

Medical record summary of Secondary Dermatitis with bilateral immunosuppressive host pneumonia treated with Lung-toxin Dispelling

Formula NO.1

The patient is a 78 year old female. On December 17, 2019 she developed rashes on both groins with large red patches, exudates, and itching. There was no pain, no other skin lesions, no joint pain, and no discomfort in the limbs. She went to the 1st Affiliated Hospital of Sun Yat-sen University. After examination, she was diagnosed with secondary dermatitis (fungus + bacteria). She received antifungal, antibacterial and symptomatic treatments and her condition improved. On January 7th, she developed coughing, chest congestion and asthma. She went to the hospital where a CT Scan was performed. The CT revealed interstitial inflammation of both lungs. Despite anti-infective treatment (the specific medication is unknown), her condition worsened. On January 14th, family members of the patients noted that the bilateral groin rash had expanded, the color was deeper, and there were skin lesions. The patient complained of severe pain. She denied new rashes on her limbs. She also denied canker sores, joint pain, fever and chills. On January 17th, her cough became worse, she became short of breath, had a low grade fever. Since the patient has multiple underlying diseases and had multiple presenting problems , she was admitted to the hospital for control of her lung infection and management of her conditions.

Admission examination: A large patch of red rash was present on both groins, from medial to lateral. The rash ranged in color from light to deep, and red granules were seen around the rashes. From when she became ill, she was consistently clear in consciousness and state of mind, and had good appetite. She complained of poor sleep and intermittent urinary incontinence. She was not monitoring her weight.

Past Medical History: 20 year history of hypertension on regular medication; blood pressure control is adequate. There was a history of "cerebral infarction" more than 10 years in the past which resulted in weakness of her left leg. In December 2017, she was diagnosed with Central nervous system non-Hodgkin lymphoma (diffuse Large B cell type). She received chemotherapy twice in Beijing, the specific protocol is unknown. After February 2018, no chemotherapy was performed. In November 2019, the primary central nervous system lymphoma recurred. On Nov 25th she began treatment with bouthinib 560mg PO QD. Her cognitive function and drowsiness improved as did her limb

muscle strength. The incontinence also improved. On January 15, 2020, she received PD-1 treatment at the Cancer Hospital of Sun Yat-sen University. The patient denied diabetes and coronary heart disease. She denied history of infectious diseases such as hepatitis and tuberculosis and denied history of blood transfusion. She described a suspicious history of "gammaglobulin" allergy. Her vaccination history is unknown.

Preliminary diagnosis: 1. Pneumonia 2. Non-Hodgkin's lymphoma of the central nervous system (diffuse large B cells) with relapse after chemotherapy 3. bilateral groin secondary dermatitis, 4. Hypertension grade III High-risk group 5. Subcortical arteriosclerotic encephalopathy 6. Sequelae of cerebral infarction (bilateral frontal parietal temporal lobe, radiation crown) 7. Brain atrophy 8. Internal carotid artery Small aneurysm of the internal carotid artery 9. Sinusitis 10. Hyperostosis 11. Esophageal hiatal hernia 12. Nodular goiter.

Complete related supplemental examination: Blood test: WBC $8.92 \times 10^9/L$, NEUT $7.24 \times 10^9/L$, RBC $3.94 \times 10^{12}/L$, Hb 119g/L, PLT $177 \times 10^9/L$; CRP 16.71mg/L; Liver metabolism combination: Sodium Na 134mmol/L, total protein TP 50.5g/L, albumin ALB 29.0g/L, calcium Ca 2.00mmol/L; Coagulation tests (bleeding/clotting routine tests): D-dimer D-Di 0.70mg/L FEU, PT 10.7 seconds, APTT 24.0 seconds; Rocephin 2g qd intravenously was prescribed for bacterial infection. Topical ointment was prescribed for rash, Imbruvica for treatment of the lymphoma. Prescriptions were also made to improve cognition, nerve nutrition, supplement iron, control blood pressure, supplement albumin, and improve the immune system. Pain and rash in her posterior groin gradually improved.

1/18/2020, body temperature increased to 38.5°C. Chest CT reexamination revealed worsening condition. The respiratory department was consulted for consideration of bilateral immunosuppressive host pneumonia.

1/19/2020, She was switched to Tazocin at 4.5g q8h for the infection. Compound Sulfamethoxazole Tablets at 0.96g QID were also added.

1/20/2020, she developed chills, shivering and fever. Her body temperature went up to 39.1°C, and finger pulse oxygen level decreased. With mask oxygen, mucus suction, and high-flow humidification, her finger pulse oxygen level increased. Since she accepted PD-1 treatment before, after expert consultation, Tazocin was discontinued and changed to zyvox linezolid injection [specialized], 300ml Q12H⁺ Meropenem for Injection 1g Q8H. Her temperature gradually decreased to normal, but her cough and sputum

production gradually got worse. She continued to receive high-flow humidification treatment supplemented with phlegm removal.

