) EMR – to maintain active list of diabetic patients and their primary providers, organize relevant results, conduct physician training session and implement dashboard notifications, 3) Structural Improvements – assured a supply of monofilaments in exam rooms and same visit lab draws in clinic, 4) Physician Education- educate on appropriate guidelines, EMR training session, checkpoints and periodic reviews of PCP Quality Reports, 5) Patient Centered Approach- mailed ophthalmology and podiatry referrals with reminders to make appointments at consolidated locations, appointment reminder phone calls from staff and physicians.

Thursday Clinic successfully improved rates of Complete Diabetic Care. Overall, JHAP’s Complete Diabetic Care increased from 4.8 to 8.2% and JHAP Thursday Clinic’s increased from 3.3% to 25.7%. We discovered a flaw in measuring process in PCP Quality Reports despite completion of diabetic care. This led to re-appropriation of resources and improved measuring process for entire TJU institution.

Limitations of the project included lack of consistent follow up visits, patients lost to follow up due to insurance or migration, lack of monetary support, inefficient EMR system, residents with extended time out of ambulatory clinic and psychosocially complex patient population.

Based on the results, we plan to extend these interventions to other JHAP clinics by holding resident training sessions. JHAP is anticipating the addition of a case manager, who will assist us in reaching our final goal and sustaining this intervention. We would like to provide visual triggers in patient rooms and involve pharmacy for diabetic teaching.

*Complete Diabetic Care = annual A1c, lipid panel or already on a statin, urine microalbumin or on ACE-I, ophthalmology referral and podiatry care.
Mounier-Kuhn Syndrome/ Congenital Tracheobronchomegaly: A case report

Introduction- Mounier-Kuhn Syndrome (Tracheobronchomegaly) is a very rare congenital anomaly of lung, characterized by marked dilatation of the trachea/mainstem bronchi, which is frequently associated with recurrent lower respiratory tract infections and bronchiectasis.

Case Report- We are reporting a case of 48Y old male with a past medical history of COPD/bronchiectasis who presented to the MICU with difficulty breathing, productive cough and subjective fevers. Chest auscultation showed B/L rhonchi with prolonged expiratory phase. ABG showed acute on chronic respiratory acidosis so he was started on BiPAP therapy and broad spectrum antibiotics. He had a history of multiple prior admissions with similar presentation. CXR on admission showed persistent right lower lobe infiltrate that had been present for several months. Subsequently, CT Chest was performed which showed markedly dilated trachea (35 mm) and left mainstem bronchi(21 mm), diagnostic of tracheobronchomegaly.

Discussion- Mounier-Kuhn syndrome is characterized by marked tracheobronchial dilation due to atrophy of the muscular and elastic tissues in the trachea and main bronchial wall. Clinical presentation ranges from mild lower respiratory tract infection to severe respiratory failure. Diagnosis is made by CT scan which shows abnormally large air passages compared to the normal measurements (diameters of the trachea >30 mm; of the right main bronchus 20 mm; and of the left main bronchus 18 mm). Treatment is mainly supportive in symptomatic patients. Surgical treatment modalities i.e. tracheal stenting and lung transplantation have shown no proven benefit in regards to the risk of morbidity and death.
Ruptured gastroduodenal artery aneurysm- deadly complication of duodenal ulcers

Introduction- Pseudoaneurysm of the Gastroduodenal artery (GDA) is a rare complication of Peptic ulcer disease. Ruptured pseudoaneurysms carry a high mortality rate (up to 100%); therefore, early recognition and emergent therapeutic interventions are imperative.

Case report- 90 y/o male was admitted to the hospital for evaluation of anemia and hematochezia. Few hours later, Rapid response team was activated as the patient was found to be pale, sweaty and unresponsive with SBP in 60s. Stat ABG done showed a Hemoglobin drop from 9.1 (4 hours ago) to 5.4. After initiating massive exsanguination protocol, decision was made to get emergent CT angiogram with intent of intervention. CT angiogram showed 3 mm aneurysm arising from gastroduodenal artery accompanied with hyperemia and bowel wall thickening of duodenum suggestive of duodenitis/ulcer. Patient was sent for emergent transcatheter embolization. Bleeding GDA pseudoaneurysm was identified and embolized with coils with resolution of extravasation. Patient was later found to be positive for H pylori Ag which confirmed the theory of duodenal ulcer leading to GDA pseudoaneurysm.

Discussion- This case illustrates the importance of early diagnosis and intervention for ruptured pseudoaneurysm. Angiography plays a critical role and is considered the gold standard for diagnosis. Conservative management of pseudoaneurysms is burdened by a death rate of more than 90%, hence making the emergent surgical/endovascular intervention imperative. Moreover, risk of rupture is not dependent on the size of the aneurysm. Hence, it is advocated that all gastroduodenal artery aneurysms, regardless of size, be treated actively at the time of the diagnosis.
First case of CA-MRSA Retropharyngeal Abscess in a healthy male

Retropharyngeal abscess (RPA) is a life threatening infection of the retropharyngeal space. Although community acquired MRSA (CA-MRSA) RPA, is a recognized entity in pediatrics, it’s rare in adults and usually seen in immune-compromised hosts. We present the first case of a RPA caused by CA-MRSA in a healthy male.

47 year old male with history of hypertension and bipolar disorder presented to our emergency department with 3-5 day history of worsening throat pain and mid-sternal chest pain radiating to neck. Patient denied any fever, chills, or rigors but complained of night sweats. On exam he had left-sided neck swelling with right tracheal deviation. Neck X-ray showed thumbprint sign. Nasopharyngolaryngoscopy revealed acute epiglottitis and patient was intubated for airway protection. Subsequent CT scan demostrated deep tissue abscess extending from oropharynx to mediastinum. Patient was started on broad-spectrum antibiotics and steroids, and taken to OR for drainage. Cultures grew MRSA and patient was initiated on vancomycin and ampicillin/sulbactam due to concern for mixed flora. Vancomycin is being continued for 28 days and patient is expected to make a complete recovery.

RPA is usually caused by polymicrobial flora. While adult cases with MRSA RPA have been described in patients with drug abuse, immune compromise and following severe sepsis or surgery, our patient is the first healthy male who has been reported to have RPA secondary to CA-MRSA. This shows the importance of awareness of CA-MRSA as a possible cause of RPA, which may lead to improved antibiotic coverage and earlier resolution of this disease.
Occult Follicular cancer presenting as bone metastasis

Follicular thyroid cancer accounts for less than 15% of all differentiated thyroid cancers. Bone metastases from well-differentiated thyroid cancer occurs in 2–13% of patients. But occult follicular thyroid cancer presenting as distant bone metastasis is very rare. We present a case of occult follicular thyroid cancer which presented initially as spinal mass causing back pain.

