Citywide Infectious Disease Conference

March 27th, 2018

Cooper Medical School of Rowan University

Cooper University Hospital

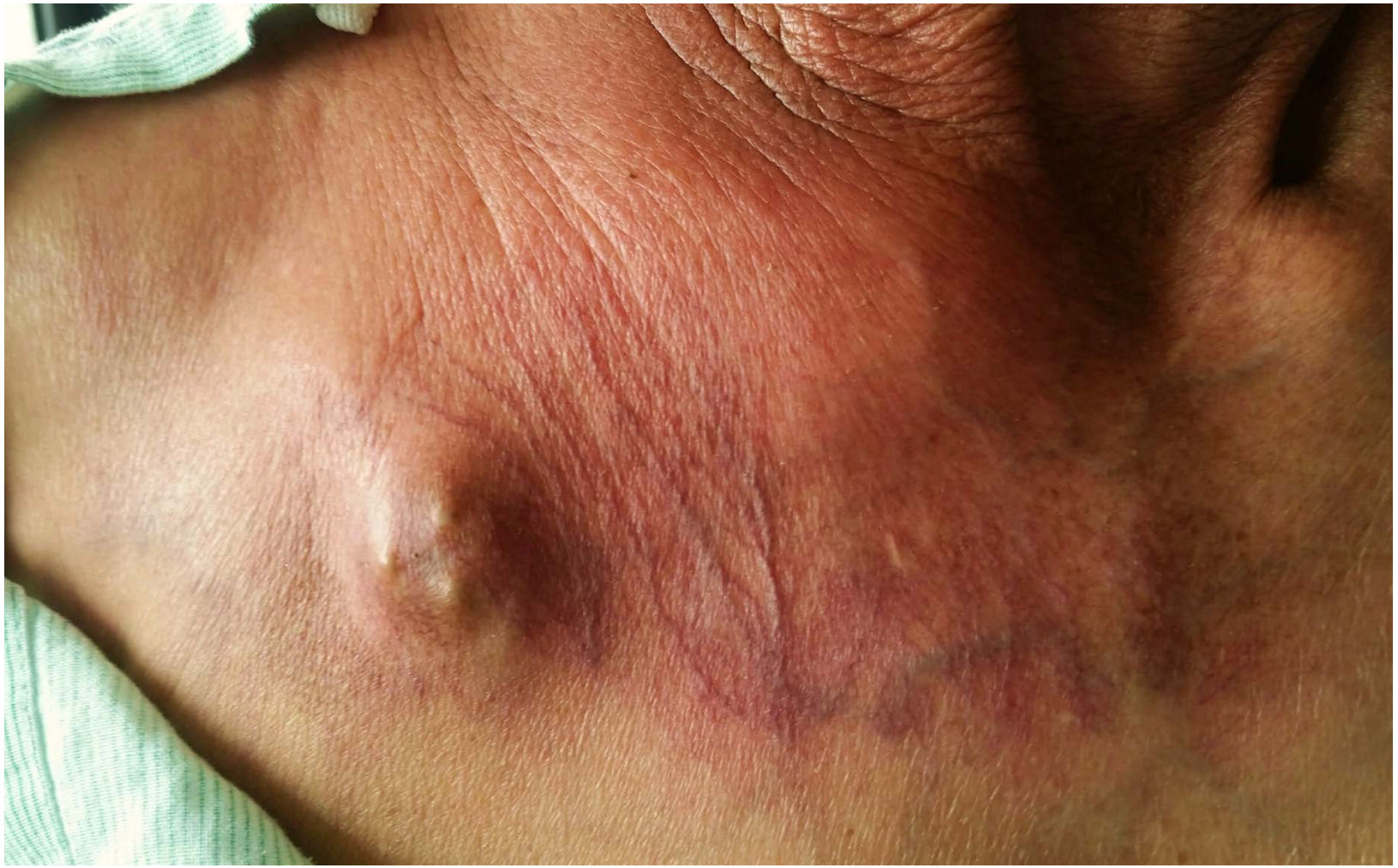
Citywide Show and Tell

Case 1 Summary

- 60’s year old Puerto Rican born man
- SCC of Esophagus, treated with radiation and chemotherapy and then esophageal pull thru in 2013
- Right chest wall port
- Disease progression in October 2016
- Several Chemotherapy regimens – most recently Docetaxol

Case 1 Summary

- Admitted 7/10 with low grade fever to 100.8 and abrupt onset of erythema and induration in the same place, one large, tender LN
- WBC 19K with left shift(post pegfilgrastim)
- Started on vancomycin and cefepime
- CAT scan
  - infiltration and mild thickening of the right SCM muscle, slightly more advanced than the study from June, no discrete collection
  - Right centrally necrotic Lymph nodes



