Chief Complaint:, Abdominal pain, nausea, vomiting, fever, altered mental status.,History of Present Illness:, 55 yo WM with reactive airways disease, allergic rhinitis who was in his usual state of health until he underwent a dental extraction with administration of cephalexin 1 week prior to admission. Approximately one day after the dental procedure, he began having nausea, and abdominal pain along with fatigue. The abdominal pain was described as pressure-like and was located in the epigastrium and periumbilical regions. He initially attributed the symptoms to a side effect of the antibiotic he was taking. However, with worsening of his symptoms, he presented to the ER 5 days after dental extraction.,At that time his vitals were T 99.9 ° HR 115 RR 18 BP 182/101. His exam was notable for mild tenderness in the central abdomen. Laboratory evaluation was notable for WBC 15.6, Hgb 13.1, Plt 189, 16% bands, 68% PMNs. Na 127, K4.7, Cl 88, CO2 29, BUN 19, Cr 1.5, Glucose 155, Ca 9.6, alk phos 125, t bili 0.7, ALT 29, nl amylase and lipase. UA with 100 protein, lg blood, 53 RBC, 2 WBC. Plain films done at that time revealed dilation of small bowel loops in mid-abdomen up to 3.5cm in diameter, thought to be most consistent with a paralytic ileus. The patient was discharged home with diagnosis of medication-induced gastroenteritis vs. UTI. He was instructed to stop his current antibiotic but start Levaquin, and he was given Vicodin, and phenergan for symptomatic relief.,Over the next 2 days, the patient began having fevers, non-bloody emesis, diarrhea, and confusion in addition to his persistent nausea, and abdominal pain. On the

night of presentation, the patient was found by a cousin in his bathroom lethargic and disoriented. EMS was called and patient was taken to the ER. In the ER, the pt was diaphoretic, unable to answer questions appropriately, hypotensive, and febrile, with some response of bp to multiple IVF boluses (4L). He received acetaminophen, and ceftriaxone 2g IV after blood cultures were obtained and an LP was performed in the ER. He was then admitted to the ICU for further evaluation and management.,Past Medical History:,Asthma,Allergic Rhinitis,Medications:,loratadine,beclomethasone nasal,fluticasone/salmeterol inhaled,Montelukast,cephalexin,hydrocodone,Allergies:, PCN, but has tolerated cephalosporins in the past.,Social History:, No tobacco use, occasional EtOH, no known drug use, works as a real estate agent.,Family History:, HTN, father with SLE, uncle with Addison’s Disease.,Physical Exam:,T 102.9 ° HR 145 RR 22 BP 99/50 98% on room air, (orthostatics were not performed due to patient’s mental status),I/O: minimal urine output after Foley insertion,Gen: lethargic, mild tachypnea,HEENT: no evidence of trauma, sclerae anicteric, pupils are equal round and reactive to light, oropharynx clear, MM dry.,Neck: supple, without increased JVP, lymphadenopathy or bruits. No thyromegaly,Chest: coarse rhonchi bilaterally,CV: tachycardia, regular, no murmurs, gallops, rubs,Abd: hypoactive bowel sounds, soft, slightly distended, mild tenderness throughout. No rebound, no masses or hepatosplenomegaly.,Ext: no cyanosis, clubbing, or edema. 2+ pulses bilateral distal extremities, no petechiae

or splinter hemorrhages.,Neuro: lethargic, but arousable, oriented to person, but not to place, or time. He was not able to answer questions appropriately. Moved all extremities equally but was uncooperative with exam. 2+ DTRs bilaterally, no Babinski reflex.,Skin: no rash, ecchymosis, or petechiae,STUDIES:,EKG: sinus tachycardia, normal axis, isolated Q in III, no TWI or ST elevations or depressions,CXR: Heart normal in size, pulmonary vasculature unremarkable, subsegmental atelectasis in the lower lobes. Acromioclavicular osteoarthritis bilaterally. Lucent lesion in the subchondral bone of the R humeral head, likely a degenerative subchondral cyst.,AXR: Minimal dilation of the small bowel loops in the mid abdomen measuring up to 3cm, no mass lesion or free air visible.,MRI brain pre and post gadolinium: No evidence of hemorrhage, abnormal enhancement, mass lesions, mass effect or edema. The ventricles, sulci, and cisterns are age appropriate in size and configuration. There is no evidence for restricted diffusion. There is mucosal thickening lining the walls of the left maxillary sinus, also containing an air fluid level with two different levels within it, most likely from proteinaceous differences. There is mucosal thickening along the posterior wall of the right maxillary sinus. Mucosal thickening is identified along the walls of the sphenoid sinus, ethmoid sinuses and frontal sinus. Sinusitis with chronic and acute features.,Echo: EF 50%, mild LV concentric hypertrophy, otherwise normal chamber sizes and function,TEE: Normal valves, no thrombi, PFO with R to L shunt, trivial MR, trivial

TR,RLE Ultrasound with Dopplers – total deep venous obstruction in distal external iliac, common femoral, profunda femoral, and femoral vein, partial DVT in popliteal and posterior tibial veins, and total DVT greater saphenous vein. No venous obstruction on the L LE. R calf 34cm, R thigh 42 cm, L calf 31cm, L thigh 39cm.,CT Abdomen (initial ER visit): Trace bilateral pleural fluid, findings in liver compatible with diffuse fatty infiltration, 3.5cm non calcified R adrenal mass was noted, along with an edematous L adrenal with no discrete mass. There was retroperitoneal edema around the lower abdominal aorta with perinephric stranding, no stone or obstruction. Moderate fullness of small bowel loops was noted, most consistent with a paralytic ileus.,Hospital Course:, The patient developed right lower extremity swelling and was diagnosed with deep venous thrombosis. Diagnostic studies were performed.