Pt is a 73 yr old Vietnamese man presented to Primary care physician initially with 6 month h/o rt leg pain radiating down the right thigh and right foot. His pain was also associated with paresthesias, he was started on gabapentin and was referred to neurology. Pt had a MRI to further investigate the leg pain which showed a large mass replacing portions of L5 and S1 on the right side. Pt had a CT scan chest, abdomen and pelvis which showed a right chest wall mass. Pt underwent fine needle biopsy of the chest wall mass. Pathology was suggestive of follicular thyroid cancer. Pt had Thyroid ultrasound which showed 8 mm thyroid nodule. Pt eventually underwent Total thyroidectomy. Cytological analysis of the resected thyroid gland showed a 1 cm follicular thyroid cancer. Pt is now scheduled for PET scan, Stereotactic Radiation treatment for his chest wall mass followed by Radioactive iodine ablation.

Follicular thyroid cancer comprises 10-15% thyroid malignancies. It is known to metastasize via hematogenous route. Lungs followed by bone are the most common sites of metastasis. The literature review showed most of the metastatic follicular carcinoma had obvious thyroid nodule/diagnosis of Follicular cancer or they were in advanced stage by the time they had distant metastasis. Bony metastasis of occult follicular carcinoma without any thyroid related symptoms is rare and is often a diagnostic challenge. With this case report we emphasize that it is very important keep this possibility in mind while working up a patient for unknown primary.
Effusion-Based Large B-Cell Lymphoma Mimicking Primary Effusion Lymphoma

Primary Effusion lymphoma (PEL) is a rare type of Non-Hodgkin Lymphoma which manifests as malignant effusion without extracavitary involvement. We present a case of large B cell lymphoma presenting as pleuropéricardial effusion, mimicking PEL.

A 79-year-old woman presented with shortness of breath. She was admitted 1 month ago with similar symptoms and was found to have pleuropéricardial effusion requiring pericardiocentesis and thoracentesis. On admission, she was hemodynamically stable. CT chest without contrast showed large pericardial effusion and small bilateral pleural effusions. Transthoracic echocardiography revealed large circumferential pericardial effusion with tamponade physiology. Cardiothoracic surgeon performed thoracentesis of right lung, pericardial window and pericardial biopsy. Endocrinologic and rheumatologic workup was negative. CRP and ESR were elevated. HIV was negative. Cytology of pericardial and pleural fluid was positive for large B cell lymphoma with germinal center type. Flow cytometry of body fluid showed positivity for CD19, CD20, CD22, HLA-DR, CD38 and CD10, consistent with cytology finding. HHV-8 and EBV stain were negative. Cytology and Flow cytometry analysis of bone marrow aspirate and CSF were negative for lymphoma. Pericardial biopsy was negative for AFB and Congo red stain. PET-CT scan ruled out any nodal and solid organ involvement. Therefore, a diagnosis of effusion-based large B-cell lymphoma was made.

Given similar presentation to PEL, diagnosis of effusion-based large B-cell lymphoma remains a challenge. Pathologic analysis, using morphologic, immunophenotypic, and virologic testing is helpful in ruling out PEL. Early diagnosis is very important as prognosis and treatment depend on an accurate diagnosis.
**Sorafenib-Induced Pancreatitis: A Rare yet Serious Side Effect**

Sorafenib is widely used for advanced renal cell carcinoma and unresectable Hepatocellular Carcinoma (HCC). Pancreatitis is a rare but serious side effect that has been reported in ≤1% of patients. With its increasing use, more attention should be given to its occurrence.

A 55-year-old female with past medical history of hepatitis C status post Ledipasvir/Sofosbuvir treatment and liver transplant was diagnosed with HCC with lung metastasis. Patient was started on Sorafenib. After 9 weeks, she presented with 3 days of intermittent severe epigastric and left upper quadrant abdominal pain. She was on Tacrolimus, Mycophenolate Mofetil, and Prednisone for 1 year at time of presentation. She denied alcohol consumption and family history of pancreatitis. She was hemodynamically stable. Her blood counts, liver function test, calcium level and triglyceride were normal. She had elevated lipase at 704. A CT abdomen pelvis showed acute interstitial pancreatitis without peri-pancreatic fluid collection or evidence of biliary obstruction in the transplant liver. Her pancreatitis was treated conservatively with hydration and analgesics. Her Sorafenib was held but immunosuppressants were continued. Patient felt better on second day of admission. Diet was restarted. Lipase trended down to 23 on the third day of admission. Patient was discharged after 3 days of hospitalization.

Based on Naranjo Adverse Drug Reaction Probability Scale, a causal association between Sorafenib and pancreatitis is probable. Pancreatitis should be considered on every patient on Sorafenib who presents with abdominal pain. Early recognition with immediate discontinuation of the drug is a very important step.
Foix-Chavany-Marie syndrome, a Rare Stroke syndrome

A 40 year old Caucasian male with past medical history of diabetes, hypertension, hyperlipidemia, myocardial infarction, and ischemic stroke with hemorrhagic conversion presented with loss of speech, difficulty swallowing and drooling for 6 hours. Neurological assessment demonstrates expressive aphasia, right-sided facial droop of upper and lower aspects of the face, and deviation of the tongue to the right. Initial MRI showed acute left fronto-parietal infarct with hemorrhagic conversion. On hospital day 6, patient had new complete paralysis of upper and lower parts of the left face resulting in bilateral facial paralysis. The patient exhibited emotional lability and involuntary spontaneous movements of the face during those episodes. Repeat MRI showed new right frontal lobe ischemic infarct with hemorrhagic conversion. There was no improvement in speech or swallowing over 2 week hospitalization, necessitating PEG tube placement.

Foix-Chavany-Marie syndrome (FCMS), also known as bilateral opercula syndrome typically manifests with facio-linguo-velo-pharyngeo-masticatory paralysis. The operculum consists of the frontal, fronto-parietal and temporal regions covering the insula. FCMS clinically mimics a pseudo-bulbar palsy of the 5th, 7th, 9th, 10th and 12th cranial nerves. FCMS lesions target motor and pyramidal pathways, sparing the extrapyramidal pathways, thus exhibiting the classic “automatic-voluntary dissociation.” Patients with FCMS have a significant risk for aspiration pneumonia. Early percutaneous endoscopic gastrostomy and use of modified feeding techniques is beneficial. Clinical improvement has been reported to be very poor in most cases. However, a case of FCMS treated with neuromuscular electrical stimulation showed improvement of the swallowing function.
**Phencyclidine-Induced Cardiomyopathy**

**Introduction:**

Non-ischemic cardiomyopathy (NICM) can be categorized in dilated, hypertrophic and restrictive types. Dilated phenotype has multiple causes. This case depicts a new onset dilated cardiomyopathy related to an uncommonly described risk factor for this disease, phencyclidine (PCP) abuse.