Case Summary

- Prior episodes of right neck and chest wall erythema and induration with low grade fever
- Hospitalized each time, exam: “non toxic, painful and erythematous right neck and upper chest wall”
- Received a variety of different antibiotics
- Most recent episode June→ Rx vancomycin and discharged on TMP-sulfa and Keflex, slow resolution
- He reports onset “three weeks” after getting his chemotherapy treatments through his port
- Received his most recent cycle of Docetaxol on June

Radiation Recall

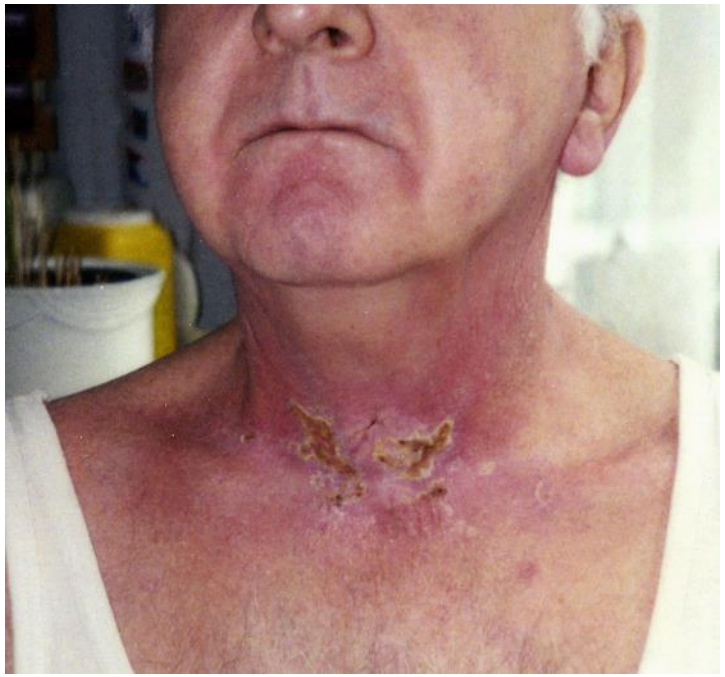
Radiation recall “dermatitis” or “phenomenon”

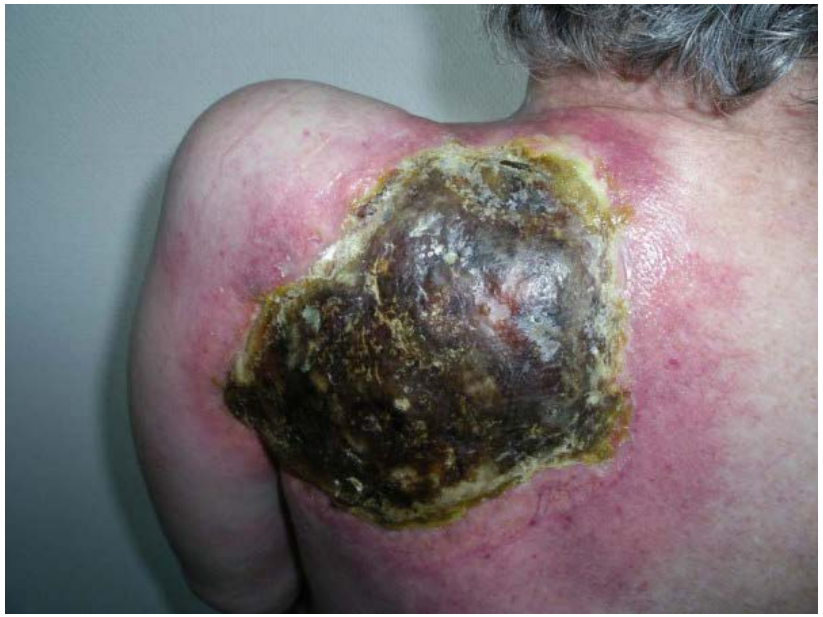
“*Radiation recall is an acute inflammatory reaction confined to previously irradiated areas that can be triggered when chemotherapy agents are administered after radiotherapy. It remains a poorly understood phenomenon*…” Burris, The Oncologist, 2010

