**SUPPLEMENTAL MATERIALS**

**CASE SUMMARIES OF FATALITIES**

**Patient #2**

A 72-year-old woman with history of recent travel to India was brought to the emergency department of Westchester Medical Center (WMC) with nonspecific symptoms. On presentation, she had a temperature as high as 400C, had an unremarkable physical examination and chest x-ray (Figure S1A), but was noted to be somnolent. She was empirically started on cefepime and vancomycin. Preliminary examination of a peripheral blood smear revealed intraerythrocytic parasites, so quinine and doxycycline were added to the regimen. The parasite was subsequently identified as *B. microti*, so the antiparasitic drug regimen was changed to quinine and clindamycin. On the third hospital day, she developed shock for which a continuous infusion of dopamine was started and also underwent endotracheal intubation for hypoxemic respiratory failure. The post-intubation chest x-ray is shown in Figure S1B. She was transferred to the medical intensive care unit (MICU) at that time, and the dopamine infusion was discontinued in favor of norepinephrine. On hospital day 4, the parasite load was 15%; exchange transfusion was initiated. The following day, due to prolongation of the QT interval, quinine was discontinued. Concurrently, she was found to be seropositive for antibodies to *B. burgdorferi* ; the drug regimen was changed to atovaquone, azithromycin, clindamycin, and doxycycline. Her parasite load progressively decreased to 0.2%. However, she remained in unresolving acute respiratory distress syndrome (ARDS) with a fraction of inspired oxygen (FiO2)requirement ranging from 80-100%. On the 10th hospital day, she was placed on veno-venous extracorporeal membrane oxygenation (ECMO). Her subsequent course was notable for persistent shock and eventual acute kidney injury. On hospital day 16, after discussion with the family, organ support was withdrawn, and the patient expired.

**Patient #7**

A 69-year-old man initially presented to a community hospital with fever and anemia. His chest x-ray was clear (Figure S2A). Upon detection of *B. microti* on blood smear, he was started on a regimen containing clindamycin, quinine, and doxycycline. On the third hospital day he developed altered mental status, reduced urine output with metabolic acidosis, and hypoxemia. He was brought to the MICU at that facility and placed on mechanical ventilation for impending respiratory failure and inability to maintain his airway. On hospital day 5, his FiO2 was increased to 100%, and the positive end-expiratory pressure was raised to 15cmH2O. A continuous infusion of norepinephrine was initiated at that time as well. The next day he was transferred to the WMC MICU for consideration of extracorporeal organ support. His chest x-ray upon arrival to the WMC MICU is shown in Figure S2B. In the course of his first day at our institution, he progressed from requiring one vasoactive agent to three to maintain an acceptable mean arterial pressure. His FiO2 was ≥75% throughout that period. On the following day, renal replacement therapy (RRT) was initiated for progressive acute kidney injury (AKI) and metabolic acidosis but had to be discontinued soon thereafter due to worsened hypotension. Concurrently, his oxygenation continued to deteriorate despite maximal ventilator settings. While awaiting cannulation for planned ECMO, he developed pulseless electrical activity. Cardiopulmonary resuscitation was performed but was unsuccessful, and the patient expired.

**Patient #8**

An 81-year-old woman was transferred to WMC on the same day that she presented to a community hospital with dyspnea and jaundice. Laboratory evaluation at that institution revealed anemia, thrombocytopenia, transaminitis, hyperbilirubinemia, and evidence of AKI. The diagnosis of babesiosis was made based on examination of the peripheral blood smear. Prior to transfer, she received initial doses of atovaquone, azithromycin, clindamycin, and doxycycline. Upon arrival at WMC, she was found to have a positive direct antiglobulin test, so she underwent one session of plasma exchange. At that time, her chest x-ray already showed subtle bilateral opacities (Figure S3A). Progressive AKI and hypoxemic respiratory failure led to MICU admission on the second hospital day following endotracheal intubation and initiation of renal replacement therapy. The corresponding chest x-ray is shown in Figure S3B. Her MICU course was otherwise significant for continued dependence on mechanical ventilation and eventual tracheostomy on hospital day 21. She failed subsequent attempts to wean from mechanical ventilation in the setting of unresolving ARDS and became increasingly encephalopathic. Per family request, she was removed from mechanical ventilation with palliative intent and ultimately expired on hospital day 32.

**FIGURE LEGENDS**

Figure S1. (A) Admission chest x-ray of patient #2 showing clear lung fields. (B) Same patient’s chest x-ray following endotracheal intubation showing new bilateral diffuse airspace opacities compatible with ARDS.

Figure S2. (A) Admission chest x-ray of patient #7 showing clear lung fields. (B) Same patient’s chest x-ray following endotracheal intubation showing interval development of bilateral mixed interstitial and alveolar opacities compatible with ARDS.

Figure S3. (A) Chest x-ray of patient #8 upon arrival to WMC showing subtle bilateral lung infiltrates consistent with early ARDS. (B) Same patient’s chest x-ray following endotracheal intubation showing marked interval worsening of the infiltrates.