**Case:**

A 46 year old African American female with past medical history of asthma, depression and long-standing PCP smoking, presented to our institution with shortness of breath and hypoxia. Her medications included inhaled budesonide-formoterol and psychotropic medications (mirtazapine, quetiapine and fluoxetine). She did not have any family history of cardiac diseases. She was found to have a NSTEMI, rhabdomyolysis, and acute kidney injury. Therapy with heparin drip, intravenous fluids and oxygen stabilized her symptoms. Urine drug screen was positive for PCP. Echocardiogram showed diffuse left ventricle hypokinesis with an ejection fraction 30-35%. There was no apical ballooning noted. Left heart catheterization showed clean coronary arteries. Patient improved clinically, was started on Carvedilol and Lisinopril, and outpatient cardiology follow-up was scheduled.

**Discussion:**

We illustrate a new diagnosis of NICM associated with PCP abuse as the most notable risk factor. Approximately 3% of NICM cases are attributed to drugs such as cocaine, ethanol and amphetamines. PCP has been rarely associated to this disease in case reports. PCP has impact on the central nervous system and has been identified as a direct cardiac irritant in addition to indirect cardiovascular effects via adrenergic and dopaminergic actions. Lack of data such as cardiac MRI and myocardial biopsy limit a better correlation between PCP intake and NICM.
Leaky Pipes: A Case Report of Pseudo-Azotemia Secondary to Intraperitoneal Extravasation of Urine Following a Urological Procedure

Azotemia is a marker of net nitrogen balance that depends on both production and excretion. BUN and creatinine may rise in the absence of kidney injury or reduction of GFR if either process is impaired, leading to “pseudo-azotemia.” We report a case of a post-operative azotemia secondary to a urinoma, initially labeled as acute kidney injury.

A 50-year-old male with history of prostate cancer underwent robot-assisted laparoscopic prostatectomy with bilateral pelvic lymph node resection. On post-operative day 1, he became oligoanuric and had a sudden rise in serum creatinine which peaked at 8.74 mg/dL. Patient was asymptomatic. He subsequently had a retrograde urogram that showed extravasation at the ureterovesical interface. He had an IR drain placed, followed by surgical placement of bilateral ureteral stents with complex foley placement, to ensure that the ureteral orifices were not draining outside of the ureterovesical anastomosis. On the following day his creatinine decreased from 8.74 to 3.31 mg/dL; his discharge creatinine was 2.22 mg/dL.

The elevation of serum biomarkers of renal failure (i.e. BUN and creatinine) following bladder rupture is well elucidated and occurs from diffusion of solutes from the extravasated urine through the peritoneal membrane. Patients can develop uremic symptoms requiring hemodialysis if the diagnosis is delayed. Where available, kidney injury biomarkers like NGAL/KIM1 may be helpful in determining true renal injury. Fortunately, with timely diagnosis and removal of the source of urinary leakage, biomarkers often return to normal very quickly as long as there is no concomitant renal injury from another cause.
Multiple Myeloma Presenting as Acute Cytomegalovirus Colitis

Introduction
Multiple myeloma is commonly found in patients presenting with anemia, renal insufficiency and fractures. A broad spectrum of myeloma-associated infections has been reported in literature. Here we present a case of severe acute colitis associated with cytomegalovirus (CMV) as the primary presentation of a patient with multiple myeloma.

Case
A 73 year old female with a past medical history of a compression fracture presented with 5 days of diarrhea. The patient reported 2-4 bowel movements per day that were watery turning to bloody the day prior to admission. Laboratory studies were significant for a serum creatinine of 3.2 mg/dl (baseline unknown), hemoglobin of 11-g/dl and serum calcium of 12 mg/dl. CT of the abdomen revealed pancolonic wall thickening along with multiple age-indeterminate vertebral compression deformities.

Bone marrow biopsy showed hypercellular marrow with plasma cell myeloma comprising about 80% of marrow cells. For continued abdominal pain and bloody diarrhea, a colonoscopy was performed revealing ulcerated and hemorrhagic appearing mucosa of the sigmoid colon. Pathologic immunohistochemical staining confirmed the diagnosis of CMV colitis.

Discussion
Increased susceptibility to severe bacterial and viral infection occurs in multiple myeloma. A rare cause of acute infectious diarrhea in a person without immunocompromise, such as CMV colitis, necessitates a complete evaluation for an underlying condition associated with high risk of opportunistic infections.
Oh My Boy-a, it’s Moyamoya!

Introduction:
Moyamoya Disease is a rarely encountered entity that is under-diagnosed. It is characterized by recurrent ischemic strokes and/or hemorrhages, leading to severe disability.

Case:
A 71-year-old female with a history of stroke in her 40’s presented with altered mental status and multiple falls. Examination showed a spastic, contracted right upper extremity.

CT imaging of her brain revealed basal ganglia, subarachnoid, and subdural hemorrhages. CT angiogram showed complete occlusion of the right internal carotid artery at the skull base, bilateral tortuosity of the lenticulostriate vasculature, and multiple additional areas of narrowing/occlusion, consistent with moyamoya.

Her hospital course was complicated by ventilator-dependent respiratory failure, persistent extremity weakness, and swallowing dysfunction. She was discharged to a rehabilitation facility on levetiracetem, aspirin, and a statin, for continued physical therapy. Following discharge, she experienced refractory seizures, unresolved paresis and dysphagia, and recurrent brain hemorrhages. The family declined neurosurgery due to poor prognosis.

Learning objective:
Moyamoya is a chronic and progressive cerebrovascular disease of unknown etiology characterized by bilateral stenosis of the arteries around the circle of Willis. If left untreated, moyamoya can ultimately lead to devastating outcomes. Medical therapy is minimally effective, and the only definite treatment is revascularization. Had this disease been diagnosed earlier, our patient may have undergone timely revascularization, and possibly avoided these severe complications. CT-angiogram or MR-Angiogram should be considered in patients who present with stroke at a young age, those with unexplained stroke, or in cases of recurrent ischemic stroke or hemorrhage.
Anomalous right coronary artery origin presenting as chest pain and ST segment elevation

Background: Anomalous origin of right coronary artery (RCA) from left sinus is a rare congenital coronary anomaly, which can present with ischemia, arrhythmias, syncope, or sudden cardiac death.

Case: 68-year-old male with history of hypertension presented with acute onset left-sided, pressure-like chest pain at rest, radiating to the left arm. Initial electrocardiogram showed ST elevation in the septal leads with reciprocal ST depressions. Patient received sublingual nitro, aspirin and ticagrelor. Once in Emergency Department, chest pain and ECG changes resolved. Bedside echo showed no wall motion abnormality. Troponins were negative. A Left Heath Catheterization showed no significant epicardial disease but anomalous origin of RCA from the left coronary cusp. A Computed Tomography Angiography re-demonstrated anomalous RCA arising from the left coronary sinus with an anterior pass between the aortic root and right ventricular outflow tract.