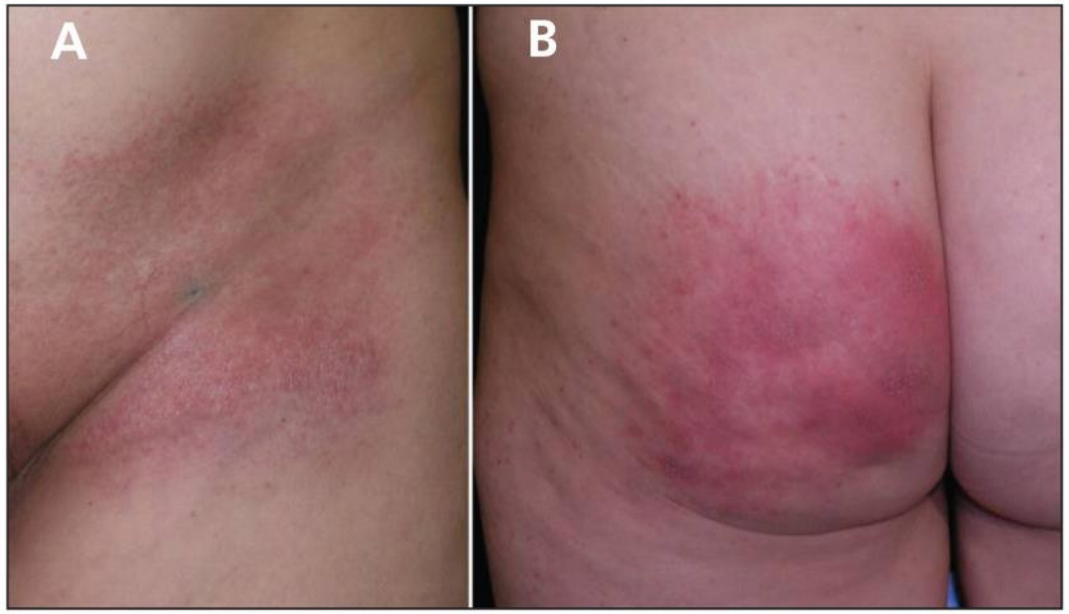
Variable time between radiation and chemo, time after administration of chemo, mechanism unknown- class effect? Regimen effect? No predictive features

Docetaxel one of most commonly implicated agents but still relatively rare: in one study 3 of 171 patients (1.8%)

Management: Stop drug, ? Corticosteroids for severe?



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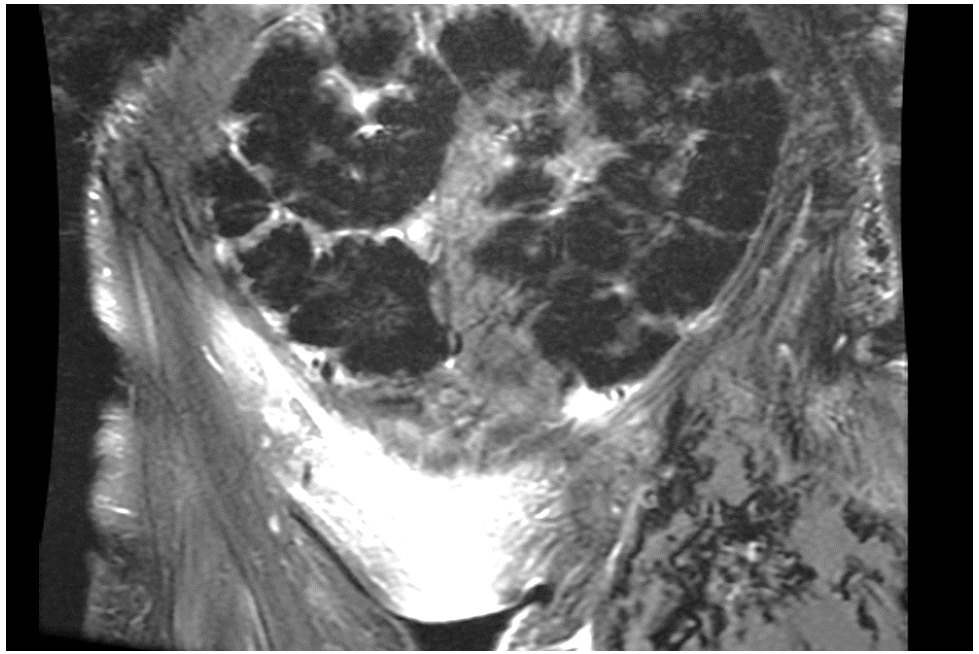
Case 2: The Case of the Missing Spleen



