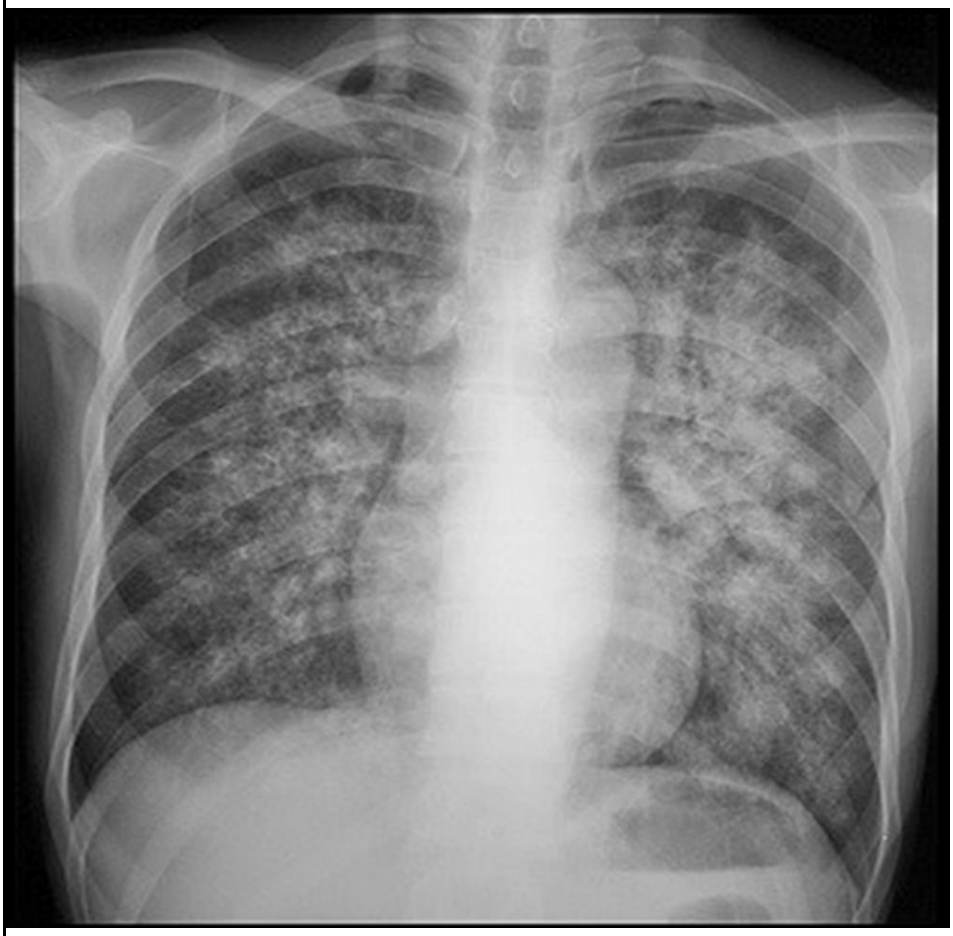
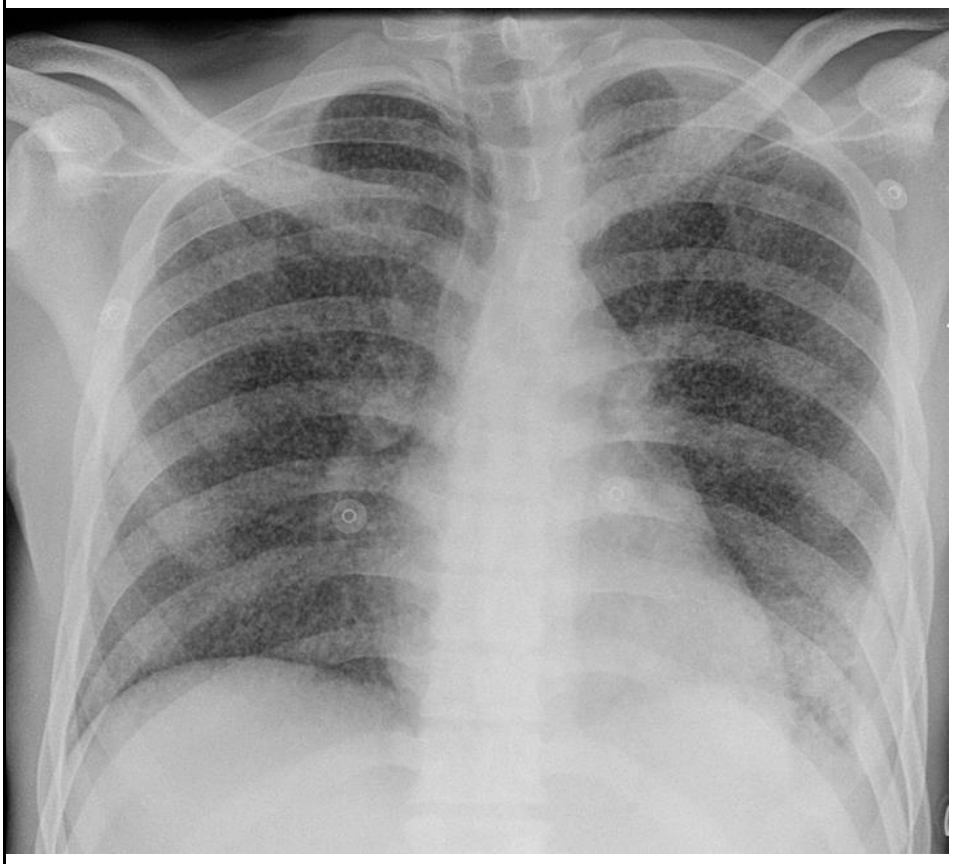


Case 5

A 45 year old male attends ED due to a 2/52 history of increasing SOB, dry cough, fever and fatigue.
He tells you he has HIV, diagnosed 10 years ago. He last attended a clinic > 1 year ago and has not been taking his anti-retrovirals since relapsing onto heroin 7/12 ago.
At clinic his last CD4 count was 164 he was prescribe a medication at clinic but hasn't been taking it.

What is the diagnosis?
What medication has he not been taking?



Case 6

45 year old male attends ED due to 1/12 history of non-productive cough and fever, in the last couple of day he has been developing increasing RUQ pain.

He is originally from sub- Saharan Africa and has recently returned from visiting family there.

O/E he has widespread crackle, temperature of 37.9 and a palpable liver edge.

What is the diagnosis?

Case 5

Diagnosis: **Pneumocystis jirovecii pneumonia**

- PJP usually only presents in the severely immunocompromised, in patients with HIV, their CD4 count is likely to be <200, at which point they will be started on prophylaxis, usually **Septrin** (co- trimoxazole), alternatives include pentamadine.
- CXR show classic bilateral patchy infiltrates
- ABG may show a PaO2 much lower than would be expected from their symptoms.
- When treating PJP it is important to consider corticosteroids in addition to antibiotics as a high proportion of patients will develop severe inflammation by the fourth day of treatment.

Case 6

Diagnosis: **Miliary TB**

- Characterised by CXR findings:
  - 1-5mm lesions
  - Throughout lung fields
  - Similar in appearance to **millet seeds →**
- Represents
  - Only 2% of all TB cases
  - 20% of extrapulmonary TB
- May present with:
  - Cough
  - Fever
  - Lymphadenopathy
  - Hepatomegaly
  - Splenomegaly
  - Tuberculous meningitis