Discussion: Anomalous origin of RCA from the left sinus is a rare congenital anomaly representing 3% of the congenital coronary artery anomalies. Majority of the patients are asymptomatic, but they can present with ischemic symptoms, arrhythmias or even sudden cardiac death. Computed tomographic angiography of the coronaries is the favored imaging modality to diagnose anomalous RCA. The treatment is often controversial. Surgery is recommended in symptomatic patients and conservative management in asymptomatic patients. Patients above 35 years old without symptoms can be treated medically with beta-blockers without surgical intervention. Young patients with symptoms should undergo surgery because of higher cumulative risk of sudden cardiac death.
Incidence & Impact of Contrast-Induced Nephropathy After Cardiac Catheterization: A Community Hospital Experience

Introduction:
Contrast-induced nephropathy (CIN) is a common complication after cardiac catheterization. We performed a six months retrospective study to evaluate the incidence & impact of CIN in a community hospital setting.

Method:
A retrospective chart review of 513 patients who underwent cardiac catheterization from June to December 2014 was performed. Patients with end-stage renal disease (n=38) & patients without pre-procedural serum creatinine (n=57) were excluded. Serum creatinine before the procedure & each day for three days after the procedure was recorded. CIN was defined as an increase in serum creatinine by >25% or 0.5mg/dl from a pre-procedural value within 72 hours of contrast exposure. Data pertaining to demographics, risk factors, & nature of the procedure were obtained. Clinical outcome of CIN was measured in terms of duration of hospital stay, length of ICU admission, requirement of hemodialysis & mortality. Chi-squared test was performed to compare incidence difference & outcome variables in CIN vs. non-CIN group.

Results:
A total of 418 patients (mean age 69.1 ± 13.8, 55% male & 45% female) were included in the study. Percutaneous coronary intervention (PCI) was performed in 28.9% (n=117) patients, of which (n= 94) were primary PCI. The mean incidence of CIN was 3.7% (n=16). Incidence of CIN was 6.7% in PCI group vs. 2.1% in non-PCI group (p=0.07). Incidence of CIN in primary PCI group was 8.1% vs. 0% in non-primary PCI group (p=0.06). While comparing the impact variables, length of hospitalization was 3 days in CIN group vs. 0 day in non-CIN group (p=0.07), length of ICU admission was 2 days in CIN group vs. 0 day in non-CIN group (p=0.001). 18.75% patients in CIN group required hemodialysis vs. 0% patients in non-CIN group (p=0.06). Mortality was 37.5% in CIN group vs. 4% in non-CIN group (p=0.0001).

Conclusion:
CIN was seen to be a major potential complication after cardiac catheterization. Higher incidence of CIN was seen whenever PCI & especially primary PCI was performed. Clinical impact like duration of hospitalization, length of ICU admission, requirement of hemodialysis & mortality was higher in CIN group when compared to non-CIN group.

Limitations:
This is a retrospective study with a single center data with a small sample size. Thus, many of the results were not seen statistically significant. Clinical outcome variables may be biased by confounding factors i.e. comorbidities.
**Right Ventricular Heart Failure Due to Isolated Calcific Pulmonic Stenosis in a Newly Diagnosed Acromegalic Patient**

**Case Presentation:** A 71yr old male presented to the hospital with increasing SOB, DOE as well as lower extremity swelling for 1 month. A TTE showed preserved EF of 80%, severe RA/RV enlargement and severely decreased RV function. The pulmonic valve was heavily calcified with moderate stenosis and moderate pulmonic regurgitation. A TTE 7 months prior showed only mild RV dilation and reduction in RV systolic function. Right heart catheterization showed normal wedge pressure and cardiac index. It also confirmed the calcific pulmonic stenosis as the cause of the patient’s RV failure and symptoms. A CTA done to rule out PE showed a left upper lobe pulmonary nodule for which a subsequent PET CT showed no metabolic activity in the nodule however a hypermetabolic lesion in the sella. Brain MRI confirmed a 2.6cm x 2.4cm x 2.9cm pituitary macroadenoma. The patient had an elevated GH of 27.3 ng/mL along with an elevated IGF-1 of 426 ng/mL. Prolactin was also elevated at 225 ng/mL. The patient was diagnosed with having acromegaly both biochemically as well as clinically. His right ventricular heart failure due to isolated calcific pulmonic stenosis was managed medically with diuretics and he will undergo a palliative balloon valvuloplasty along with transsphenoidal pituitary macroadenoma resection.

**Discussion:** Having an isolated heavily calcified pulmonic valve that presents as rapid RV failure over 7 months at advanced age is rare. The duration of how long this patient had acromegaly is uncertain, however his acromegaly likely contributed to worsening of both his valve stenosis as well as his cardiomyopathy. This case shows the unique impact that long standing acromegaly can have on the pulmonic valve.
Title
To assess the clinical yield of inpatient renal ultrasound for evaluation of acute kidney injury.
S. Kudakachira, K.S. Foong, J. Ng, C. Okechukwu, Y. Wang, A. Surana, Aparna, A. Kunkel

Abstract
Acute kidney injury (AKI) occurs commonly in hospitalized patients. Renal ultrasound is often performed to rule out urinary tract obstruction as the cause of AKI. Several studies found that the yield of renal ultrasound is low in determining the cause of AKI. The excessive use of ultrasound is not consistent with high value care and may lead to unwarranted intervention when incidental ultrasound findings are noted. However, the clinical yield of the ultrasound can be increased with clinical features of obstruction. In this study, we assessed the yield of inpatient renal ultrasound for evaluation of AKI.

Methods
We conducted a retrospective cohort study of all inpatient adults at our teaching hospital who underwent renal ultrasound for evaluation of AKI from January 2014 to December 2015. The definition of AKI in our study is defined by creatinine > 0.3mg/l from baseline. Baseline creatinine is defined by lowest creatinine value in the 3 months prior to admission. The frequency of renal ultrasound abnormalities and clinical characteristics that predicted the finding of urinary tract obstruction was determined. We then assessed the risk factors that are associated with a positive renal ultrasound finding for hydronephrosis using a multivariate logistic regression model. The statistical analysis was performed with a 2-sided p value of 0.05 denoting a statistical significance.

Results
820 renal ultrasounds were obtained and 60.95% (500) were included in the study based on the inclusion and exclusion criteria. Hydronephrosis was detected in only 9% (47/500) of the subjects and 55% (26/47) of these patients received subsequent interventions. In a multivariable logistic regression model with outcome being hydronephrosis, risk factors such as urinary retention, flank pain, microscopic hematuria and a history of hydronephrosis were found to have a statistically significance of being associated with hydronephrosis (adjusted odd ratio 2.516-11.04; 95% confidence interval 1.015-25.8, p<0.01).

Conclusion
Inpatient renal ultrasound in evaluating AKI has low clinical yield in detection of hydronephrosis in the absence of certain risk factors suggestive of urinary tract obstructions. Most of the other ultrasound findings were incidental and did not establish an etiology for the acute kidney injury. We plan to further adopt a risk stratifying model to increase the positive predictive value of renal ultrasound for detection of hydronephrosis. This may defer any unnecessary imaging and lead to the practice of high value care.
Lymphoma masquerading as subcutaneous masses with sporotrichoid spread

Lymphoma is a hematologic malignancy that, while common, can present in insidious ways particularly in immunocompromised patients.

