HIV Patients in the Emergency Room

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Case 1

HPI: A 37-year-old female presents to the ER with 3 weeks of nausea, vomiting and diarrhea. It is progressively worsening. There is associated right upper quadrant pain. The patient also reports cough, fever, fatigue, headache. The patient also says she has a rash on her labia.

PMH: None
PSH: None
Social History: Denies tobacco, alcohol and illicit substance abuse

Physical Exam: Vitals: T 38.1 BP 130/78 HR 117 RR 20 POx: 100% room air
HEENT: Oral mucosa dry
Lungs: Clear to auscultation
Cardiac: Tachycardic
Abdominal: Right upper quadrant tenderness.
Pelvic: Several open, tender sores on the labia. Vaginal discharge. No CMT or adnexal tenderness.

Labs: Electrolytes: Na 131, K 2.3, Ca 6.8 otherwise normal
CBC: WBC 3.4, Hemoglobin 9.7, Platelet 84
Differential (Total): Neutrophils: 1.9, Monos: 0.6, Lymphs 0.7 (Low)
Lipase: normal
LFTs: AST 90, Albumin 1.6, Bilirubin 3.6/1.8
PT/INR/PTT: 20.7/1.97/41
U/a: Positive esterase and nitrite, 10 WBCs, Few bacteria
Lactate: 3.6
Wet mount: Positive for trichomonas

X-ray: Acute abdominal series is negative.

Questions to ponder:
1. As an astute clinician, you diagnose HIV in the patient. What lab test suggested that she had HIV/AIDS?
2. List 5 AIDS defining conditions.
3. What are the next steps in the evaluation and management of this patient?
4. How will the patient’s HIV status change the management of the patient?
Case 2

HPI: A 53-year-old female presents to the ER with 4 days of left flank pain. It is associated with dysuria. Patient admits to smoking crack and drinking alcohol the past 3 days. She also has central, non-radiating chest pain and a productive cough. Patient also has a sore throat. Patient is questioned about having HIV and denies that she is HIV positive.

PMH: ? HIV
Meds: None
Allergies: Penicillin, Aspirin
Social History: Tobacco user, Occasional alcohol use, Crack use
Physical Exam: Vitals: T 36.6 BP 122/75 HR 108 RR 20 POx: 100% room air
  HEENT: White plaques on hard palate
  Lungs: Clear to auscultation
  Cardiac: Tachycardic
  Abdominal: Left lower quadrant tenderness, no rebound or guarding
  Extremities: No swelling or erythema

Labs: Electrolytes: Normal
  CBC: WBC 5.8, Hemoglobin 11.6, Platelet 217
  Differential (Total): Neutrophils: 4.3, Monos: 0.6, Lymphs 0.7 (Low)
  U/a: Positive for esterase and nitrite, WBC 121, Bacteria many
  UCG: negative

  X-ray: Chest xray is normal.

Questions to ponder:
1. The patient has oral candidiasis, which is an AIDS defining illness. Is there any lab abnormality which suggests a low CD4 count?
2. What are the next steps in evaluation and management of this patient?
3. What antibiotic(s) will you use to treat this patient?
4. How is the management of this patient different from that of the non-HIV patient?
Case 3
HPI: A 64-year-old female presents to the ER with change in mental status. The patient was found altered in bed this morning and had a glucose of 60. Patient was given oral glucose but is still altered. He is a pastor in the church and has been noted to be “not acting right” by the members and giving nonsensical services recently. The patient had a similar presentation to another hospital a few weeks ago and was discharged after a short admission.

PMH: Diabetes
Medications: Unknown
Allergies: Unknown
Social History: Unknown

Physical Exam: Vitals: T 36.4 BP 118/39 (manual 82/48) HR 90 RR 18 POx: 100% room air
  HEENT: Normal
  Lungs: Clear to auscultation
  Cardiac: Normal
  Abdominal: No tenderness
  Neurologic: Alert and oriented times two. Patient thinks the year is 9147. Patient with 5/5 strength in all extremities with no sensory or cerebellar deficits.

Labs: One touch: 139
  Electrolytes: Normal
  CBC: WBC 11.1, Hemoglobin 11.7, Platelet 238
  Differential (Total): Neutrophils: 8.4, Monos: 0.9, Lymphs 1.6
  Lactate: 4.3
  LFTs: normal
  U/a: Positive esterase, 1400 RBCs, 18 WBCs, Many bacteria

Chest X-Ray: Negative
CT Head without contrast: No acute process

Follow up: You speak with the primary care physician who does not know what medications the patient is on but reports he had a similar episode last month at Providence Hospital where he had a negative workup including a neurologic consultation.

Questions to ponder
  1. Are there any other diagnostic studies you would like to perform? If yes, what studies?
  2. How do you know this patient has HIV?
  3. Can HIV patients with CD4 counts above 200 have opportunistic infections? What is the role of the CD4 count in determining the risk of opportunistic infections?
  4. How is the evaluation and management of this patient different from the patient without HIV/AIDS?