Abstracts from the 2017 Annual Louisiana American College of Physicians (ACP) Associates Meeting

Each year medical students in Louisiana and residents from the eight Internal Medicine training programs in Louisiana are invited to submit abstracts for the Annual Louisiana American College of Physicians (ACP) Associates Meeting. The content of these abstracts includes clinical case vignettes or research activities. The abstracts have all identifying features removed (i.e., names, institutional affiliations, etc.) before being sent to physician judges. Each judge scores each abstract independently and then the scores from all judges are averaged and ranked. This year we are excited to be able to publish the 28 most highly ranked abstracts presented at this year's competition. These abstracts (15 oral; 13 poster) were presented at the Associates Meeting held at Ochsner Medical Center in New Orleans on January 24, 2017. We would like to thank the Journal of the Louisiana State Medical Society and appreciate its efforts to publish the hard work of these trainees.

Shane Sanne, DO
Chair, Louisiana Associates Liaison Committee
Lee S. Engel, MD, PhD, FACP
Governor, Louisiana Chapter ACP

DELAYED PRESENTATION OF TUBEROUS SCLEROSIS COMPLEX IN AN ADULT WOMAN

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Introduction: Tuberous sclerosis complex (TSC) is an autosomal dominant disorder characterized by the formation of hamartomatous lesions in multiple organs, with a birth incidence of around one in 10,000. Although it usually manifests itself in early life, we present a case of an adult woman who we diagnosed with TSC.

Case: A 27 year old woman presented to Emergency Department with worsening right flank pain and progressive dyspnea. Physical examination findings revealed Shagreen patches and multiple angiomyolipomas of the skin. Computed tomography scan of the chest and abdomen was remarkable for pulmonary lymphangioleiomyomatosis and renal angiomyolipomas. Brain imaging revealed multiple subependymal nodules and cortical dysplasias. Subsequent genetic testing later confirmed pathogenic mutation in the TSC2 gene and patient was referred for Genetic counseling and further management.

Discussion: Clinical features of TSC continue to be the principal means of diagnosis, with the inclusion of identification of a pathogenic mutation in TSC1 and TSC2 as an independent diagnostic criterion. Affected patients may present early in life with the classic triad of seizures, intellectual disability, and cutaneous angiofibromas, but some findings, notably renal angiomyolipomas and pulmonary lymphangioleiomyomatosis (LAM), emerge later, placing adults with undiagnosed TSC at increased risk for morbidity and mortality. Recent advances in the treatment of TSC highlight the need to identify and follow affected patients.

WEIL'S DISEASE FROM A LOCAL NEW ORLEANS BAR

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Introduction: Leptospirosis is a zoonotic infection that typically presents with fever, myalgias, nausea, and vomiting after contact with contaminated waters or infected animals (typically rodents) and their excrements. Conditions favorable to the transmission of leptospirosis are common in LA and, without treatment, leptospirosis can lead to both liver and renal failure, meningitis, pulmonary hemorrhage and ultimately death.

Case: A 56 year old woman with no past medical history presented to the Emergency Department with weakness, myalgias, jaundice and decreased urine output for one week. On arrival, she appeared septic with a heart rate of 130 and fever. Her exam was significant for significant jaundice and diffuse abdominal pain. Laboratory studies were notable for WBC 14, hemoglobin of 12 and platelet count of 63. Creatinine was 8.5mg/dL with a blood-urea nitrogen of 96mg/dl. Total bilirubin was 19.4mg/dL and direct bilirubin was 13.7mg/dL. AST/ALT were 69/38 U/L, respectively and the alkaline phosphate was 160U/L. The patient was admitted to the hospital medicine wards for sepsis and multi-organ failure. She was started on broad spectrum antibiotics but her clinical condition continued to worsen with progressive decline in her hemoglobin and thrombocytopenia and worsening liver failure. She quickly became anuric necessitating dialysis and developed respiratory distress with bilateral pulmonary infiltrates and hemoptysis. Additional history was obtained from her employer that she works at a local New Orleans bar and had been cleaning out rats from the kitchen. Leptospirosis antibody was sent, which returned as positive. Her antibiotics were de-escalated to IV Ceftriaxone. She made a slow recovery over the next two-week period.

Discussion: Since 1987, there has been an average of 3 cases of

Leptospirosis diagnosed per year, most of which have been from southeast LA. This case illustrates the importance of considering the diagnosis of Leptospirosis and Weil's Disease in patients in the southeast region of LA who present with multi-organ failure. In addition, our patient's occupational exposure was key to her diagnosis which emphasizes the importance of a detailed history in clinical decision making and patient outcomes.

NOT ANOTHER ACS RULE OUT

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Case: A 50 year old African-American woman with diabetes, hypertension, and hyperlipidemia presented with progressively worsening retro-sternal chest pain, exacerbated by activity and relieved by rest. She also endorsed a thirty-pound unintentional weight loss, and dysphagia. She was dysarthric with left-sided Bell's Palsy and a palpable left axillary lymph node. She had been evaluated at several hospitals in the previous months for similar typical chest pain. Her troponin values were normal, and an EKG showed T-wave inversions in leads I and aVL. On echocardiography, her ejection fraction was 45% with antero-lateral hypokinesis. She was treated for NSTEMI, and an angiogram showed 95% stenosis of the right coronary artery. A modified barium swallow study revealed weakened swallowing with aspiration of thin liquids. An MRI Brain demonstrated scattered T2/FLAIR hyper-intense foci in the subcortical white matter and focal meningeal thickening. ANA, dsDNA, ANCA, and Lyme antibodies were all negative, and a chest CT showed hilar lymphadenopathy. Cardiac MRI demonstrated scattered foci of delayed enhancement in the mid-myocardium and sub-epicardium without infarction. An endobronchial biopsy of hilar lymph nodes showed two small epithelioid granulomas, consistent with Sarcoidosis. She was started on high-dose corticosteroids with rapid improvement. A repeat modified barium swallow study was normal and a repeat echocardiogram demonstrated recovered ejection fraction of 55% with improved wall motion in the septum and apex. Additionally, her left-sided Bell's Palsy and dysarthria improved after several days of therapy.

Discussion: To our knowledge, this report is the third case of multi-organ Sarcoidosis presenting as ACS. This case depicts the simultaneous presentation of neurologic, pharyngeal, pulmonary, and cardiac Sarcoidosis. Myocardial involvement in Sarcoidosis is rare and usually presents as conduction abnormalities with arrhythmia rather than ACS. Though her symptoms were consistent with Sarcoidosis, she had multiple risk factors for coronary atherosclerosis including diabetes, hypertension, and hyperlipidemia. This case highlights the importance of including Sarcoidosis in the differential diagnosis for patients with recurrent typical chest pain of uncertain etiology.

GONOCOCCAL ENDOCARDITIS: THE GIFT THAT STOPS GIVING! AN UNCOMMON PRESENTATION OF A COMMON DISEASE.

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Introduction: Gonorrhea is the 2nd most common sexually transmitted disease in the US with 800,000 cases of gonorrhea each year. Disseminated gonorrhea infection occurs in 0.5%- 3% of these patients and is more frequent in woman younger than 40 years of age.