A 32 year old farmer in Botswana presented with several weeks of shortness of breath, fever and skin masses. His medical history included HIV (CD4 158). He had developed progressive dyspnea on exertion with a 5-kg unintentional weight loss, daily fevers and chills for several weeks. He developed painful swelling of his left fifth finger two weeks prior, followed by multiple other masses throughout his left arm, chin and chest. He denied any trauma or significant contact with animals.

Physical exam revealed moderate dyspnea and diffuse cervical, submandibular and inguinal lymphadenopathy. It also revealed a swollen, tender and erythematous left fifth finger with multiple 3-4cm nonfluctuant, erythematous, mildly tender subcutaneous masses ascending up the left arm in a sporotrichoid pattern, with similar scattered masses overlying his face and chest. Diffuse rales and rhonchi were heard in all lung fields bilaterally.

Therapy was initiated with broad spectrum antibiotics, antiretroviral treatment and antituberculosis medications. Biopsy of several of the skin masses was performed. The patient's respiratory status worsened after several days, with no improvement in his skin lesions, prompting initiation of amphotericin. Despite this the patient died of respiratory failure several days later. Biopsy results ultimately revealed aggressive T-cell lymphoma.

This case highlights the value of maintaining a broad differential diagnosis with regard to rashes in immunocompromised patients. The differential diagnosis of a lymphangitis includes infectious and noninfectious etiologies. Although uncommon for lymphoma to present in a sporotrichoid pattern, awareness of this possibility, especially in a patient with profound immunodeficiency, is crucial to instituting appropriate therapies.
Systolic Anterior Motion of the Mitral Valve Unmasked by Combined Septic and Cardiogenic Shock

Introduction
Systolic anterior motion (SAM) of the mitral valve was initially considered to be specific to hypertrophic obstructive cardiomyopathy (HOCM). To our knowledge, this is the first reported case of SAM in a patient with mitral valve endocarditis in the setting of combined septic and cardiogenic shock.

Case Report:
A 65-year-old male presented with progressive dyspnea, hypertensive emergency, and required intubation. He was started on a nicardipine drip initially, however his blood pressure quickly deteriorated. He had profound hemoptysis with pulse oximetry dropping to 30%. He failed numerous methods of ventilation before we were able to maintain adequate oxygen saturation with pressure control inverse ratio ventilation. TEE revealed a mitral valve leaflet vegetation with severe mitral regurgitation. Repeat echocardiogram next morning showed evidence of SAM. Streptococcus sanguinis grew in 4/4 blood cultures.

Combined cardiogenic and septic shock unmasked SAM, making attempts at afterload reduction difficult. His oxygen requirements increased during his stay and repeat echocardiogram revealed an additional vegetation on the aortic valve. Renal failure ensued and CVVHD was initiated. He was not a surgical or ECMO candidate and despite continued life support, he died.

Discussion:
SAM is known to occur after mitral valve repair or in conditions like HOCM. The severity dictates therapeutic options ranging from medications to surgical interventions. This case demonstrates the dynamic effects from septic shock on the cardiovascular system, and how this can unmask anatomical derangements that can impair the ability to manage the patient effectively.
**Introduction:** Spontaneous pneumothorax is a well-known complication of the human immunodeficiency virus (HIV) infection. It often presents in the context of an infection or due to iatrogenic trauma.\(^1\)-\(^5\) We present two patients who experienced spontaneous pneumothorax without either of these factors.

**Case Descriptions:**

**Case 1**  
A 32 year-old man living with HIV (CD\(_4\) = 579, not on antiviral therapy) presented with extreme chest pain for two days. He experienced shortness of breath, palpitations, and diaphoresis, but denied fever and chills. Chest X-ray showed left pneumothorax secondary to an apical bulla. He was treated with a left upper lobe blebectomy.

**Case 2**  
A 43 year-old man living with HIV (CD\(_4\) = 716, on antiviral therapy) with a history of tobacco abuse presented with chest pain and shortness of breath starting three days prior to presentation. He did not present with palpitations, light-headedness, or dizziness. Chest imaging showed a left-sided pneumothorax. A chest tube was placed causing re-expansion of his lungs and resolution of his chest pain.

**Discussion**  
The rare presentation of these cases makes it unclear what caused the spontaneous pneumothoraces in our patients. There are few others cases reported of pneumothorax occurring in patients with HIV in settings that did not include infection or trauma.\(^6\)-\(^9\) As a whole, these unusual presentations of pneumothorax in patients living with HIV may contribute to understanding the cause of our unique presentations. Further research is needed to study if HIV is an independent risk factor of pneumothorax.

**References**


TITLE: Recreational clonidine intoxication causing altered mental status

ABSTRACT (248 words)

Clonidine is an imidazoline derivative used to treat hypertension. It has selective alpha-2 agonist properties that produce vasodepressor effects. Clonidine toxicity is rare and can present with cardiovascular and central nervous system depression.

We describe a 29-year-old man who presented to the emergency room after being found unresponsive on a city bus. On arrival, his Glasgow-coma scale was 9 and vital signs were significant for a heart rate (HR) of 42 beats per minute and blood pressure (BP) of 84/54mmHg. His physical examination revealed pinpoint pupils, depressed reflexes, bradycardia and lethargy. He was given ammonia spirit inhalation and had a partial response but remained lethargic. Three liters of intravenous (IV) 0.9% normal saline was given to improve his BP. Naxolone 0.4 milligrams IV (x3) was then used that showed some improvement in his mental status. He was started on a continuous infusion of naloxone and transferred to the Intensive Care Unit. His work up was unrevealing but the following day, he was back to his baseline mental status with normal vital signs. On further questioning, he admitted to ingesting ‘4 pills’ of clonidine that his friend offered at a party. His urine drug screen was positive for clonidine and negative for opioids.

The signs of acute clonidine intoxication include depressed mental status, miosis, hypothermia, hyporeflexia and respiratory depression. [1] A high clinical suspicion is required to diagnose clonidine toxicity as it can be confused with opioid overdose. Naloxone is recommended as first line therapy in clonidine poisoning. [2]

REFERENCES:


A Rare Find: Adult Onset Still’s Disease

Introduction
Adult Onset Still’s Disease (AOSD) is an extremely rare systemic inflammatory disease with approximately 1.5 cases per 100,000-1,000,000 people every year. There are no pathognomonic findings for the disease and its etiology is unknown.

Case Presentation
Our patient is a healthy 35-year old African American male who presented with right knee pain, swelling and fevers for one week. On exam, initial temperature was 102.3 F; knee was warm, erythematous and swollen down to his toes. A macular rash was noted on his proximal extremities. An x-ray revealed an effusion and no bony abnormalities. Joint aspiration revealed elevated WBC’s, no crystals and was negative for gonorrhea and chlamydia. During his hospital course, the patient developed nightly fevers, diffuse lymphadenopathy, an expanding rash and migratory arthralgias. Positive labs were notable for an elevated ferritin, LDH, ESR, CRP and ANA. Without a diagnosis to pinpoint his constellation of symptoms, the patient was started on IV methylprednisolone, methotrexate and folic acid for suspected AOSD. After one day of treatment, the patient’s arthralgias and fevers subsided.

