**Weekly Calendar**

<table>
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<th>Date</th>
<th>Event</th>
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<tr>
<td>4/17</td>
<td>Noon Report: Journal Club</td>
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<td>4/18</td>
<td>Noon Report: Yellow Team</td>
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<td>4/19</td>
<td>Grand rounds: Kathleen Scrivens, RN, JD: “Professional Liability Coverage and Claims Avoidance Strategies” (MSB 7051)</td>
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<td>4/20</td>
<td>AHD: Diagnostic Critical Thinking; Senior prep: Infectious Diarrhea</td>
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<td>4/21</td>
<td>Noon Report: Intern: Hosp 2; Senior: GI</td>
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**Resident mischief both in and out of the hospital**

**Anonymous Feedback**

Our website has a section for anonymous feedback. Think of this like an electronic suggestion box that you can use at any time. The message will be sent directly to Dr. Warm, and is completely anonymous. If you have constructive feedback that you would like to share, please use this tool. The link is: [http://www.med.uc.edu/intmed/residency/internal-medicine/residency-feedback](http://www.med.uc.edu/intmed/residency/internal-medicine/residency-feedback)
GRADUATING RESIDENTS:
If you plan on taking the ABIM Boards in August of 2017, the deadline to register is April 15 and the cost is $1,365. Sign up at: https://www.abim.org

Finding Meaning in Medicine
When: Tuesday, April 18th, 6-8pm
Where: Terri Brody’s home, see RSVP or email Caitlin for address
Theme: "First time you felt like a doctor"
RSVP: https://goo.gl/forms/bNve3DiVlwG2pvFC2
Please feel free to join us, even if you have never come before! We would love to have you.

Life Planning, Financial and otherwise, for Residents!
When: 4/19 and 4/26, 7:30 to 9 AM
Where: MSB 2001
What: Day 1 will be financial planning/risk management (insurance issues), Day 2 will be contract review/negotiations with Attorney Orly Rumberg. Breakfast will be served!

David Nathaneal NeCamp

Dear Friends,

On April 6 - two months before we expected - my wife Carissa and I welcomed our son David Nathanael into the world; seven short hours later, we had to say goodbye. This has been the hardest thing that we could ever imagine going through, but the time with our boy was also more precious than we could have fathomed. Thank you for all of your thoughts and prayers and kindness toward my family, and thank you especially to you who have covered the AOD shifts so that I could have time with my wife and son. You all have truly been a blessing. And don't worry, AODad will be back soon.

Yours,

Josh
Q. A 28 year old African American male presents to your clinic with dark urine. He is healthy and has no significant past medical history, other than a recent diagnosis of bacterial sinusitis for which he was prescribed trimethoprim-sulfamethoxazole 2 days ago. This has never happened before. He does not smoke, use illicit drugs, or drink alcohol. He denies any new sexual partners and has been monogamous with his wife. On exam, he is afebrile, vitals signs are within normal limits, and scleral icterus is noted as well as some mild sinus tenderness to palpation. There is no hepatosplenomegaly on abdominal exam. Labs obtained reveal a hemoglobin of 7.6, platelet count of 300k, and LFTs show normal AST/ALT and alkaline phosphatase with a total bilirubin of 5. Reticulocyte count is 13% with a reticulocyte production index of 3. Lactate dehydrogenase is then checked, which is 287, and so a peripheral blood smear is ordered and shown here. What test will establish the diagnosis?

A. The correct answer is B, Glucose-6-Phosphate deficiency. This patient is experiencing hemolytic anemia, as evidenced by his dark urine, icterus, anemia, hyperbilirubinemia, and elevated LDH. This episode of hemolysis was the result of the Bactrim that the patient was taking for bacterial sinusitis, as the Bactrim results in oxidative stress that causes hemolysis and therefore anemia. This is common in people of Mediterranean and African descent. It is important to consider etiologies like thalassemias and sickle cell disease (diagnosed by hemoglobin electrophoresis), that can then result in hemolysis, however the patient’s history of recent Bactrim use make this less likely. In a patient with sickle cell, severe anemia can result from aplastic anemia related to parvovirus, however there is no evidence that this patient has sickle cell, and his reticulocyte index is appropriate for his degree of anemia (RPI should be >3 if bone marrow response is appropriate). TTP is a life threatening syndrome that results in renal failure, microangiopathic hemolytic anemia, thrombocytopenia, and thrombosis, however this patient’s platelet count is reassuring that this is not the case, so an ADAMTS13 test is not indicated.

Residency Improvement Meetings

Even if you didn’t sign up, please consider coming and making your voices heard about the particular issues that need improvement. We can’t rebuild residency processes and structures without YOU!