Case: A 36 year old woman with a history of polysubstance abuse presented with 10 day history of feeling generally unwell. At presentation, vitals were remarkable for tachycardia and hypotension. Physical exam was remarkable for conjunctival pallor, bibasilar crackles, and tachycardia with grade III/VI systolic murmur loudest over the 2nd inter-costal space and loudest with expiration. No skin lesions were noted. Labs demonstrated leukocytosis (WBC 20,200 with 84% neutrophils), anemia (Hb 6.7), thrombocytosis (platelets 423 k/uL), abnormal liver function tests (alkaline phosphatase 239 IU, AST 151 IU ALT 71 IU, albumin 2.5g/dL), PT/INR 17.1/1.5. Troponin 0.42, BNP 823, D-dimer 619, and a urine drug screen that was positive for benzodiazepines, opiates, barbiturates, amphetamine, and THC. Hep panel and HIV were negative. Chest radiograph showed mild cardiomegaly and early interstitial edema. The patient was placed on broad spectrum antibiotics and given adequate fluid resuscitation and blood products. Blood cultures grew Neisseria gonorrhoeae. 2D ECHO showed a large pedunculated/mobile echo density adherent to the non-coronary and lefts cusps of the aortic valve. Proximal aortic root and aorto-mitral continuity were thickened, consistent with aortitis and/or abscess formation. Initial EKG on arrival showed junctional tachycardia which progressed into complete heart block. Cardiology was consulted and a pacemaker was placed emergently. However despite all aggressive measures the patient died of cardiac complications.

Discussion: Endocarditis is a rare complication of disseminated gonorrhea, occurring in only 1-2% of patients with gonoccocemia. The aortic valve is most commonly affected. Valve replacement is warranted in cases with severe dysfunction. Mortality remains around 19-20. Neisseria gonorrhoeae endocarditis should be included in the differential diagnosis in sexually active patients with endocarditis.

A CASE OF EARLY NEUROSYPHILIS

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Introduction: Neurosyphilis is an infection of the central nervous system by Treponema pallidum, which can occur after the initial syphilis infection. Although commonly associated with late stage disease, patients with early neurosyphilis may present with acute syphilitic meningitis, meningovascular syphilis, or uveitis.

Case: A 28 year old man with a past medical history of HIV (CD4 364), and recent diagnosis of uveitis presented to the Emergency Department with a positive RPR result. His visual acuity had been gradually declining over the past few months. He denied painless or painful ulcerating lesions on his penis, or scrotum, difficulty concentrating, dermatitis on the soles/palms, or difficulty with proprioception. Physical exam was notable for atrophic hyperpigmented polycyclic, annular plaques and patches along the hairline as well as several areas of confluent hyperpigmented polycyclic plaques and nodules on the patient's face, back, left arm, and right posterior leg. Fundoscopic exam revealed bilateral posterior uveitis and chorioretinitis. Evaluation of cerebrospinal fluid revealed a lymphocytic pleocytosis with a positive VDRL and FTA-ABS. Aqueous crystalline penicillin G was initiated for treatment of early neurosyphilis. Within six hours of beginning the infusion, the patient had a documented temperature of 101.8°F, heart rate of 128 beats per minute, blood pressure 142/84, with generalized malaise and headache. Fever and tachycardia resolved over the next 12 hours, with weakness and headache resolving within 1-2 days. His symptom complex was consistent with the Jarisch-Herxheimer reaction. Histopathology of skin biopsy of the back showed perivascular inflammation and rare spirochetes, consistent with secondary syphilis. The patient completed 14 days of aqueous crystalline penicillin G and was discharged after receiving the first of three benzathine penicillin injections.

Discussion: The initial manifestations of syphilis in this patient were posterior uveitis and pruritic skin plaques. His diagnosis should be appropriately classified as secondary syphilis with concomitant symptomatic early neurosyphilis, requiring 14 days of aqueous crystalline penicillin G. This type of presentation is not specific to immunocompromised populations and must be considered even in the general population. Making the diagnosis of early neurosyphilis, regardless of stage, is critical, as it necessitates a longer duration of treatment. Furthermore, clinicians should be reminded of the profound immunologic reaction, Jarisch-Herxheimer, which may occur when treating any treponemal disease.

JUST A "PUFF OF SMOKE"

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Case: A 44 year old woman with a history of stroke s/p aneurysm clipping, seizure, and substance abuse was brought to the hospital after a family member received a call from her friend saying she was acting unusual and may have had a seizure while hanging out on the street. At her baseline, she needed modest assistance in daily activities after her CVA and conversed without issue. Her mother died of a stroke. On exam the patient was afebrile, normotensive with mild tachycardia to 110. The patient moved all her extremities but was lethargic, agitated, responded to pain but would not follow commands and moaned nonsensical speech. Labs were unrevealing with mild leukocytosis (WBC: 11.7 × 109/L), normal metabolic panel, ammonia, glucose, and a negative urine toxicology. Initial computed tomography (CT) of her head demonstrated atrophy with large area of encephalomalacia in Left middle cerebral artery (MCA) area. Repeat CT, 1 day later showed edema and sulcal effacement in the right occipital, posterior, temporal, and posterior parietal lobes with evolving infarct in right posterior cerebral artery (PCA) and right MCA territories. CT angiogram showed occlusion of the clinoid segments of both internal carotid arteries, consistent with Moyamoya pattern of collateral flow. Neurosurgery was consulted and recommended cerebral bypass. The patient was unable to consent for surgery and her closest relative refused surgery. The patient received supportive therapy with minimal improvements in word findings/communication and no improvement in inability to perform daily activities. She was accepted to inpatient stroke rehab upon discharge.

Discussion: Moyamoya disease is a rare vascular condition which leads to progressive stenosis of the internal carotid arteries through wall thickening of the associated arteries which leads to progressive strokes and the development of collateral vessels. Moyamoya is a Japanese term for a "puff of smoke" which describes the appearance on imaging of the small collateral vessels that develop around the progressively blocked arteries. There is a hereditary association and our patient's mother likely had the disease as well. The prognosis is poor and the disease will lead to a cognitive decline with associated CVAs. Treatment includes cerebral revascularization or bypass. The case highlights the need for early diagnosis, as our patient was too debilitated to make medical decisions for treatment at the time of her diagnosis.

THE MYSTERIOUS CASE OF DYSPNEA

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Introduction: Dehiscence of a mitral valve annuloplasty ring is a rare occurrence that often manifests as mitral regurgitation and heart failure. We present a case of mitral ring dehiscence which was initially unrecognized by standard 2-dimensional transthoracic echocardiography (2D TTE) and 2-dimensional transesophageal echocardiography (2D TEE).

Case: A 65-year-old woman was referred to Cardiology clinic for evaluation of dyspnea. Her history included tobacco abuse, atrial fibrillation status post pulmonary vein isolation, nonischemic cardiomyopathy, and prior mitral valve repair with annuloplasty ring for rheumatic valvular disease. She had been asymptomatic post-surgery. Physical examination, cardiac rhythm and initial ischemic workup were unremarkable. Pulmonary function tests revealed moderate emphysematous type obstructive lung

disease. A 2D TTE demonstrated moderate mitral regurgitation with normal left ventricular function. In right heart catheterization, large v waves were noted and 2D TEE also revealed severe mitral regurgitation. On 2D TEE, the mitral valve annuloplasty ring was visible above the native anterior mitral valve leaflet. Color Doppler flow estimated the effective regurgitation orifice area of 0.4cm2 using the proximal isovelocity surface area method and regurgitant volume of 58 cc, consistent with severe mitral regurgitation. A "floating mitral ring" and dehiscence measuring 1 cm in diameter were seen on high resolution three-dimensional reconstruction resulting from the detachment of the ring from the weakened posterior annulus. Based on these findings patient was referred to cardiothoracic surgeon for re-do mitral valve surgery.