Discussion
We present this case to shed light on the presentation and diagnosis of this rare disease. Further, early diagnosis and treatment as evidenced by this case can result in rapid resolution of symptoms and prognosis. The more cases that are identified and treated, the more we can understand the inner workings of this rare disease.
The Impact of Patient Hand Hygiene Intervention at the Acute and Long-Term Care Facilities: A Randomized Trial.

**Background:** Effective hand hygiene is essential to prevent transmission of healthcare-associated pathogens. Most hand hygiene programs in healthcare settings focus on compliance of healthcare workers because transient contamination of their hands is considered the major source for transmission of pathogens. There is increasing awareness that the hands of patients may also become transiently or persistently contaminated by pathogens, but limited efforts have been made to engage patients in hand hygiene interventions.

**Methods:** We conducted a randomized trial to determine the impact of patient hand hygiene intervention compared to the standard care of patients newly admitted to the facility. Patients were randomized by flipping a coin. Our interventions included patient education on the importance of hand hygiene using a “Four Moments for Patient Hand Hygiene” poster, real time pictures of hands colonized with bacteria and providing information on methods to avoid contamination, thus preventing infections. Patients’ hands and surroundings were cultured for MRSA, *C. difficile* and VRE on the day of admission and hospital days 2, 4 and 5.

**Results:** Ninety-five patients were enrolled in the study. For patients who had negative hand cultures on admission, 16 of 46 (35%) of patients hands were contaminated in the control group versus 1 of 44 (2%) in the intervention groups (p<.0001). MRSA was the most common pathogen that was recovered (14 in controls, 1 in intervention) followed by fluoroquinolone resistant gram negative bacilli on 2 control patients and 0 in intervention groups. Twelve of 69 (17%) of the patient surroundings were contaminated by day 5 or discharge from the facility.

**Conclusion:** In our study patient hand hygiene intervention during admission to the facility has significantly reduced the acquisition of healthcare associated pathogens on hands. Further studies are needed to determine the acquisition routes in order to direct the infection control practices.
Title: Can Polymerase Chain Reaction Cycle Threshold values be used in determining the Severity of *Clostridium difficile* infections?

**Background:** Current commercial polymerase chain reaction (PCR) assays for *Clostridium difficile* provide information on Cycle threshold values (Ct) with low values indicating a high burden of organisms. However, Ct values are not used clinically. We hypothesized that Ct values could provide useful information to clinicians by indicating severe infections or infection with North American Pulsed Field type 1 (NAP1) strains that have been associated with *C. difficile* infection (CDI) outbreaks.

**Design:** We performed a 1-year retrospective study of CDI cases diagnosed at the Cleveland VA Medical Center. CDI testing was performed with a commercial PCR assay (*Xpert C. difficile* Version 2.0; Cepheid, Sunnyvale, CA, USA) that detects toxin B, binary toxin and *tdcD* genes and presumptive NAP1 strains. Medical record review was conducted to determine the severity of CDI.

**Results:** Sixty of 115 patients with CDI (52%) were infected with NAP1 strain. Twenty two (37%) NAP1 cases developed severe CDI compared to 7 (13%) patients infected with non-NAP1 strains (*p*=.005). The median Ct value for NAP1 cases was significantly lower than for non-NAP1 cases (24 versus 29, *p*=.0009). Fifteen of 60 (25%) patients infected with NAP 1 developed recurrent CDI compared to 3 (5%) patients infected with non-NAP1 (*p*=.004). The median Ct value for severe CDI was lower than for mild to moderate cases (23.8 versus 27.8, *p*= 0.07).

**Conclusion:** Our data suggests that patients infected with NAP1 strain are more prone to develop severe and recurrent CDI. Lower Ct values could be used to identify patients infected with NAP1 strain and to predict severity of CDI and risk for recurrence. In addition to clinical signs, this information could potentially be used to guide the management of CDI.
When Back Pain Goes Wrong: *Escherichia coli* Native Vertebral Osteomyelitis Secondary to Urinary Tract Infection Leading to Quadriplegia

**Introduction:** Native Vertebral Osteomyelitis (NVO) can lead to significant morbidity. Unfortunately, back and neck pain are extremely common symptoms, often leading to a delay in diagnosis or mismanagement as a degenerative process.

A 58 year-old female presented with 4 days of bilateral upper and lower extremity weakness that rapidly progressed to quadriplegia. She described 6 weeks of progressively worsening mid-thoracic and neck pain. She had no fevers. Cervical and lumbar spine radiographs 3 weeks ago revealed no pathology. Eight weeks prior, an *Escherichia coli* urinary tract infection with right-side nephrolithiasis was diagnosed, and a percutaneous nephrostomy tube was placed. There was no bacteremia at the time, and she completed 14-days of Cefazolin.

**Physical Exam:** Afebrile with normal vital signs. There was moderate tenderness to palpation in the C5 region, quadriplegia, and sensory deficit below T4.

**Data:** WBC 17.8 K/UL, 84% neutrophils. Alkaline phosphatase 866 U/L. ESR 120.

Spine MRI with gadolinium showed destructive changes of the C6 and C7 vertebral bodies with cord compression. Surgical cultures grew *Escherichia coli*.

**Pertinence:** This case highlights the high index of suspicion required to diagnose NVO and the devastating consequences of delayed diagnosis. *Escherichia coli* is an infrequent but destructive cause of NVO. In patients with recent urinary tract infection or instrumentation who present with back pain, NVO must be considered. The majority of patients are cured with a 6-week course of targeted antimicrobial therapy. If initiated promptly, antibiotics can prevent permanent spinal cord injury/neurological deficits, and may obviate the need for surgical intervention.
**Embolic stroke secondary to direct calcific embolization from caseous mitral annular calcification**

**Introduction**

Mitral annular calcification (MAC) is a known risk factor for stroke but it remains unclear whether this is due to its association with other stroke risk factors or because it directly causes stroke through propagation of emboli.

**Clinical vignette**

A 55 year old female presented with aphasia, right facial droop, and right hemiparesis. Brain imaging demonstrated an acute infarct in the territory of the left middle cerebral artery (MCA) and a segmental flow gap consistent with a left MCA embolus.

Echocardiography demonstrated caseous MAC with several mobile elements, one protruding through the valve and becoming ensnared between leaflets during systole, without superimposed thrombus. Other embolic sources including paroxysmal embolism, LAA thrombus, calcified aortic valve or aorta, and carotid stenosis were excluded.

On further review of the CT brain, we identified a small calcific embolus within the left MCA.

**Conclusion**

This vignette supports the theory that MAC can cause a stroke from direct embolization, and offers an alternative mechanism to the small number of previous reports endorsing this theory.