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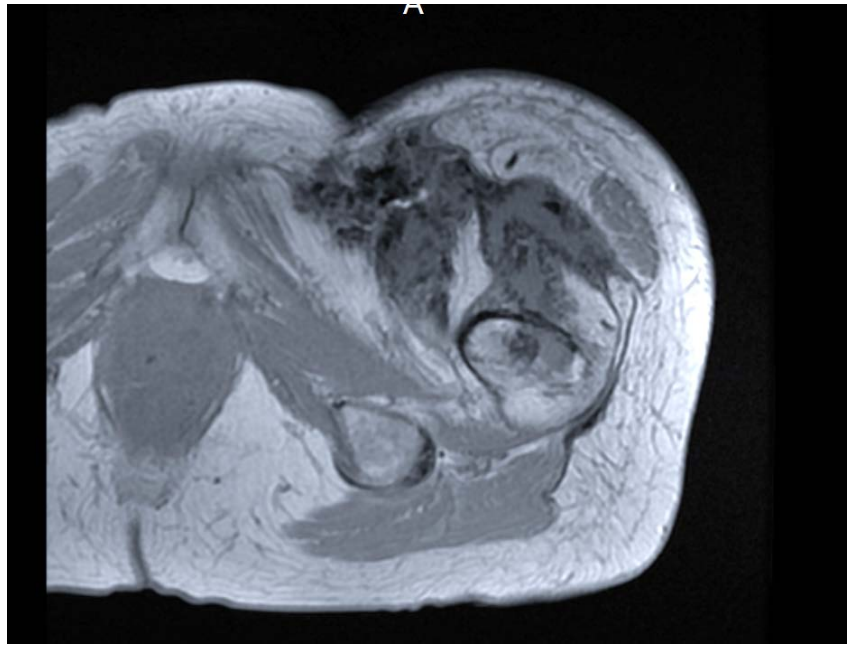

