**INTRODUCTION**
Although a well-defined treatment protocol exists for septic shock, an overreliance on this approach can result in unfavorable outcomes. Here, we present a complex case that encompasses both septic and cardiogenic elements within the context of undifferentiated shock.

**CASE DETAILS**
- **Patient Information:**
  - Age: 37 years old Female
  - Medical history: No significant past medical history
  - Recent event: Post cesarean section (G2P2L2) with an iatrogenic bladder injury, 4 weeks postpartum
- **Clinical Presentation:**
  - Sudden onset high-grade fever: 101.4°F with persistent flank pain
  - Imaging: Mild-to-moderate right-sided hydronephrosis and hydroureter
- **Initial Diagnosis and Treatment:**
  - Diagnosed as Urinary tract infection (UTI) and started on cephalexin outpatient
  - Condition worsened within two days, admitted to ICU
- **ICU Admission Events:**
  - Respiratory rate: 38b/min, Heart rate: 130/min, Blood pressure: 60/40 mmHg, Fever: 104°F
  - Disoriented along with severe bandemia and leukopenia on labs
  - Hemoglobin levels dropped from 10.4 to 7.4 in two hours
  - Immediate transfusion of two units of packed red blood cells (PRBCs)
- **Diagnostic Imaging and Intervention:**
  - CT angiogram ruled out intra-abdominal bleeding
  - Confirmed persistence of hydronephrosis and hydroureter
  - Urgent stent placement to alleviate obstruction
  - CT urogram showed no evidence of kidney stones
  - Started on clindamycin, cefepime, and vancomycin for broad spectrum coverage.

- **Hemodynamic Support:**
  - Persistently hypotensive
  - Norepinephrine infusion initiated
  - Vasopressin and stress-dose steroids added to treatment due to non-improvement
- **Cardiac Evaluation and Management:**
  - Point-of-care ultrasound (POCUS) showed:
    - Severely reduced left ventricular ejection fraction (LVEF)
    - Enlarged left ventricle (LV) (Figure 1, A)
    - Dobutamine infusion initiated
    - Swan-Ganz catheter inserted for hemodynamic monitoring
    - Improvement in cardiac function within 24 hours (Figure 1, B)
- **Causative Agent Confirmation:**
  - Blood and urine cultures confirmed Escherichia coli (E. coli) infection
- **Initiation of targeted antibiotic therapy**

**DISCUSSION**
In this case the patient’s presentation post partum raised suspicion of peripartum cardiomyopathy, a diagnosis of exclusion. However, with sepsis as a major contributing factor to the clinical picture, we leaned more towards septic cardiomyopathy as the diagnosis. Notably, studies indicate that concurrent myocarditis is found in as many as 78% of such cases(1). Despite the absence of a singular causative factor, we adopted a systematic approach which proved crucial in saving the patients life.

**CONCLUSION**
In critical cases characterized by shock, a comprehensive evaluation becomes indispensable. The evaluation should thus encompass, potential factors such as hypovolemia, vasoplegia, and cardiac dysfunction(2). Cardiomyopathy in the setting of sepsis presents an intricate clinical challenge, especially when we direct treatment anchoring to sepsis, which was the initial presentation here. A highly specialized approach involves the utilization of Point-of-Care Ultrasound (POCUS) as a diagnostic aid, along with continuous hemodynamic monitoring with tools such as the Swan-Ganz catheter. These along with an in-depth evaluation of the entire clinical picture is crucial for management of such cases.

**REFERENCES**