Previous reports have described a thromboembolic etiology from thrombi superimposed on MAC. Ours is the first to compellingly illustrate the mechanism of calcific embolization directly from MAC; we were able to vividly observe mobile elements of the same echogenicity as the MAC, with one seen trapped between the leaflets during early systole, suggesting high embolic risk. We ruled out alternative embolic sources. Most importantly, we were able to identify a calcific embolus within the left MCA on CT of the brain.
Title: A Rare Case of Parvovirus B19 Associated Myocarditis, Collapsing Glomerulopathy, and Acute Interstitial Nephritis.

Introduction
Collapsing glomerulopathy (cFSGS) is defined pathologically by prominent capillary loop collapse, podocyte hypercellularity and proliferation. The most common infectious etiology is HIV [1]; however, Parvovirus B19 (PB19) has also been implicated [2, 3]. We present a case of myocarditis, cFSGS, and acute interstitial nephritis (AIN) following PB19 infection.

Case Presentation
A 54 year old morbidly obese female with stage 2 chronic kidney disease and hypertension was admitted 4 weeks after a viral upper respiratory tract infection complicated by myocarditis complaining of bilateral leg swelling, oliguria, confusion, and asterixis. She required emergent hemodialysis for a serum creatinine of 9.1 mg/dL (baseline 1.1 mg/dL), potassium 7.3 mmol/L, and anion-gapped metabolic acidosis. Work up revealed nephromegaly, microscopic hematuria, proteinuria, hyaline casts, and a spot urine protein to creatinine ratio of 2.97. Renal biopsy revealed cFSGS, AIN, and moderate interstitial fibrosis. Her HIV test was negative. Initially elevated PB19 IgG and IgM (2.2 and 8.5 indices, respectively) progressed as expected (4.5 and 3.4, respectively) four weeks later, when PB19 was not detected by PCR of the blood. Despite prednisone for AIN, renal function never recovered.

Discussion
Though the pathogenesis is poorly understood [1, 4], outcomes of PB19 cFSGS appear to be poor [1,5-7]. Myocarditis and cFSGS are individually uncommon manifestations of PB19 infection, making our patient’s presentation particularly striking as she had both. Similar to prior reports, renal function did not improve in the post-convalescent phase, and the patient remained to have a small but improved pericardial effusion with unchanged ejection fraction (>55%) from her myocarditis.

References
Title: The impact of reported penicillin allergy on patients with *Streptococcus* bacteremia at an urban community hospital

Introduction: Streptococci are human commensals [1] that can cause a number of local and systemic infections [2]. Intravenous penicillin is the antibiotic of choice in most Streptococcal bacteremias (especially Groups A and B) [3-7]; but patients reporting penicillin allergy often receive alternative or suboptimal antibiotic regimens [8, 9]. Reported penicillin allergy is common with an estimated prevalence of 10%; but up to 90% of these patients can tolerate penicillin [10, 11]. Measures such as careful allergy history evaluation, penicillin skin test and challenge could reduce the negative impact caused by inaccurate labelling of penicillin allergy [12-14]. While the impact of penicillin allergy labelling has been studied, the impact on patients with Streptococcal bacteremia remains unclear. Our study compares the clinical outcomes of Streptococcal bacteremia in patients with (exposed) versus without (unexposed) history of reported penicillin allergy.

Methods: This is a retrospective cohort study reviewing medical records of all adult patients with positive streptococcus bacteremia admitted to Albert Einstein Medical Center over the period of January 2014 to December 2015. Those that were considered contaminants were excluded. Various clinical parameters were compared between the exposed and unexposed groups.

Results: In our cohort of 331 patients with positive *Streptococcus* blood cultures, the prevalence of reported penicillin allergy was 12%. We compared 15 exposed patients with 15 unexposed patients with matching demographics and clinical presentation. Reported allergies to other drugs (including other antibiotics) were more frequent in the exposed group compared to the unexposed group (p=0.02). More classes of antibiotics were used in the exposed group (3 classes) than in the unexposed group (2 classes, p=0.05). Interestingly, the duration of antibiotic treatment was significantly lower in the penicillin allergic group compared to the non-allergic group (mean of 10 versus 20 days respectively, p=0.04). Acute kidney injury (AKI; 46.7% vs 31.3%) and overall infectious complications (including endocarditis, metastatic infection, septic shock; 60% vs 43.8%) were more frequent in the penicillin allergic group compared to non-allergic group, although the differences were not statistically significant. Mean and median lengths of hospital stay, ICU admissions, inpatient deaths, and 7 and 30 day re-admission rates were not significantly different between the two groups.

Conclusions: Our preliminary results suggest penicillin allergic patients are more likely to report allergies to other drug/s and possibly have a higher preponderance of developing AKI and other infectious complications. The reduced duration of antibiotic treatment noted in the exposed group suggest more cautious antibiotics use in those with reported penicillin allergy history. The current selected cohort study is underpowered for comparison of other clinical outcomes.
References:

Title:
A case of neurosarcoidosis exacerbation complicated by panhypopituitarism presented with visual and auditory hallucinations.

Introduction:
Neurosarcoidosis is an uncommon manifestation of sarcoidosis, characterized by inflammation and non-caseating granulomas of the central and/or peripheral nervous system [1-4]. Neuroendocrine dysfunction has been linked with neurosarcoidosis, involving in one or multiple anterior and/or posterior pituitary hormone/s [5-7]. Here, we present a case of neurosarcoidosis exacerbation associated with panhypopituitarism presenting with visual and auditory hallucinations.

Case Presentation:
A 48 year old woman presented after falling at a psychiatric facility where she was residing due to recent diagnosis of schizophrenia. For several months she had altered mental status associated with auditory and visual hallucinations. She had a longstanding history of neurosarcoidosis and mild depression, and an empty sella was incidentally noted on previous MRI’s. MRI for the head trauma from the fall revealed a full sella turcica. The pituitary gland appeared diffusely and homogeneously enlarged, convex, and avidly enhancing. The stalk was thickened and extended into the hypothalamus. Endocrine evaluation revealed panhypopituitarism with low morning cortisol, low TSH and thyroxine, and low FSH and LH with amenorrhea for eight years. Suspecting a neurosarcoid flare, high dose prednisone was started. Levothyroxine was given for hypothyroidism. Within a few days, the patient’s hallucinations resolved. After a short stay at a rehabilitation facility, she was discharged home without need for psychotropic medication.

Discussion:
This case illustrates the importance of evaluating organic causes of psychosis. It also highlights the importance of evaluating pituitary hormone functions in patients with a history of neurosarcoidosis.