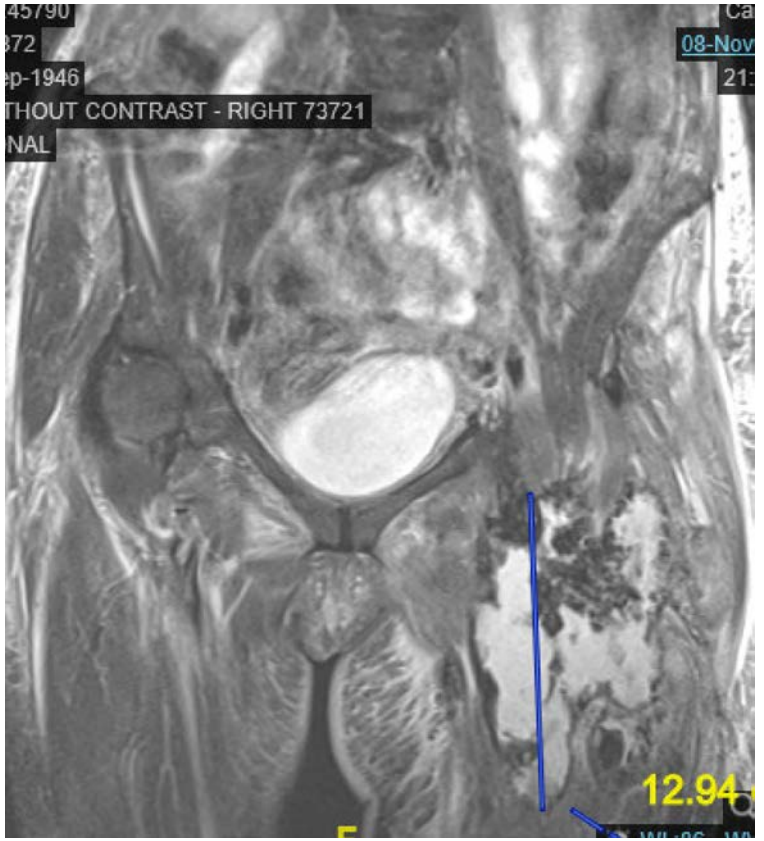

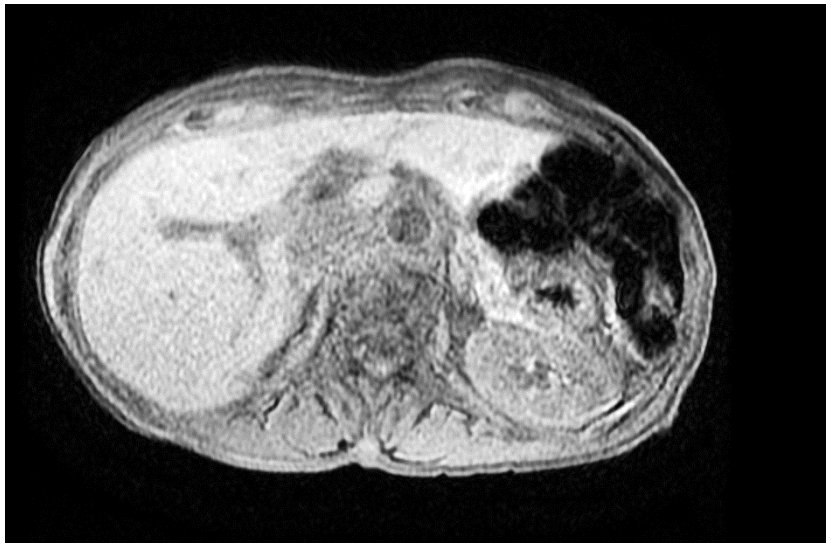

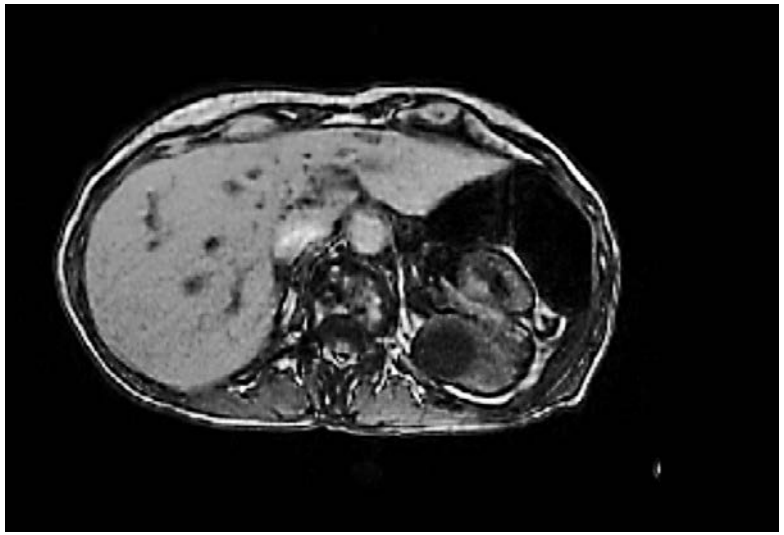

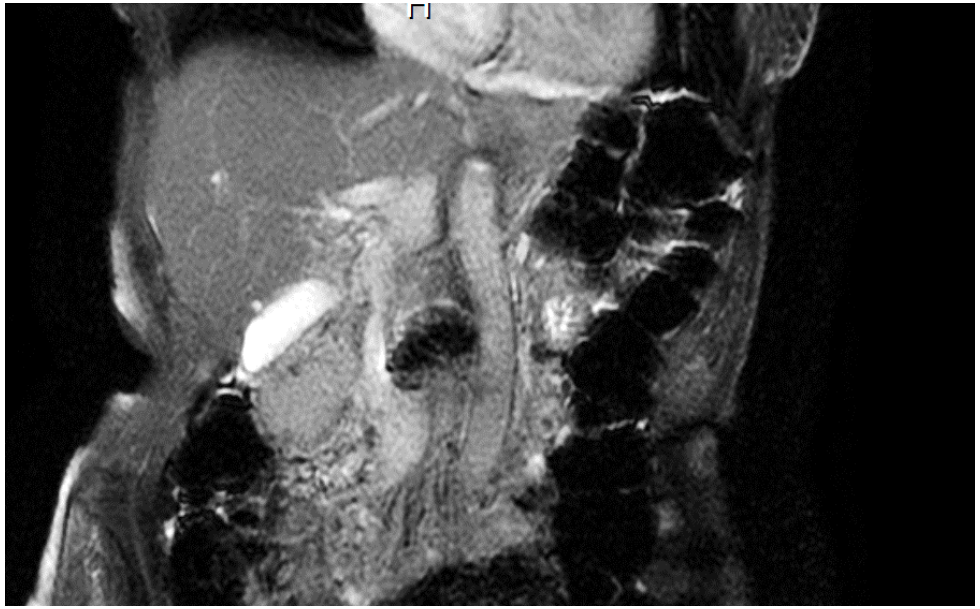

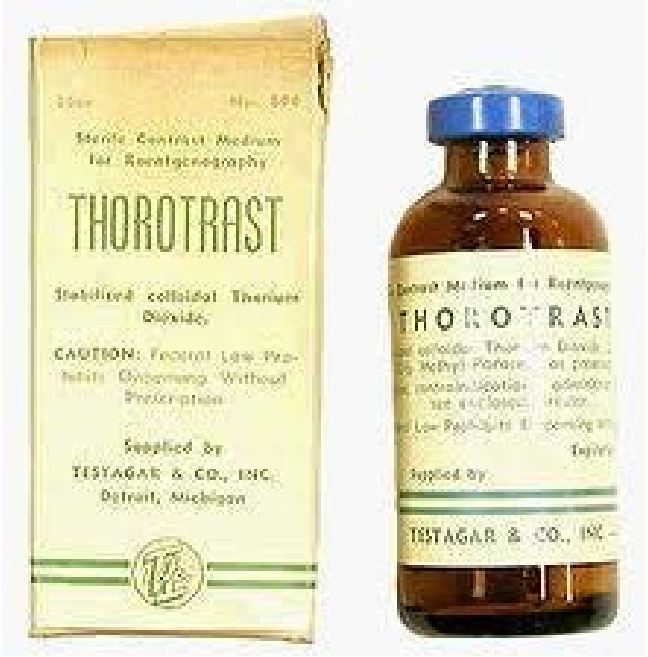
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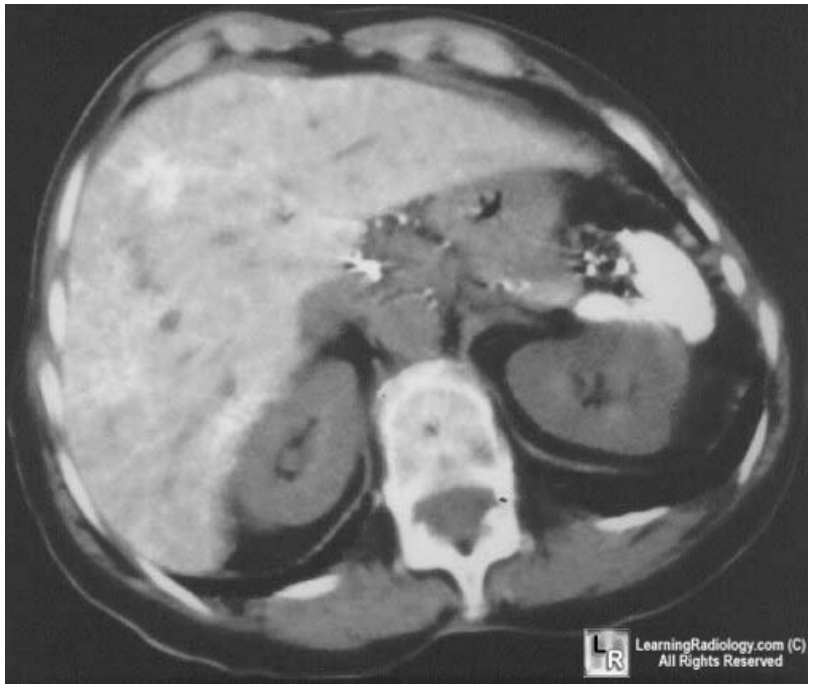
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“It’s not a tumah”

Dana Byrne MD, MSCE

HPI:

- 20’s y/o man presents with abdominal pain to the ED
  - Multiple episodes of abdominal pain in past
  - Difficulty gaining/maintaining weight
  - Not associated with fevers, sweats, vomiting
  - Intermittent diarrhea
- PMHx: None
- Meds: None
- Surg Hx: None

Further History:

- Born in Puerto Rico
  - Moved to US at age 4
  - Never has traveled back
- No other travel
- Works in construction (when he can find jobs)
- No tobacco, no IV drugs, occasional alcohol

Physical Exam & Labs:

- Afebrile, Normal vital signs
- Very thin male, weight 115lbs, height 5’5
- No rashes
- Abdominal tenderness, especially in RLQ

- CBC significant for mild microcytic anemia (Hb 11.5), WBC WNL- no diff
- Normal chemistries
- HIV rapid test negative

Hospital Course:

- Pt has a CT scan in the ED with the following result:
  - Focal wall thickening along the posterior wall of the proximal ascending colon extending into the adjacent fat. The differential diagnosis includes infection or inflammation versus neoplasm
- Pt is admitted and prepped for colonoscopy with the following findings:
  - “In the right colon, the patient appeared to have an area of stricturing that appeared to be at the level of the proximal ascending colon. I could not pass through this area as it did appear to be consistent with stricturing from the outside of the colon."

