# Morning Report with @CPSolvers

**CC**: 20 M with chest pain

**HPI**:
5 days, progressive
Middle of chest, sharp, burning
Worse with inspiration, swallowing, & coughing

**ROS:** productive cough, no hemoptysis +odynophagia, no dysphagia, +night sweats, no fever/chills/weight loss

**PMH**: none

**Meds**:
Recent 4000 mg tylenol daily, no herbs/supplements

**Fam Hx**: none

**Soc Hx**:
Moved to Colorado, no sick contacts. Works in warehouse. 1 female sexual partner. Neg STI screening. No smoking, vaping or IV drug use, +cannabis use.

**Vitals**: afebrile, BP 140/72, HR 105, RR 16, SpO2 95% on RA

**Exam**:
Unremarkable, no rash, no LAD, RRR, no murmurs, CTAB. Normal testicular exam

**Notable Labs & Imaging**:
CMP normal, HIV non-reactive
WBC 19 (left shift, no eos), Hg 15, Plt 405, TSH normal
ECG: sinus tachycardia
CXR: no acute process
Troponin < 0.01, D-dimer 1100
hCG, LDH, AFP normal
CT-PE: no acute PE, large centrally hypoattenuating, subcarinal mass, coarse calcification, mass effect, displacement of esophagus, bronchus intermedius. Mediastinal LAD, calcified granulomas in lungs/spleen
VATS biopsy: grew strep anginosus + mixed anaerobes

**Problem Representation**:
20M sub-acute pleuritic chest pain, odynophagia, e/o inflammation localizing to anterior mediastinum

**Differential Diagnosis**:
4+2+2 = emergency causes of CP
Pericarditis, GI cause
Myocarditis, endocarditis less likely given exam
Germ cell tumor, lymphoma, infection

**Teaching Points**:
HIV testing can have a window period → false negative. 4th gen test, Ab+Ag → should be positive within a week of exposure.

Thoracic inflammation DDx: parenchymal, pleural, pericarditis, myocarditis, endocarditis. Watch out for tylenol masking a fever!

Mediastinal masses DDx: consider metastatic solid tumors (exp: lung Ca esp w/ driver mutations like ALK)