References:
Diffuse alveolar hemorrhage associated with *de novo* IgA nephropathy in a patient with previous renal transplant

Case Description: A 60 year old male with a history of hypertensive nephrosclerosis and renal transplant presented with a petechial and maculopapular rash, abdominal pain, nausea, and vomiting. Vitals were significant for new onset hypoxia requiring oxygen via nasal cannula. Labs were significant for acute kidney injury. Initial chest radiograph demonstrated bibasilar atelectasis with a left pleural effusion. His workup included skin and transplanted kidney biopsies one week into his hospital stay that demonstrated IgA deposition. He was diagnosed with IgA nephropathy and started on pulse dose steroids. One week later he developed hemoptysis and was transferred to the intensive care unit. A new chest CT scan showed diffuse ground glass opacities. Bronchoscopy with lavage revealed progressively bloodier aliquots consistent with diffuse alveolar hemorrhage (DAH). Plasmapheresis was initiated for 6 treatments; however, his hypoxia worsened, requiring intubation and initiation of cyclophosphamide. His respiratory and clinical status improved with combination therapy of plasmapheresis, steroids, and cyclophosphamide.

Discussion:

This case demonstrates a patient with no history of IgA disease who developed IgA deposition years after transplantation, leading to acute renal failure, hypoxic respiratory failure, and diffuse alveolar hemorrhage. This disease process has been shown in a recent systematic review to be responsive to steroids, plasmapheresis, and cyclophosphamide, similar to our patient (Messina et al 2016, Rajagopala et al 2016). While recurrence of IgA nephropathy post renal transplant has been described, we believe this is the first case report of *de novo* IgA nephropathy causing DAH in a kidney transplant patient.

References:
Case

59-year-old man with a history of SIADH, psychogenic polydipsia, and coronary artery disease was admitted from prison for altered mentation. After being unable to urinate for a required random urine drug screen, he consumed 30 glasses of water. He had a witnessed seizure in the emergency room from hyponatremia (111meq/L). On day 3, the patient’s mental status improved and sodium was 124 meg/L. He complained of a new right foot drop with inability to dorsiflex his right ankle. Stat CT scan raised concern for anterio-tibial compartment syndrome; serum CPK was 37096 u/L. Fasciotomy was performed. The muscles appeared ischemic. Four days post-surgery, the patient’s serum creatine kinase trended down to 1469 u/L.

Discussion

While only two cases of bilateral anterior acute compartment syndrome have been reported in patients undergoing treatment for psychogenic polydipsia-induced hyponatremia, \(^1\) \(^2\) unilateral anterior acute compartment syndrome associated with this condition has yet to be described in the literature.

The mechanism of hyponatremia-induced muscle injury is unclear. It is hypothesized that acute hyponatremia from water intoxication causes cellular swelling due to lowered osmolality of extracellular fluid. As cellular swelling normalizes within hours from extrusion of intracellular potassium, this lowers the transmembrane potential leading to rhabdomyolysis with release of muscle creatine kinase and myoglobin. \(^3\)

Conclusion

Acute neurological limb symptoms, during sodium correction, should instigate a high clinical suspicion for acute compartment syndrome from rhabdomyolysis in these patients. Early diagnosis and treatment can prevent permanent neuromuscular dysfunction.
Diagnosis of Brugada Syndrome in a Young Male Presenting with Spinal Cord Injury Secondary to Syncopal Episode.

Brugada Syndrome is an inherited cardiac arrhythmia which can present with syncope or sudden cardiac death. It is diagnosed by clinical picture, family history, and ECG. Treatment is with an implantable cardioverter defibrillator.

A previously healthy 23 year-old male fell and lost consciousness while running into a lake. He was brought to shore, resuscitated, and transported to a hospital, where CT demonstrated cervical spinal cord injury. The patient was stabilized and transferred to rehabilitation with C3 ASIA A tetraplegia, status post-tracheostomy.

The rehabilitation course was complicated by episodes of symptomatic bradycardia and unresponsiveness. The first occurred during tracheal suctioning and was attributed to vasovagal response. The second occurred in the absence of vagal stimulation, with a heart rate of 26 and a 60-second period of unresponsiveness. He was transferred for cardiology evaluation, where ECG demonstrated early repolarization of malignant pattern with lateral J waves—concerning for Brugada Syndrome.

Further history revealed that the patient had felt faint before his initial fall, suggesting syncope as the cause. Additionally, the patient and multiple relatives had all experienced prior unexplained syncopal episodes. Given the clinical picture, history, and ECG, the diagnosis of Brugada Syndrome was made. An ICD was placed and the bradycardic episodes resolved. The patient’s relatives were advised to receive screening ECGs.

When a patient presents after a fall, it is imperative to obtain a complete history, as signs of syncope may indicate the presence of underlying disease. Brugada Syndrome must be on the differential for unexplained syncope, as ICD placement can prevent life-threatening arrhythmias.
The Prevalence of Binge Eating Disorder in Patients with Non-Alcoholic Fatty Liver Disease

**Introduction:** Non-alcoholic fatty liver disease (NAFLD) is the most common liver disease in the United States (U.S.) and is predicted to become the most frequent indication for liver transplantation by 2020. Binge eating disorder (BED), now part of Diagnostic and Statistical Manual V (DSM-V), carries an estimated lifetime prevalence of up to 3% among U.S. adults, thereby the most common form of eating disorder. Risk factors for NAFLD include obesity, insulin resistance, and metabolic syndrome. BED, characterized by recurrent episodes of binge eating, has been correlated with type 2 diabetes. The aim of our study was to examine the prevalence of BED among patients with NAFLD.

**Methods:** Patients with diagnosed NAFLD seeking care at our tertiary Fatty Liver Center were approached following their visit to complete the Binge Eating Scale, a 16-item questionnaire, which has been validated to screen for BED with a maximum of 46 points allotted to responses. A score of 18 or above is considered positive for binge eating whereas a score 27 or above is indicative of severe binge eating.

**Results:** Our preliminary results show that 8 of the 36 NAFLD patients screened had binge eating tendencies; with 1 of the 8 scoring 29 points, suggestive of severe binge eating. In total, we had 24 females and 12 males participate, with 4 females and 4 males positive for BED. 26 Caucasians, 6 African Americans, 2 Hispanics, and 2 Asians participated; of which 6 Caucasians, 1 African American, and 1 Asian screened positive for BED. 13 patients had steatosis, 10 steatohepatitis, and 13 cirrhosis; of which 3 with steatosis, 2 steatohepatitis, and 3 cirrhosis screened positive for BED. Prevalence of steatosis, steatohepatitis, and cirrhosis were similar among both BED and non-BED NAFLD patients. Of our BED NAFLD patients, 62.5% had insulin resistance (defined as pre-diabetic and diabetic), 62.5% had hypertension, and 37.5% had hyperlipidemia. Of our non-BED NAFLD patients, 67.9% had insulin resistance, 53.6% had hypertension, and 53.6% had hyperlipidemia. The mean BMI for BED NAFLD patients was 38.41, median 37.23, range 30.65 to 47.65 whereas mean BMI for non-BED NAFLD patients was 34.35, median 31.41, range 23.40 to 54.21.

**Conclusions:** This pilot study suggests that BED may have a higher prevalence in patients with NAFLD as compared to the general population, given that 22.22% of our NAFLD patients screened positive for binge eating. With these preliminary results, further study into the prevalence of BED is recommended. More data will be needed to identify the effects of BED on morbidity and mortality as well as metabolic syndrome of patients with NAFLD.