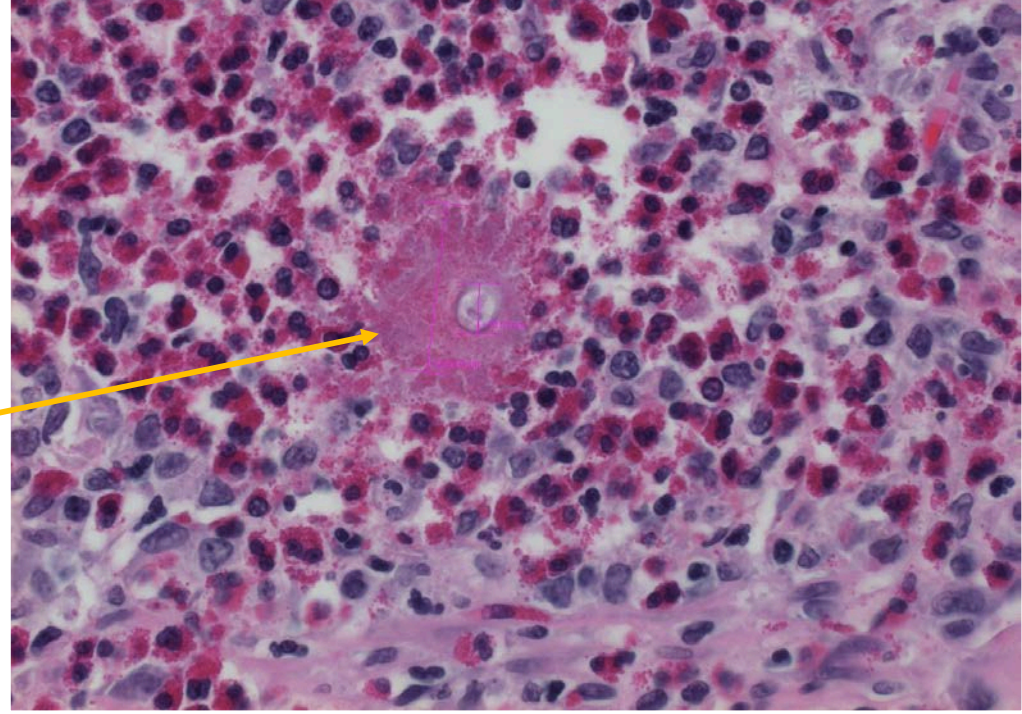
Hospital Course

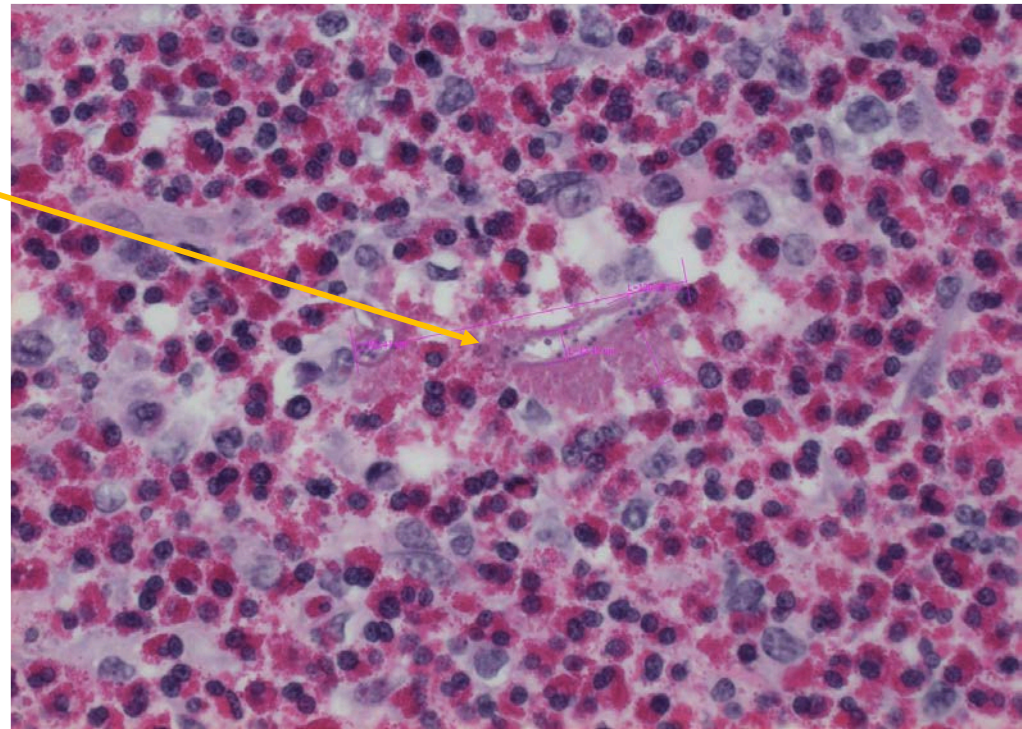
- Pt has laparoscopic ileocolectomy
  - multiple enlarged lymph nodes in mesentery of ileum
  - submucosal mass in prox ascending colon
  - specimens removed included cecum, ileum and prox right colon

Initial Thoughts?