1/28/2020, Since the patient's condition had stabilized, her fatigue condition was improved, and the cough and sputum were reduced, zyvox and Meropenem were discontinued and she was switched to Tazocin 4.5g q8h.

2/5/2020, blood test revealed that her Hemoglobin had dropped to 75g/L. This was attributed to the Compound Sulfamethoxazole which had been used for 17 days. Since chest imaging appeared improved, the Compound Sulfamethoxazole was discontinued.

2/9/2020, the patient's condition waivered, her body temperature increased. In addition to Tazocin, Tigecycline (50mg q12h, initial dose with 100mg qd) was added. This did not improve her fever.

2/10/2020, chest CT scan result: compared with 1/18/2020, the patient's lung infection was not alleviated. Tazocin was discontinued and, in addition to Tigecycline, Sulperazon 3g q8h was added to treat the pneumonia. Her fever gradually resolved.

2/12/2020, In the morning, the patient suddenly vomited, her heart rate was 53 beats / min, and her blood pressure was 168 / 98mmHg. The symptoms improved over the next hour. At that time, the body temperature was 36.9°C, the heart rate was 51 beats / min, the blood pressure was 147/82mmHg, the finger oxygen was 98%, and she was noted to have mental weakness, cough, less phlegm, and increased shortness of breath. At this point, Chinese medicine diagnosis was performed: her body temperature was 36°C, and she had chills, cough and phlegm, dyspnea, red tongue, yellow greasy fur, and slow pulse. The syndrome is a deficiency of lung and kidney. This was treated by supplementing lung and benefiting kidney, absorbing Qi and relieving asthma. At the same time, heat and detoxification were given. **Prescription:** White ginseng 30g, Schizonepetae 15g, Honeysuckle 15g, Fructus forsythia 30g, Radix Scrophulariae 15g, Honeylocus Spine 10g, Apricot kernel 10g, Honeycomb 10g, Licorice Root 6g. 3 doses, 1.5 doses daily, decoct it and drink the soup in the morning and evening. At the same time, tigecycline + cefoperazone sodium and sulbactam continued to be used to treat her pneumonia, and at the same time, treatments for cognition, nutritional nerves, iron supplementation, blood pressure reduction, albumin supplementation, and immunity were continued. At 5pm on February 12th, the patient took the Chinese medicine decoction for the first time without

dinner. After taking the medicine, her head began to sweat. After half an hour, her body temperature rose to 36.6 °C, the blood pressure was 154/85mmHg, and the heart rate rose to 71 beats / min. She began to produce white foam from her mouth until 10pm. At this time, blood pressure was 147/82mmHg, heart rate was 51 beats / min, body temperature was 36.8 °C, and symptoms were stable.

2/13/2020, She had a bowel movement at 1 am. The stool was thin and heavy. At 7am, her blood pressure was measured at 147/82mmHg, heart rate was 53 beats/min, body temperature was 36.1 °C, finger oxygen was 99%. She was able to eat food slowly, her shortness of breath improved, and she was able to walk slowly. At 9am and 4pm on the same day, she took the Chinese medicine again. After that, she spit out a small amount of white foam and sweated slightly. She had six episodes of diarrhea. At 10pm, her blood pressure was 126/78 mmHg, heart rate was 55 beats/min, body temperature was 36.3 °C, finger oxygen was 98%, and vital signs were stable.

2/14/2020, in the morning, the blood pressure of the patient was 139/83 mmHg, the heart rate was 67 beats/min, the body temperature was 36.7 °C, the finger oxygen was 99%. There was no cough, her condition was good, and the fatigue was significantly reduced. The patient's condition was improving, so tigecycline was discontinued and the Chinese medicine continued to be taken. After each dose, she occasionally spit foam 2 to 3 times, the cough was significantly reduced, the bowel movements were reduced to twice, the color was dark, the consistency was thin, and the volume was increased. Her spirits improved significantly, her the limb muscle strength was improved, as was her willingness to move independently.

15-16/2/2020, she continued to take the Chinese medicine twice a day with no more foaming at her mouth. She did slightly sweat after taking the medicine, and experienced bowel movements 1 to 2 times. Her stools were black and normal in nature and quantity. Her mental, mobility, and cognitive functions improved significantly.

17/2/2020, Blood tests: C-reactive protein 14.29mg/L, WBC $8.75 \times 10^9/L$, NEUT $3.83 \times 10^9/L$, Hb 97g/L, PLT $348 \times 10^9/L$; CRP 14.29mg/L; Blood biochemistry was basically normal. The patient's cough and sputum improved significantly compared with previous, and she was discharged.

There was no chest tightness, shortness of breath, or other discomforts when

discharged. Physical examination: 20 breaths/min, blood pressure 133/75mmHg, heart rate 76 beats/min, occasional early beats, finger oxygen 99%. There were no abnormal lung sounds. There was no ulceration of the skin, and no edema in the lower limbs.

Upon discharge, she was switched to levofloxacin tablets 500mg QD to continue treating the pneumonia and she was instructed to continue taking the traditional Chinese medicine.