Feedback 4/17 from 3-4 pm in the NRR
UH Wards 4/17 from 6-7pm in the NRR
Research 4/19 from 3-4pm in the NRR
AAP 4/19 from 5-5:30 pm in the NRR
Procedure Training 4/21 from 1-2pm in the NRR

Puppy Corner

Lambeau Levin-Boschuetz, Blaze Nolte, Pupa Alzamora, and Leo Singam are making their ’SCOOP debuts!
Noon Report Round-up!

Green team presented a case of cryptococcal meningitis in an immunocompetent host. Let’s talk about it!

To the left, Cryptococcus neoformans on India ink staining. Cryptococcus is encapsulated yeast that is found in the soil around the world, especially in areas where there are a lot of birds, particularly pigeons and chickens, though rarely is extensive pigeon exposure the discovered etiology for a patient’s infection with cryptococcal disease. Below, an unknown but probably famous statue covered in pigeon poop. Humans become infected with Cryptococcus when they inhale the basidiospore form of the fungus.

When we think of cryptococcal disease, we typically think of meningitis, though it can also cause primary pulmonary disease. When it occurs outside of the CNS or pulmonary system, it is likely representative of disseminated infection, and can present with skin lesions (seen in up to 15% of patients with disseminated disease), bony lesions, liver, lymph nodes, GU tract, adrenal glands (remember, fungus loves the adrenals), and the eyes.

We typically think of cryptococcal meningitis occurring in immunocompromised patients, particularly HIV/AIDS, however it can occur in patients who are immunocompetent, and the incidence is increasing. Don’t forget that when thinking about immunocompromised patients, you should think about not only patients with HIV and organ transplantation, but also those with significant steroid exposure, liver disease, malignancy, and sarcoidosis.

One retrospective case study showed that immunocompetent patients were more likely to present with meningitis, were less likely to have fungemia, and had longer mean time from illness onset to presentation. They also had a more intense inflammatory response with higher CSF white cells and protein, but had improved clinical outcomes than patients who were immunocompromised.


Remember, in order to establish the diagnosis of cryptococcal meningitis, you need to first have a high index of suspicion. Certainly the diagnosis should be considered in immunocompromised patients presenting with fever and headache or other neurological signs, but should also be considered in patients who are immunocompetent who present with a subacute to chronic meningitis picture, like the patient discussed in the case Green team presented. Usually, imaging of the CNS will be unremarkable, and may be normal or show cerebral atrophy. Rarely will cryptococcomas (shown above to the right) will be seen. An LP is typically necessary to establish the diagnosis, and should be obtained with an opening pressure, which may be markedly elevated. The role of the cryptococcal antigen is very important in establishing the diagnosis—the antigen test is very sensitive and specific in the CSF, and less so in the serum. However, the serum cryptococcal antigen testing is less sensitive in patients with non-HIV infected patients than in HIV patients—meaning that a negative serum cryptococcal antigen cannot be used to rule out cryptococcal meningitis in patients without HIV infection. In AIDS patients, the cryptococcal antigen in the serum has similar sensitivity to the CSF.
Weekend to-do!

**Friday:** First Light Night: 172 Years of Astronomy at Cincinnati Observatory, 8-10 p.m., Cincinnati Observatory Center, 3489 Observatory Place, Mount Lookout. Learn story of people who made Cincinnati “birthplace of American astronomy.” $5, free members. www.cincinnatiobservatory.org.


**Saturday:** FC Cincinnati Soccer home opener, 7 p.m., Nippert Stadium, University of Cincinnati, University Heights. v. Saint Louis FC. $30, $20, $12, $10; $10 UC students. 513-977-KICK; www.fccincinnati.com.

Beer-Lingual, 2-10 p.m., Amerasia, 521 Madison Ave., Covington. Parking lot next to restaurant. Breweries including Madtree, Rhinegeist, Braxton, Urban Artifact, West Sixth and New Belgium serve beer, with vendors. live music, DJ, food and games. bit.ly/2nawabB.

**Sunday:** Cincinnati Reds Baseball, 1:10 p.m., Great American Ball Park. vs. Brewers. Kids Fathead Wall Decal. $5 and up. www.reds.com.

What is the diagnosis?

**TRIVIA**

No one recognized this ulcer with a pigmented spot, Forrest Classification IIc. These are low risk for rebleeding and generally, the patient can be discharged.

SHOUT OUTS!!!

- To the great Jeopardy residents of the past two weeks for all their coverage—thank you Greg Wigger, Patricio Alzamora, Scott Merriman, and Bo Franklin, for being awesome with a lot of jeopardy coverage over the past two weeks.
- To Danielle Clark for doing some last minute shift rearrangement to help out a colleague. Thank you!!!
- To Megan Caroway for helping out with MICU shifts!
- To Scott Call for being flexible with days off in order to help a colleague. Thanks!
- To Brian May, Erin Connolly, and Marc Guerini, for helping out a chief and a co-resident. Thank you!
- To the many residents who participated in initial Residency Improvement meetings this week, thank you for your commitment!