Discussion: This was a perplexing case as the patient's dyspnea could be explained by many disease processes including atrial fibrillation, mitral regurgitation and chronic obstructive lung disease. The standard imaging modalities did not help us to formulate a diagnosis. 3D TEE provided invaluable and unparalleled information of mitral valve pathology. Annuloplasty ring dehiscence is a well described complication of mitral valve repair and should always be considered in symptomatic patients.

AUTOIMMUNE DIABETES PRESENTED WITH DIABETIC KETOACIDOSIS INDUCED BY IMMUNOTHERAPY IN AN ADULT WITH MELANOMA

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Introduction: Immunotherapy has been approved for treatment of melanoma. Autoimmune endocrinopathies have been reported in trials involving immunotherapy but autoimmune diabetes has not been definitively linked to them. Here we describe a case of autoimmune diabetes presenting with DKA after receiving combined immunotherapy with anti-CTLA4 and anti-PD1 monoclonal antibodies.

Case: A 47year old gentleman with metastatic melanoma presented to our institution with confusion, abdominal pain and decreased oral intake. The patient had a history of diabetes on metformin which was discontinued two years prior. He was started on Novilumab/Iplimumab for metastatic melanoma. He had received two cycles of immunotherapy and treatment was initially well tolerated. However, eight days after the second cycle the patient developed lethargy, confusion, vomiting and abdominal pain. CT of the head was negative for intracranial abnormalities and without evidence of brain metastasis. His laboratory results included: serum sodium 126 mmol/L, potassium 6.7 mmol/L, BUN 55 mg/dL, creatinine 3.5, bicarbonate 5 mmol/L, chloride 94 mmol/L, albumin 3.2 g/dL. Serum beta-hydroxybuterate was elevated (4.7 mmol/L, N: 0.0-0.5 mmol/L) and the calculated anion gap was 43 mmol/L. Serum lipase elevated (535 u/L, N: 4-60 u/L). The diagnosis of diabetic ketoacidosis was made and he was started on intravenous fluids and insulin therapy. Given his history of metastatic melanoma, his DKA was initially thought to be secondary to pancreatic metastasis especially considering the elevated lipase level. A non-contrast CT of the abdomen showed no evidence of pancreatic metastasis. Interestingly, further investigation identified high serum titers of anti-glutamic acid decarboxylase (anti-GAD) antibodies (0.43 nmol/L, N: <0.02 nmol/L), a low C-peptide level (0.2 ng/ml, N: 0.9-5.5 ng/ml), supporting an autoimmune etiology of the diabetes. Other islet autoantibodies were not elevated and his Hemoglobin A1C was 8.0%.

Discussion: There are few case reports about diabetes and immunotherapy. Autoimmune mechanism was suggested as the culprit, although not all cases reported with positive antibodies. Moreover, it is unlikely that patient developed latent autoimmune diabetes (LADA) and not related to immunotherapy due to the course of LADA is quite more gradual and our patient presented with acute DKA few days post the second cycle. Physicians and patients should be aware that autoimmune disorder such as DKA may be a rare but important immunotherapy related adverse events.

SECOND REPORTED CASE OF CANDIDA CATENULATA FUNGEMIA

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Introduction: There are over 20 species of Candida yeasts that can cause infection in humans, the most common of which is Candida albicans. This is the second reported case of Candida catenulata fungemia. Candida catenulata is not usually associated with invasive infection in humans. The previously reported case was in a patient with gastric cancer. Candida catenulata is a natural contaminant of dairy products. Cases of candidaemia with this species are uncommon.

Case: A 57 year-old white man with a history of alcoholic cirrhosis, recurrent pancreatitis and pseudocysts, intra-abdominal abscess and prior partial small bowel obstruction, and prior extended courses of IV antibiotic therapy presented to the emergency department with fevers, malaise, and abdominal pain. The patient was initially admitted to the intensive care unit because of sepsis, placed on broad spectrum antibiotics, and received image-guided drainage of the largest abscesses. His course was complicated by recurrent small bowel obstruction attributed to one abscess that was not amenable to drainage. The patient had poor oral intake, only liquids including milk. He eventually required PICC placement for TPN. He subsequently experienced fever and altered mental status. Preliminary blood cultures from the PICC and periphery indicated "budding yeast species". Micafungin was added and the catheter was removed. Blood cultures from the PICC and periphery grew C. catenulata, while vancomycin-resistant Enterococcus grew only from the PICC line cultures. The patient improved, and follow-up cultures remained negative. The patient completed a two week course of micafungin and was eventually discharged to a long-term acute care facility for completion of antimicrobial therapy.

Discussion: This case highlights C. catenulate, a rare cause of fungemia. The previously reported case involved a gastric cancer patient and a presumed GI portal of entry. In our case although the organism may have entered through the GI tract the PICC line and TPN represented additional risk factors. Thus, this case underscores the importance of maintaining a high index of suspicion for fungal pathogens when risk factors are present as well as the need to promptly initiate antifungal therapy when fungemia is confirmed.

A CASE OF HEPATOSPLENIC T CELL LYMPHOMA-A RARE, AGGRESSIVE TUMOR OF THE YOUNG

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Introduction: Hepatosplenic T-cell lymphoma (HSTCL) is an unusual entity first described in 1990 that predominantly affects middle-aged men and is classified by WHO under peripheral T-cell lymphomas. We present a 26-year-old man with HSCTL treated with a non-CHOP regimen.

Case: A 26 year old immigrant from Cameroon without significant past medical history presented with abdominal discomfort that was first noted 1 month prior at which time he was elbowed in abdomen during a basketball game. His abdominal discomfort continued to gradually worsen and was associated with nausea, vomiting, early satiety and decreased appetite. He developed subjective fever, chills, night sweats, fatigue and epistaxis 3 days prior to presentation. CBC with differential revealed WBC 8 x 103/ul, RBC 4.50 x 103/ul, Hemoglobin 12.9 mg/dl, Hematocrit 38.2 %, Platelets 30 x 103/ul, elevated monocytes and nRBC's. EBV serology was positive for VCA IgG and Nuclear-antigen Antibody IgG, indicating past infection. Abdominal CT revealed marked hepatosplenomegaly with displacement of abdominal viscera. PET revealed heterogeneously increased FDG uptake in liver and spleen. Bone marrow showed increased cellularity, increased atypical lymphocytes with clustering, and sinusoidal infiltration. Lymphoid cells mainly expressed CD2, CD3 and CD8. Cells were negative for TdT, CD1a, and increase in Ki-67 expression. Bone marrow flow cytometry revealed predominance of atypical gamma/delta T cells. Cytogenetics revealed normal male karyotype. Based on imaging, bone marrow, and flow cytometry, diagnosis of HSCTL was made. The patient was treated with 4 cycles of Ifosfamide, Carboplatin and Etoposide (ICE). PET showed complete resolution of uptake in liver and spleen. Repeat bone marrow showed no residual disease. He underwent splenectomy and pathology revealed no evidence of residual T-cell lymphoma. The patient then underwent autologous SCT with BEAM (Carmustine-Etoposide-Cytarabine-Melphalan) conditioning. He remains in remission after transplantation.

