4/2/20 Morning Report with @CPSolvers

CC: 35 F with no known PMH p/w acute SOB and left sided chest pain radiating to the back

HPI:
4 days prior: low grade fevers, cold symptoms
2 days prior: progressive, sharp pain, SOB

Pericardiocentesis → pericardial window → ICU

Per family, recent unintentional weight loss, alopecia, Raynaud's

PMH: None

Fam Hx: None

Meds: None

Soc Hx: n/a

Vitals: afebrile, HR 130, RR: 24, BP: 85/61 (unresponsive to IVF), SpO2: 92% on RA

Exam:
JVD, tachycardia, diminished heart sounds, fine crackles

Notable Labs & Imaging:
Flu testing negative in outpatient clinic
Bedside echo: pericardial effusion, fixed dilated IVC, no dissection, PA very large, R ventricle dilated.
CT-PE: moderate large effusion, multiple enlarged lymph nodes, 3.6 cm pulmonary artery
PA catheter: 70/48, PCWP 9, PA → systolic 59 on milrinone
HIV negative
Pericardial fluid: no WBC, no organisms, no malignant cells.
RVP: coronavirus pos (years ago, not COVID)
Negative: BCx/UCx/SpCx, legionella
ANA: positive speckled, < 1:2560
Positive SSA/SSB > 8
Negative dsDNA, RF, Scl70, centromere, Jo-1
ACE: 12 (normal)

Problem Representation:
Young adult woman with secondary Raynaud's p/w cardiac tamponade found to have chronic pulmonary HTN, SSA/SSB pos c/w primary Sjogren's syndrome

Differential Diagnosis: Venn diagram of pericardial effusion, autoimmune phenomena Overlap syndrome: SLE vs. SS vs. MCTD

Teaching Points:
Emergency CP 4+2+2: cardiac (ACS, dissection, pericarditis/tamponade, takotsubo, pulm (PE, PTX), GI (rupture, impaction) + acute anemia
Shock: cardiogenic, obstructive, distributive, hypovolemic. Consider mixed shock!
PA pressure: > 25 abnormal. If very high, probably not acute, indicates chronic pulmonary hypertensive process
Pulmonary HTN: PAH, Cardiac, Lung Dz, CTEF, other.
Toxic causes of pulm HTN: fen-phen, amphetamines
Infectious causes of pulm HTN: HIV, schisto