A Case of Diffuse Alveolar Hemorrhage

Shama Patel  
*Henry Ford Health System*

Scott Sipp  
*Henry Ford Health System*

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Hospital Course 10/13/2018:  
On initial presentation, a code sepsis was called based on presenting vitals – blood cultures, UA, CBC, BMP, Coags, CXR, lactic acid, influenza, monospot, and strep culture were ordered. 30 cc/kg fluid bolus and Tylenol was ordered.  

Labs significant for:  
WBC: 3.3  Hgb: 8.3  Lactic Acid: 2.7 Na:129 K: 3.1  

Patient initially improved clinically, lactic acid cleared after fluid bolus, however during the ED course, patient became hypoxic on room air at 88%, improved with 2 L of oxygen when sitting upright, patient felt short of breath lying flat, patient had bilateral coarse breath sounds, worse on the right, chest x-ray was repeated, BNP and troponin obtained. Patient's repeat chest x-ray showed worsening right lung intersitial pattern, concerns for pneumonia, at this time sepsis identified, IV Rocephin and IV azithromycin were started and patient was admitted for further evaluation.  

Hospital Course 10/14/18-10/15/2018:  
Patient continued to have recurrent fevers and tachycardia, repeat troponin was ordered, elevated at 110, peaked at 250 then trended down, likely secondary to NSTEMI type 2. ECHO 10/14/18 : EF: 57%. No evidence of ischemic, valvular, hypertrophic, or pulmonary heart disease.  

17-48  
Rapid response is called for tachypnea and tachycardia, patient was febrile 102.8F, HR 130s  RR 26 | Effort normal | Lungs clear | No rhonchi | Effort normal  | No murmurs | No edema | EOM normal  | No clubbing  | No cyanosis   |   

10/15/18  
Per ID notes, there was concern for disseminated zoster as patient was not improving on antibiotics, started on acyclovir. Due to patient being a high risk pregnancy, with worsening respiratory status, requiring HFNC – decision was made to transfer to Henry Ford Main.