Discussion: Although HSTCL is rare, recognition is important as it is aggressive, refractory to conventional therapies, and carries a uniformly poor prognosis. Conventional therapy consists of CHOP (cyclophosphamide-doxorubicin-vincristine-prednisone) with or without autologous stem cell transplantation (SCT). A novel approach reported by Hoss et.al with a non-CHOP induction therapy with or without splenectomy followed by autologous SCT may have better outcomes as demonstrated with our case.

DIULAFOY'S LESION – AN UNCANNY ETIOLOGY OF GASTROINTESTINAL BLEED

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Introduction: Dieulafoy's lesion is a relatively rare, but potentially life-threatening, condition. It accounts for 1–2% of acute gastrointestinal (GI) bleeding.

Case: A 99-year-old woman was initially admitted due to left lower extremity cellulitis related to chronic venous stasis ulcer and was receiving broad-spectrum IV antibiotics. Upon admission to the medical floor, she had an episode of hematemesis and multiple bowel movements with black-tarry stools. The patient denied chronic non-steroidal anti-inflammatory drug use. Her past medical history was significant for dyslipidemia and remote history of colon cancer status post colon resection. Home medications included atorvastatin 20 mg and aspirin 81 mg. Digital rectal exam demonstrated melenic stool in the rectal vault. Hemoglobin and hematocrit on admission were noted to be 12.1 g/dl and 40.7 % respectively which dropped to 8.1 g/dl and 28.3 % following her GI bleed. A rise on BUN was also noted from 14 mg/dl to 34 mg/dl. Platelets and INR were normal. She received fluid resuscitation with 2 liters of crystalloid and a total of 2 units of pack red blood cells. Emergent EGD revealed a protruding and oozing vessel surrounded by normal gastric mucosa located at the greater curvature of the stomach body. The lesion was covered by a prominent fresh clot, which was cleared. Endoscopic hemostasis was achieved with a combination of epinephrine injection followed by BI-CAP electrocautery. The patient had an uncomplicated post-operative course and hemoglobin remained stable.

Discussion: Given this patient's clinical presentation, an upper GI bleed was suspected. Based on the patient's advanced age and history of previous history of colon cancer, the initial differential diagnosis included peptic ulcer disease versus a GI malignancy. However, her EGD findings were consistent with a Dieulafoy's lesion. Dieulafoy's lesions are twice as common in men as compared to women. These lesions can occur in any age group are diagnosed more frequently in the elderly population. Dieulafoy's lesions should be included in the differential diagnosis of obscure GI bleeding in all age groups.

THREE'S A CROWD – AN EXTREMELY RARE CASE OF COR TRIATRIATUM DEXTER

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Introduction: Cor triatriatum is a congenital cardiac anomaly in which the left (sinister) or right (dexter) atrium is divided into two compartments by residual embryonic tissue, resulting in a tri-atrial heart. As cor triatriatum dextrum can present clinically in various ways and have multiple associated cardiac anomalies, this report attempts to contribute to what is known about this exceedingly rare disorder.

Case: A 40 year old Hispanic man with a medical history of gastritis presented with complaints of palpitations, dizziness and bilateral lower extremity edema. He was found to have atrial fibrillation and new onset heart failure. The patient was admitted for rate control and further evaluation, which revealed several cardiac anomalies. Initial 2D echocardiography demonstrated severe right atrial enlargement, right ventricular hypertrophy and an engorged coronary sinus, which prompted further assessment of the patient's cardiovascular anatomy. Transesophageal echocardiography (TEE) revealed a severely enlarged, septated right atrium with a possible unroofed coronary sinus and a small patent foramen ovale (PFO). Left- and right-heart catheterization established a coronary-cameral fistula between the right coronary artery (RCA) and right atrium, as well as left-to-right shunt. The patient improved clinically with conservative management including diet modification, furosemide and digoxin for fluid and rate control, and was referred to cardiothoracic surgery for further evaluation.

Discussion: Cor triatriatum dextrum is an extremely rare cardiac condition: In high-volume echocardiographic laboratories, prevalence is <0.01%. This case highlights the association between cor triatriatum and other congenital cardiac anomalies, including persistent left superior vena cava with an unroofed coronary sinus, PFO and left-to-right shunt; all of which were found in this patient. While cases of cor-triatriatum sinistrum often require correction in infancy (due to left sided heart failure, pulmonary edema and cyanosis), cor-triatriatum dextrum is sometimes diagnosed in adulthood due to the lack of left heart and pulmonary involvement.

A STRONG AND FORTUITOUS CASE OF DYSPNEA

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Case: A 48 year-old man with no past medical history was sent to our emergency department (ED) from a primary care clinic for hypertensive urgency of 200/130. The man reported an intermittent non-productive cough of approximately one year's duration and worsening dyspnea on exertion and orthopnea over the last month with lower extremity swelling. Of note, he emigrated from Honduras twenty years ago. Blood pressure normalized with administration of Lasix in the ED. Physical exam revealed rales in lung bases bilaterally, jugular venous distension, lower extremity pitting edema with serpiginous patches of erythema and excoriation, and a cardiac gallop. Labs showed peripheral eosinophilia, thrombocytopenia, elevated creatinine, hyperbilirubinemia, hyperglycemia, and mild transaminitis. Transthoracic echocardiogram revealed a dilated left ventricle with global hypokinesis and severely depressed systolic function with an ejection fraction less than 15%. The patient was diuresed, and subsequent left and right heart catheterizations were normal. CT chest showed a small nodule in the right upper lobe. Tests for Coccidiosis, Trypanosoma cruzi, and Mycobacterium tuberculosis were negative; however the acid fast bacilli culture grew Mycobacterium fortuitum. A Strongyloides stercoralis antibody test was positive, and the patient was treated with two doses of oral ivermectin with one dose of intravenous ceftriaxone, and discharged. Two months later, his eosinophilia resolved, but he remained symptomatic with productive cough and weight loss, and was started on an outpatient course of oral ciprofloxacin and trimethoprim-sulfamethozole for M. fortuitum.

Discussion: Strongyloides-infected patients may carry the parasite for years without prominent symptoms. Endemic throughout South America, Strongyloides persists in its hosts through a lifecycle of autoinfection, which, over time, increases parasite burden and can lead to a hyperinfection syndrome whereby filiariform larvae penetrate organ tissue, most commonly: heart, central nervous system, lungs and liver. We suspect chronic eosinophilia and disseminated filiaria to be the etiology of the non-ischemic dilated cardiomyopathy in this patient. Standard treatment of strongyloidiasis is ivermectin, however, mortality owing to transient bacteremia in the setting of hyperinfection syndrome is high. Therefore, bacteremia prophylaxis with gram negative rod coverage should be considered before antiparasitic agent initiation.

PURULENT PERICARDITIS DUE TO AN INFECTED PACEMAKER LEAD

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Introduction: Intravenous drug users have a substantially increased risk of infective endocarditis, especially in the setting of implanted cardiac devices. Purulent pericarditis is a rare occurrence that can occur iatrogenically or through direct or hematogenous spread.