Pathology:

- Ileum, appendix, and colon with Eosinophilic enteritis, and eosinophilic appendicitis with eosinophilic abscesses
- Rare structures within lymph node and colonic mucosa most suggestive of parasitic organisms (larvae form)
- Thirty-seven lymph nodes with eosinophilic lymphadenitis, no evidence of malignancy.



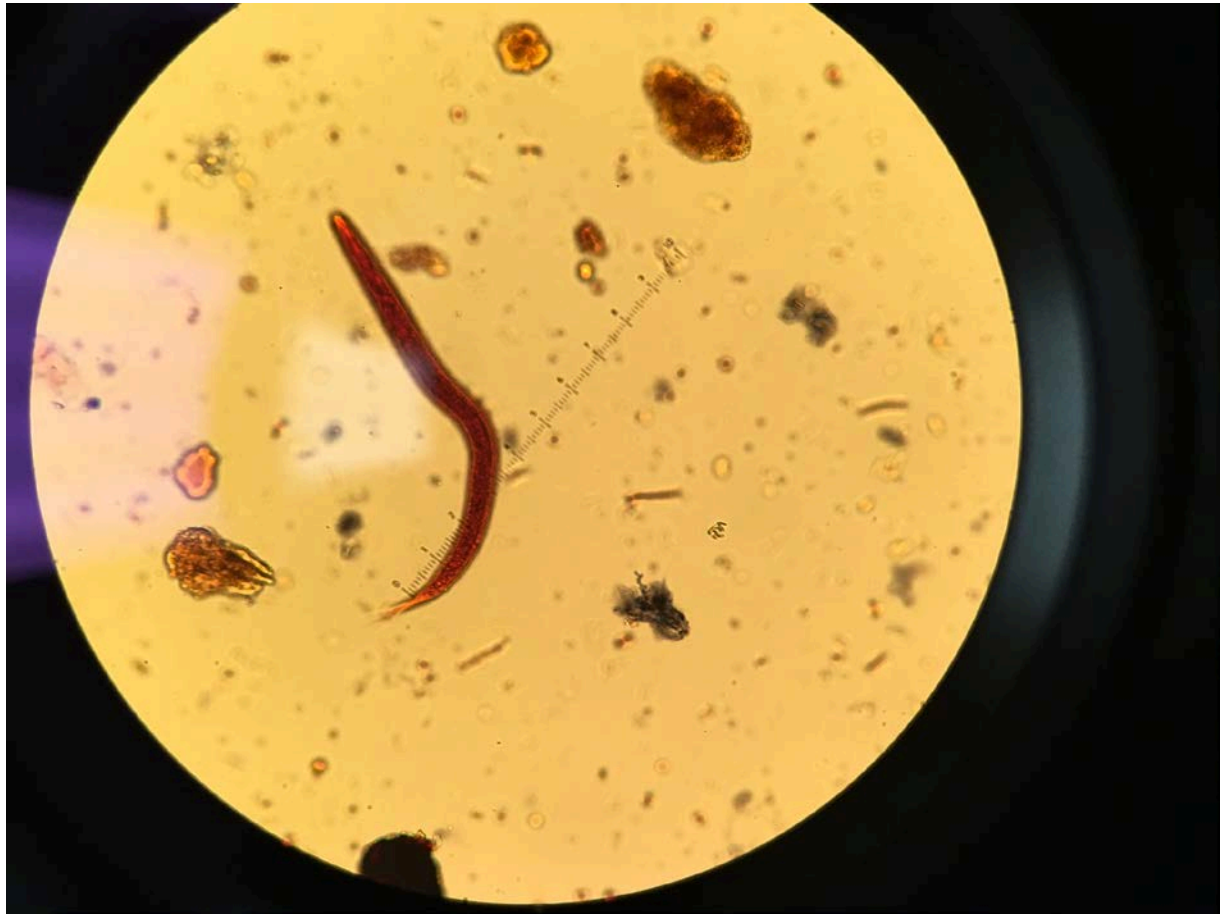


More Thoughts?

- A diagnostic test was performed…

Results:

- Stool O & P was performed:



Diagnosis: Strongyloidiasis

- Pt treated with Ivermectin daily x 3 days, then repeat dosing at 2 weeks
- Stool O & P became negative
- At 1 month follow up, the patient had gained 7lbs

Thank you!


DOCTOR FUN
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WHAT KINDS OF OPENINGS DO YOU HAVE?
Parasite job hunting