56-year-old male with HIV on HAART, has ESRD status post renal transplant in November 2019, chronic HPV infection, DM, hypertension, recurrent UTIs, presenting with blood cultures from the ID clinic positive for cryptococcal antigen. On ED admit, patient states he has had intermittent fevers for the past 2 months. Had been seen several times in emergency department and diagnosed with recurrent UTIs. Was seen at the ID clinic today for follow-up. Other than the fevers, patient has also been feeling generalized malaise and weakness. Denies headaches, neck pain/rigidity, cough, sore throat, chest pain, nausea/vomiting or diarrhea. Patient has baseline shortness of breath and denies any worsening of this.

Per ID, pt had positive blood cultures for cryptococal antigen. He was discharged with fluconazole with the following dosing: Cryptococcal Infection: induction: Fluconazole 800mg po daily PLUS flucytosine 2500mg po q12h x 2 weeks. Then, for consolidation: Fluconazole 400mg po x 4 weeks (to assess if flucytosine is required by txp ID); Suppressive therapy: continue fluconazole per txp ID (for at least 12 months). Upon hospital DC, pt was instructed to decrease warfarin dose (due to drug interaction with fluconazole) to 2.5mg daily. During visit today, pt reports doing okay. Still on taking fluconazole 800 mg daily. No N/V. No bleeding. In agreement to frequent INR monitoring for now in light of fluconazole interaction.

ADMIT DATE: 8/28/20

DISCHARGE DATE: 9/1/20

ATTENDING: DiCocco

Primary Discharge Diagnosis: cryptococcosis

Secondary Discharge Diagnoses: s/p DDKT, h/o HIV

CONSULTATIONS: transplant nephrology, transplant ID

PROCEDURES: LP

HISTORY OF PRESENT ILLNESS: 56 y/o M with HIV on HAART, hx of KT 11/2019, admitted via ER on 8/28/20 for evaluation of fevers and fatigue at home for >1month and + serum crypto Ag (titer 1:40).

PHYSICAL EXAMINATION:
General: HM in NAD
HEENT: MMM, poor dentition
Cardiovascular: RRR, no LE edema
Lungs: unlabored respirations

Abdomen: Soft, nontender, +BS

HOSPITAL COURSE: Pt underwent LP. CSF chemistry not suggestive of infection, and CSF CrAg is negative, but given his reported fevers, elevated LP opening pressure and + serum CrAg in setting of IMS (s/p renal transplant, HIV) will treat empirically. He did not tolerate Amphotericin (even with pre- medication), and he has been on Flucytosine and Fluconazole which he tolerated.
His IMS regimen was changed to Cyclophosphamide and Prednisone, which could interact with Ritonavir so he was started him on Biktarvy 2/2 drug interactions. Pt has remained HDS. He denies h/a or vision changes. He will be d/cd to home today.

please see ID plan as below (appreciate recs)

-c/w Flucytosine and Fluconazole to complete a two- week (induction) phase of therapy.
-Monitor CBC weekly (next 9/820). Flucytosine may cause cytopenia. If he develops cytopenia while on the Flucytosine + Fluconazole regimen, DC Flucytosine and c/w only Fluconazole 800mg daily to complete the two week course.
-If there are no adverse events on Flucytosine + Fluconazole regimen, then complete the two week course as described above.
-After the two- week induction phase, D/C Flucytosine and continue Fluconazole 400mg daily x2 months
-After this, c/w Fluconazole 200mg daily x1 year
-Pt has ID clinic f/u on 9/25.

DISCHARGE INSTRUCTIONS:

1) ACTIVITY: please refer to depart process

2) FOLLOW-UP: CBC w/ diff 9/8/14 to assess for cytopenia,
kidney transplant, ATC and ID appointments (please refer to depart process for dates)

[x] Follow-up appointment made

3) MEDICATIONS: please see PharmD med rec

4) DIET: CCD

5) DISCHARGE DISPOSITION: to home

CONDITION UPON DISCHARGE: stable