Case description: A 75 year old man with a past medical history significant for hepatitis C, IV drug abuse, and sick sinus syndrome status post pacemaker was brought in by EMS with a chief complaint of diaphoresis and chest pain. Initial EKG revealed atrial fibrillation with ST elevations in multiple leads. The patient was taken urgently to the cardiac catheterization lab due to concern for STEMI. Left heart catheterization revealed nonobstructive CAD; bedside echo was significant for a pericardial effusion and a pacemaker lead vegetation. CT of the chest revealed extension of the ventricular pacemaker lead through the anterior right ventricular wall and pericardium and into the pleural cavity. Cardiothoracic surgery performed a pacemaker removal as well as pericardial window due to early tamponade; approximately 900 mL of purulent fluid was drained from the pericardial space. The patient was septic with initial blood cultures growing

MSSA. He was also found to have multiple other foci of infection including a left-sided pleural effusion and a perihepatic fluid collection, both of which were drained and also grew out MSSA. The patient initially improved on antibiotics after his pacemaker removal and drainage of the infected fluid collections. However, several days after the pacemaker removal he gradually became more bradycardic; due to his multiple comorbidities and active infection, he was not a candidate for a replacement implanted pacemaker. He became profoundly bradycardic and hypotensive overnight and died despite the use of multiple pressors to maintain his blood pressure as well as transcutaneous pacing to maintain his heart rate.

Discussion: Purulent pericarditis has become a relatively uncommon occurrence since the development of effective antibiotics. This case illustrates a rare example of purulent pericarditis and cardiac tamponade secondary to the extension of an infected pacemaker wire through the pericardium and into the thoracic cavity. The presence of multiple other infected fluid collections in this case also illustrates the need to thoroughly assess for secondary foci of infection in cases of bacterial endocarditis.

A CLOT (POSSIBLY) DUE TO LOSS OF TNF-α SUPPRESSION

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Introduction: Inflammation and venous thrombosis enjoy a close Relationship. We present a patient who had multiple DVTs following the discontinuation of anti- TNF-α therapy.

Case: A 34 year old African American female with a history of multiple DVT's, miscarriages, and reported Crohn's disease presented with shortness of breath. In the Emergency Department, CTA showed bilateral pulmonary emboli. The patient had been off adalimumab for one year and reported abdominal pain with 6-7 non-bloody bowel movements daily. She had been prescribed lovenox for her unprovoked DVTs yet reported missing several doses prior to admission. Following admission, she developed severe abdominal pain prompting an emergent CT angiogram and she then developed a pulseless painful left lower extremity. CT revealed a partially occlusive thrombus in the infra-renal abdominal aorta, proximal left common iliac artery, and right renal artery with subsequent right renal infarction. Following emergent vascular surgery to restore blood flow to the left lower extremity, the patient received four days of plasma exchange and high dose steroids for potential catastrophic antiphospholipid syndrome. Serology for APLA was negative. The patient was discharged with lifelong anticoagulation.

Discussion: The endothelial surface is a complex organ that works in concert with the surrounding environment. Inflammation and thrombus formation is closely associated. TNF-α can increase the expression of adhesion molecules, specifically, tissue factor, on the surface endothelial cells and promote thrombosis. Suppression of TNF-α expression by low molecular weight heparin has been shown to inhibit the inflammatory cascade and reduce thrombus formation in animal models. Clinical data is less clear. Interruption of TNF blockers has been shown to increase the risk of DVT in patients with rheumatoid arthritis undergoing orthopedic surgery. For patients with Bechet's syndrome, anti-TNF agents appear help treat patients with pulmonary artery thrombosis. Further review of anti-TNF-α therapy in our general medicine patient population may disclose additional risks associated with discontinuation of these medications.

CASE REPORT OF SARCOIDOSIS AS A GREAT MIMICKER IN VARIOUS POPULATIONS

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Introduction: The prevalence of sarcoidosis varies as much as 1-40 cases per 100,000 depending on region and population. Sarcoid typically occurs in people younger than 50 years old, with a peak incidence with ages between 20 and 40 years old. African Americans are 3 times more likely to develop sarcoidosis than Caucasian Americans, and woman are more likely than men to develop sarcoidosis in any ethnic group; nonetheless, it remains a valid differential across any population.

Case: A 32 year old Hispanic man presented to the Emergency Department with night sweats, fatigue, and 35 pound unintentional weight loss over the last several weeks. He also reported a sore throat, occasional cough w/ yellowish sputum, and new onset dyspnea with exertion. He moved from Mexico to the U.S. 20 years prior and last visited the country 7 yrs ago. He never smoked and denied any TB exposure. His vitals at admit demonstrated tachycardia (pulse 108) and temperature of 99.4 ^{O}F. He had coarse bilateral breath sounds on exam. Serum chemistries were unremarkable. Chest radiograph demonstrated perihilar fullness. Chest CT revealed enlarged mediastinal and perihilar LAD and airspace consolidation in right middle and lower lobes bilaterally. The patient was admitted to a negative pressure room w/ airborne precautions and RIPE therapy was initiated. PPD and AFB's were negative. He underwent bronchoscopy and was discharged on RIPE. Lung biopsy showed non-caseating granulomas. RIPE therapy was stopped, and he was referred to ophthalmology to rule out uveitis. Cultures from the procedure were negative for fungal growth, and he was started on prednisone 40 mg daily with taper 6 weeks later as his weight returned, night sweats subsided, and dyspnea on exertion improved.

Discussion: Sarcoidosis should be considered as a diagnosis in any gender of any racial or ethnic group. Sarcoid is a great mimicker of many serious illnesses including malignancies such as lymphomas, TB and atypical mycoplasma, fungal infections, and other granulomatous diseases, and other autoimmune disorders such a hypersensitivity pneumonitis. Diagnosis requires patient investigation and careful analysis of these differentials.

PHEOCHROMOCYTOMA OF THE ORGAN OF ZUCKERKANDL: A CASE REPORT

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Introduction: Pheochromocytomas (PCCs), or intra-adrenal paragangliomas (PGLs), are neuroendocrine tumors arising within the adrenal medulla. Extra-adrenal paragangliomas may arise in the sympathetic or parasympathetic paraganglia and more rarely in other organs. One of the most common extra-adrenal sites is in the organ of Zuckerkandl, a collection of chromaffin cells near the origin of the inferior mesenteric artery or near the aortic bifurcation. The following is a case of a patient with resistant hypertension secondary to an extra-adrenal paraganglioma in the organ of Zuckerkandl.

Case: The patient is a 43 year old man with a history of depression, type 2 diabetes mellitus, and hypertension who was sent to the emergency department by his primary care physician for severely elevated blood pressures. Patient also had diaphoresis, tachycardia, and a new, fine tremor of his left hand. Upon presentation, the patient's blood pressure was 260/120 mmHg with a heart rate of 140 beats per minute. Plasma fractionated metanephrines sent on admission revealed significantly elevated levels of total plasma metanephrines (2558 pg/mL), free metanephrine (74 pg/ml) and free normetanephrine (2484pg/mL). An I-123 metaiodobenzylguanidine (MIBG) scan showed abnormal uptake in the lower abdomen at the level of the aortic bifurcation. Patient was started on alpha-blockade, with subsequent addition of a beta-blocker prior to surgery. Patient underwent surgical removal of the tumor with pathology consistent with a paraganglioma.

Discussion: Pheochromocytomas and paragangliomas are responsible for approximately 0.5% of cases of secondary hypertension. Many different biochemical markers have been used to aid in the diagnosis of PCC/PGL including plasma catecholamines, plasma metanephrines, urine fractionated metanephrines, urine catecholamines, total metanephrines and vanillymandellic acid. Definitive management of a PCC and PGL involves surgical removal of the tumor. Finally, there should be a discussion with each patient to determine if he or she should undergo genetic testing, as studies show that approximately 25% of catecholamine producing PCCs and PGLs are due to heritable genetic mutations.

A RARE CASE OF TROPICAL PYOMYOSITIS ACQUIRED ON VACATION IN A HEALTHY MALE

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Introduction: Pyomyositis has traditionally been considered a tropical disease. Increasing prevalence has been observed in more northern climates, especially with HIV, immunosuppression, and IV drug abuse as predisposing factors. Pyomyositis has the tendency to mimic other conditions, such as muscle contusion, necrotizing fasciitis, or septic arthritis. The rarity of this disease and non-specificity of its symptoms often lead to delay in appropriate diagnosis and treatment.

Case: 24-year-old man, seen 2 days prior in orthopedics clinic and the Emergency Department for persistent gluteal pain thought to be due to right-sided sciatica, was admitted following worsening pain, diffuse generalized weakness with polyarthralgias and myalgias These symptoms were associated with night sweats, shaking chills, and difficulty walking. Prior to onset of symptoms, the patient vacationed in Cayman Islands and experienced a stingray bite on his right hand as well as numerous cuts on rocks in stagnant waters. He was febrile with WBC count of 18.7 K/μL and was found to have methicillin-sensitive Staphylococcus aureus (MSSA) bacteremia. Magnetic resonance imaging (MRI) of his lumbar spine on admission was unremarkable. Repeat MRI 4 days later showed extensive inflammation within musculature with multiple abscesses around right sciatic foramen and septic arthritis of the sacroiliac joint. The patient was subsequently diagnosed with MSSA septic polyarthritis and required several orthopedic procedures. Infectious and oncologic work up was unremarkable. Transesophageal echocardiogram showed 0.3 cm x 0.5 cm aortic valve vegetation, which was managed medically. Repeat MRI 11 days after initiation of appropriate antibiotics and surgeries showed improvement in muscular edema. Based on the MSSA susceptibilities, the patient was treated with 6 weeks of intravenous cefazolin and 2 weeks of oral cephalexin thereafter.

Discussion: Awareness of tropical pyomyositis in colder climates remains scarce, although cases have been reported in immunosuppressed patients. However, in healthy patients, accurate history of travel and trauma is important in evaluation for predisposing factors for pyomyositis. Early antibiotic and appropriate surgical interventions are imperative for management of this disease in order to prevent systemic toxicity, dissemination of infection, and long-term debility.

WHAT THE EYES DON'T SEE, THE HEART DOES GRIEVE OVER

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Case: A 71 year old Peruvian woman presented with blurry vision and bilateral eye pain and had evidence of bilateral endophthalmitis on eye examination. Her past medical history was notable for multiple abdominal surgeries within the preceding months, including an incarcerated inguinal hernia repair which required an ileostomy placement, and cholecystitis requiring cholecystostomy tube placement. Over her multiple long hospitalizations, she developed bacteremia and fungemia on several occasions, with organisms including Enterobacter cloacae, Klebsiella pneumoniae, Bacteroides fragilis, Pseudomonas aeruginosa, Enterococcus faecium, and Candida

albicans. On exam, she was febrile and tachycardic. She had bilateral conjunctival injection, hypopyon, and severely decreased visual acuity. She also had a III/VI harsh holosystolic murmur at the apex. Her lungs were clear to auscultation. Transesophageal echocardiogram revealed severe mitral regurgitation and a 16 x 15 mm mitral valve vegetation and a perforated aneurysmal posterior mitral valve leaflet. The patient underwent bilateral vitrectomy and was treated with flucytosine and ambisome. Blood and vitreous humor cultures were obtained, but remained negative, likely due to being drawn after the patient had been empirically treated with antifungals and antibiotics. She continued to spike fevers and developed heart failure, but refused valve replacement surgery as she wished to return to her home country.

Discussion: A systemic source of infection should be sought in the presence of bilateral endophthalmitis. In our case, we suspected seeding from endocarditis or an intra-abdominal infection, given the patient history of multiple complicated abdominal surgeries and recurrent bacteremia and candidemia. Based on the vegetation's large size and bilateral endophthalmitis, we believed Candida was the most likely culprit. Additionally, eye lesions observed during surgery appeared consistent with fungal endophthalmitis. Candida is a rare but very morbid cause of infective endocarditis. Arterial embolization and metastatic infections such as endophthalmitis are more frequent in candidal endocarditis, likely due to the generally larger vegetation size. Valve replacement should be strongly considered regardless of other factors, as some studies have shown a mortality benefit for antifungals and surgery compared to antifungals alone. In cases in which valve replacement is not feasible, the patient should be kept on lifelong suppressive antifungal therapy.

MISSED OPPORTUNITY: TOF DIAGNOSED IN 4TH DECADE OF LIFE

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Introduction: Tetralogy of Fallot (ToF), the most common cyanotic heart disease after infancy, has a 3% survival rate at 40 years without surgical intervention. Although most cases are diagnosed in infancy, patients can less commonly go undiagnosed into adulthood. Clinicians in the primary care setting may unknowingly encounter these patients while caring for their other chronic illnesses.

Case: A 40 year old woman with a history of HIV, congestive heart failure secondary to an unknown congenital heart defect, and hypertension presented to our emergency department with worsening edema. On room air, oxygen saturation was 55%. On 5L of oxygen via nasal cannula, oxygen saturation was 88%. Physical examination was notable for central cyanosis, facial and lid edema, a II/VI holosystolic murmur across right chest radiating to entire right back hemithorax, decreased breath sounds at bases with pulmonary crackles, clubbing of fingers and edema of bilateral lower extremities. The patient related lifelong knowledge of a congenital heart defect, but had not been seen by a cardiologist as an adult. She was asymptomatic, yet sedentary until one year ago when she had the first of multiple hospitalizations for acute decompensated heart failure. A chest x-ray showed massive cardiomegaly with right-sided calcified aortic arch and patchy bilateral infiltrates. Transthoracic echocardiogram revealed severe right ventricular hypertrophy, ventricular septal defect, overriding aorta, and ejection fraction of 50%, consistent with unrepaired ToF. We utilized multimodality imaging techniques including CT angiography and Cardiac MRI which further defined her cardiac anatomy. Findings were consistent with unrepaired ToF with pulmonary atresia. The pulmonary arteries arose directly from the aorta in a confluent fashion via a large patent ductus arteriosus, major aortopulmonary collateral artery. The arterialized pulmonary arteries were aneurysmal with dissection and mural thrombus formation.

Discussion: This case illustrates how a patient with a rare presentation of unrepaired ToF with pulmonary atresia can go undiagnosed into adulthood. Early recognition utilizing a multimodality imaging approach can lead to proper diagnosing and hopeful surgical repair which can provide considerable improvement in functional status and long-term survival.

A RARE CAUSE OF ABDOMINAL PAIN

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Case: A 54 year old woman with hypothyroidism presented with right flank pain that began acutely one week prior to presentation. She was told initially she had a urinary tract infection and treatment resulted in mild symptomatic improvement. The pain returned and she presented to another Emergency Department (ED) and was told the pain was due to constipation. She returned to the ED the next day when her pain worsened and her labs were notable for WBC of 19,000/uL, BUN/Cr of 28/0.75 mg/dL, AST of 31 U/L, ALT of 92 U/L and total bilirubin of 0.6 mg/dL. RUQ ultrasound was notable for dilation of the common bile duct. Given concern for choledocholithiasis, she was started on cefepime and metronidazole. MRCP demonstrated a distended gallbladder without stones and a small amount of pericholecystic fluid. Also noted were two areas of increased signal in the right kidney, concerning for neoplasia or infarction. Contrasted abdominal Computed tomography showed a moderate size area of hypodensity, consistent with renal infarct. Workup for embolic source of the infarction was unrevealing. Renal artery angiogram demonstrated a spontaneous dissection of the superior branch of the right renal artery. PCI was not performed due to risk of jeopardizing the other vessels and so she was managed medically with rivaroxaban along with hydrochlorothiazide and metoprolol succinate to keep her systolic blood pressure below 140 mmHg. The morning after the procedure, the patient told the treatment team that her grandson liked to jump from a height and she would catch him on her right side. This was felt to be a likely etiology of her spontaneous dissection. At the time of discharge, her pain was improved and repeat angiogram performed eight weeks later noted healing of the dissection.

Discussion: Spontaneous renal artery dissection is a rare cause of abdominal pain and often presents a diagnostic and therapeutic challenge. This case highlights the importance of considering alternate etiologies of localized abdominal pain when other common pathologies have been excluded.

WHAT CAN ERODE THROUGH LUNGS, BONE AND SKIN?

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Case: A 51 year old African American Man without significant past history presented with three weeks of persistent cough productive of copious yellow sputum. He denied fevers, chills, hemoptysis, dyspnea, weight or appetite changes, sick contacts, recent travel. On physical examination, the patient was afebrile and appeared comfortable. He had decreased air entry of the left lower lobe with dullness to percussion. A 5x3 cm fluctuant mass was incidentally found on the left anterior chest wall at the level of the 11th rib with yellow expressible exudate at which time the patient reported a minor trauma sustained 3 weeks prior.

WBC count was 17,300/mcL. CT chest identified a peripherally enhancing fluid-attenuation structure in the left lower lung measuring 11.8 cm x 11.3 cm x 9.6 cm. The collection appeared to be tracking out from the pleural space to the exterior skin that corresponded to the site of the chest wall swelling. There was also a focal lytic lesion of the adjacent ribs. He was empirically started on Vancomycin, clindamycin and piperacillin-tazobactam. CT-guided aspiration failed because the material was too viscous to be aspirated; a chest tube drained copious yellow exudate. Blood cultures and respiratory cultures were negative. Gram stain of the purulent material demonstrated clusters of branching gram positive rods. Pathology showed necrotic debris with clusters of filamentous gram negative organism. Acid fast and Kinyoun stains were negative. He was started on empiric Penicillin G for empyema necessitans with a presumed etiology of actinomyces. Due to development of hypersensitivity drug eruption from PCN, intravenous doxycycline was started for total of 14 days followed by 6 months of oral therapy. Imaging four weeks after treatment showed significant reduction in size of the lesion. Culture confirmed Actinomyces israelii.
Discussion: Actinomyces are anaerobic gram positive commensals of the oral cavity notorious to breach though tissue planes. Thoracic manifestations are varied and can mimic malignancy. Astute microbiology and pathology tests are necessary to make an early diagnosis and prevent invasive surgery as the organism is a slow growing anaerobic bacteria. Excellent clinical and radiologic response were noted in our case following treatment with chest wall drainage and antibiotics thus avoiding invasive thoracic surgery.

A LEFT MAIN CORONARY ARTERY THROMBUS PRESENTING AS A NON ST ELEVATION MI

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Introduction: Left main coronary artery (LMCA) thrombus with an acute myocardial infarction identified with coronary angiography is a clinically rare condition with an extremely high mortality rate. We present a case of LMCA thrombus that presented as a non-ST elevation myocardial infarction (NSTEMI).

Case: A 45-year-old woman with a history of tobacco use and hyperlipidemia presented with a complaint of 10/10 "hard pain" across her chest radiating to her left shoulder and breast which woke her from sleep. The pain was constant and severe, with no alleviation with rest. She had not experienced anything like this before. Workup revealed an upward trending troponin (1.9→8.98→9.79), and an EKG with some tachycardia but no ST elevation or T wave changes. Her CBC, CMP and coagulation studies were unremarkable. A toxicology screen was positive for opiates and benzodiazepines, medications she was on for pain and anxiety respectively. ACS protocol was started with DAPT, LMWH, Statin, ACEi, and Beta-blocker. An angiogram revealed a large thrombus in the LM coronary artery extending into the aorta with concomitant 99% stenosis of distal LAD. 2D Echo w/ bubble contrast was significant for PFO, akinetic apical inferior and anterior wall. The mid antero-septum and apical lateral wall were hypokinetic. Interventional Cardiology and CTS recommended conservative management with medical optimization (Continue DAPT, heparin), watchful waiting for the thrombus to resorb.

Discussion: Left main coronary artery thrombosis (LMCAT) identified during coronary angiography is a rare and challenging condition. It is a life threatening condition with an approximate incidence rate of 0.8%. It is thought to be secondary to plaque rupture with subsequent thrombus formation that is associated with persistent hypercoagulable state, cocaine induced plaque rupture or coronary vasospasm, post-partum state and embolization of intra-cardiac masses. The patient presentation can vary from sudden cardiac death to STEMI, NSTEMI, unstable angina and cardiogenic shock. Standardized therapy has not been developed due to the small number of reported cases.

RECURRENT HYPERTRIGLYCERIDEMIC PANCREATITIS (HTGP) AND THE USE OF INSULIN DRIP AS TREATMENT

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Introduction: Chronic pancreatitis by definition is a recurrent episode of acute pancreatitis and is commonly associated with alcoholism in the US. Another cause of chronic pancreatitis is hypertriglyceridemia (HTGP), occurring in 1-5% of cases. The incidence of HTGP is higher in patients with diabetes and HIV, usually requiring triglyceride levels > 1000 mg/dL.

Case: A 33 year old man with uncontrolled type 1 diabetes and recurrent pancreatitis, first diagnosed 5 years prior, presented as a transfer from an outside hospital for a recurrent episode of HTGP. He reported recurrent pain episodes, requiring 6-9 hospitalizations within the last year for pancreatitis. He reported poor compliance with his insulin regiment at home. Other home medications included gemfibrozil, lisinopril, niacin, and omega-3 fatty acid. On transfer, his glucose was 296, triglyceride level was >3600, and A1C of 12.4. Transfer report lab work showed a triglyceride level >7000 and a lipase of 600. The patient had severe, diffuse abdominal tenderness on examination. He was diagnosed with pancreatitis secondary to hypertriglyceridemia due to a lipoprotein metabolism disorder and long-standing uncontrolled DM1. An intensive insulin drip was started on this patient, with goals of correcting his TG to <500 along with lowering his glucose. After 13 days, mostly on insulin drip, his TG decreased to 995 and pain was controlled, eventually tolerating a diabetic diet. He was encouraged to modify his diet and take his medications as directed at discharge.

Discussion: The relationship between hypertriglyceridemia and pancreatitis is poorly understood. In HTGP, a decrease in triglyceride concentration is a management priority. Rapid triglyceride concentration lowering is managed by insulin or plasmapheresis. As HTGP often presents in patient with uncontrolled diabetes, insulin is frequently used as treatment to lower both blood glucose and triglycerides; insulin decreases serum triglyceride levels by enhancing lipoprotein lipase activity and inhibiting hormone sensitive lipase, accelerating metabolism and decreasing adipocyte breakdown. Patients should be educated on the importance of compliance with drug therapy and lifestyle modifications.

WHO SHOT THE CANNONBALLS? EXTENSIVE LUNG METASTASES IN A 39 YEAR OLD MAN

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Case: A 39 year-old man presented to the emergency department complaining of a cough of 2 months in duration. He also complained of weight loss of 20 pounds in two months and night sweats over the same period. An x-ray of the chest was performed and revealed innumerable lung nodules and masses. Computed tomography of the chest and abdomen were subsequently performed which confirmed the masses, but imaging did not reveal an obvious primary source. A testicular exam was performed but no obvious abnormalities were noted. Because of his age as well as the appearance of the lesions, a testicular ultrasound was then performed. The ultrasound found evidence of a 1.5 cm hypoechoic mass on the right testicle with dystrophic calcification in the interpolar region. Urology performed a right radical inguinal orchiectomy. Pathology demonstrated a malignant mixed germ cell tumor with seminoma and yolk sac components being prominent. He underwent four cycles of etoposide, ifosfamide, and cisplatin. His last positron emission tomography scan did not demonstrate active disease.

Discussion: Each year about 8700 men are diagnosed with testicular cancer. 75% of these occur between the ages of 20 to 44, and the median age of diagnosis is 33. Testicular cancer should be suspected when a young male presents with metastatic disease such as in this case. In this patient, the genital exam was normal due to the small size of the testicular mass, but he had significant metastatic lesions. When cannonball metastases are seen on imaging, germ cell tumors and renal cell carcinoma should be high in the differential diagnosis.

ASSOCIATION OF STATE-MANDATED ABSTINENCE-ONLY SEXUALITY EDUCATION WITH RATES OF ADOLESCENT HIV INFECTION AND TEENAGE PREGNANCY

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Introduction: Abstinence-only sexuality education (AOSE) is required in the public school systems of many states, raising public health concerns and perpetuating health disparities through school systems. This study aimed to determine the correlations between state-mandated AOSE and the rates of adolescent HIV and teen pregnancy.

Methods: Using publicly available data on all 50 United States' laws and policies on AOSE, states were ranked according to their level of abstinence emphasis on sexuality education (Level 0 – Level 3). We calculated the relative proportion of Black students in public schools and the proportion of families below the federal poverty line then ranked them by state. We compared the states' ranks to the incidence of adolescent HIV and teen pregnancy in those states to identify associations between variables.

Results: The majority of states (~44%) have legally mandated AOSE policies (Level 3) and adolescent HIV and teen pregnancy rates were highest in these Level 3 states. There were significant, positive correlations between HIV incidence rates of 13-19 year olds, HIV rates of 20-24 year olds, teen pregnancy rates, and AOSE level, with the proportion of the population that lives below the federal poverty level, and whether they attended schools that had a greater than 50% of an African American population.

Discussion: These data show a clear association between state sexuality education policies and adolescent HIV and teen pregnancy rates not previously demonstrated. Our data further show that states that have higher proportions of at-risk populations, with higher adolescent HIV and teen pregnancy rates, are more likely to also have restrictive AOSE policies. These populations may be more likely to attend public schools where AOSE is taught, increasing their risk for HIV and teen pregnancy. The World Health Organization considers fact-based Comprehensive Sexuality Education a human right, and the authors believe it is past time to end harmful, discriminatory sexuality education policies in US public schools.

SEVERE SEPSIS AND SEPTIC SHOCK CASES MEETING GUIDELINES AMONG PATIENTS IN A UNIVERSITY HOSPITAL SETTING

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Background: A diagnosis of severe sepsis or septic shock has been shown to significantly increase mortality rate independent of other factors. Research has revealed all cause hospital case fatality rates have declined yet the percentage of severe sepsis cases continues to increase and age-adjusted mortality rates from severe sepsis and septic shock has significantly increased during the same time period. Patients with severe sepsis demonstrate ongoing mortality rate increases for up to 2 years following hospitalization when compared to aged matched controls of non-septic patients. International guidelines with mortality benefit for the management of severe sepsis and septic shock have been illustrated in the latest surviving sepsis campaign.

Objective: The objective of this study was to increase the percentage of patients admitted to the hospital with a diagnosis of severe sepsis or septic shock who met guidelines based on surviving sepsis campaign.

Methodology: A retrospective chart review was conducted for patients admitted to UHC from January 2016 to present to identify cases with a diagnosis of severe sepsis or septic shock, and whether they met guidelines set forth by surviving sepsis campaign both before and after an intervention program which included interviews with providers failing to meet protocol, educational sessions on guidelines to meet protocol, resident led quality improvement workshops to address barriers to meeting protocol, and development of an EMR power plan to assist providers on meeting protocol.

Results: 139 cases with a diagnosis, or meeting criteria for, severe sepsis or septic shock were identified during the period of 1/1/2016-9/30/2016 with an average of 43% of total cases which met guidelines. Trend analysis revealed increased compliance following resident lead intervention program with 31% and 49% before and after intervention, respectively. ICU data is currently being analyzed for meeting guidelines and have not been included in current data. The most common reason for failing guidelines was failure to obtain or repeat lactic acid on time (46%) and failure to give timely antibiotics (22%).

Conclusions: The percentage of patients admitted to the hospital with a diagnosis of severe sepsis or septic shock at UHC meeting guidelines set forth by surviving sepsis campaign has improved following resident lead intervention program. Intervention strategies to further improve compliance with guidelines with a goal >60% are currently being analyzed.

DISSEMINATED CRYPTOCOCCAL DISEASE WITH DIFFUSE PULMONARY INFILTRATES IN A NON-HIV HOST

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Introduction: We present a case of disseminated Cryptococcus in a non-HIV host, where the primary manifestation was pulmonary with diffuse pulmonary infiltrates. This patient was on high dose corticosteroids for autoimmune hemolytic anemia.

Case: A 79 year old Caucasian man with a history of autoimmune hemolytic anemia on 100 mg of prednisone daily, coronary artery disease s/p bypass surgery, ischemic cardiomyopathy, chronic obstructive pulmonary disease, sleep apnea, chronic kidney disease, and history of bilateral pulmonary emboli presented to Hematology/Oncology clinic with symptoms of productive cough, worsening shortness of breath, hemoptysis. Anticoagulation had been stopped due to symptoms. The patient was referred to the emergency department from clinic where a chest CT demonstrated numerous calcified lymph nodes and diffuses grand glass opacities worse on the right and new compared to imaging from 6 months prior. The patient was placed on empiric antibiotics for treatment of pneumonia after blood and sputum cultures were obtained. Initial blood cultures grew Cryptococcus neoformans in both sets. CSF obtained by Lumbar puncture was negative for Cryptococcal. Serum Cryptococcal antigen titer was 1:2560. Infectious disease was consulted and the patient was started on induction therapy with liposomal Amphotericin B, followed by Fluconazole consolidation therapy. Hematology/Oncology reduced the patient's prednisone dose gradually but further complications attributed to corticosteroids eventually necessitated the need to transition to Rituximab therapy. Follow up imaging on return to pulmonary clinic demonstrated marked improvement in the bilateral infiltrates.

Discussion: This patient was unique in that he demonstrated disseminated Cryptococcus but lacked neurologic complications, which is often how disseminated disease is clinically suspected. Blood cultures resulted positive for Cryptococcus and appropriate antifungal therapy was initiated before other sites were affected. The patient was HIV negative and not a post-transplant patient but was on high dose chronic prednisone for his AIHA, and therefore immunosuppressed. Opportunistic and atypical infections should be considered in all immunosuppressed patients to aid in earlier diagnosis and prevention of further dissemination of disease and further complications.