8/11/20 Morning Report with @CPSolvers

***Case Presenter**: Anusha Chidharla **Case Discussants**: Joshua Morris and Rafael Medina dos Santos (@rafameed)*

CC: recurrent syncope

HPI: 55 yo Vietnamese M
-5 episodes of syncope in last 2 months
-No seizure like activity or post-episode confusion, no dizziness or rhythmic movements
-Some lightheadedness, occasionally occurs when lying in bed
-Witnessed by wife, episodes last 1-2 minutes

2 months of R shoulder pain, 15 pound weight loss (3 months), occasional cough

No shortness of breath, chest pain, or hemoptysis

PMH:
none

Meds:
none

Fam Hx:
none

Soc Hx:
Travel to Vietnam 3 months prior

Health-Related Behaviors:
No ETOH, illicit drug use
Tobacco 1PPD for 30 yrs

Allergies:
none

Vitals: **T**: 98 **HR**: 51 **BP**: 110/60 **RR**: 16 **SpO_2**: 100% RA; orthostatic vital signs normal, HR increased with exertion
Exam:
Gen: A&O well appearing NAD
HEENT: NCAT, no JVD
CV: RRR, nl S1S2, no murmurs, pulses 2+ & symmetrical
Pulm: CTAB
Abd: nontender, soft, nondistended
Neuro: A&Ox3, no focal neurologic deficits
Extremities/Skin: no pedal edema, no clubbing or cyanosis, no pain over right shoulder, TTP over right scapula

Notable Labs & Imaging:
Hematology:
WBC: 10 Hgb: 13 Plt: 400
Chemistry:
Na: 134 K: 4 Cl: 100
CO2, BUN, Cr, glucose: normal
AST, ALT, Alk-P, T. Bili, Albumin: normal
Troponin normal

Imaging:
CXR: mass noted in left upper lobe
EKG: sinus bradycardia, rate 51
CT Chest: large left lung mass, lymphadenopathy, lytic lesion in right scapula
Biopsy of scapula: squamous cell carcinoma
PET: LUL hypermetabolic lesion with vagus nerve impingement, mediastinal mass with recurrent laryngeal nerve impingement

Problem Representation:
Middle aged male with recent travel to vietnam and a 30PY tobacco use presenting with recurrent syncope, right scapular pain and weight loss found to have LUL & mediastinal mass consistent with squamous cell carcinoma with compression on vagus nerve leading to syncope & bradycardia

Teaching Points (Anna):

- .Syncope: transient drop in BP (influenced by CO, systemic resistance)
  - First rule out mimics (seizure, TIA)
  - Use prodromal sx to guide ddx
  - Decreased CO (obstructive, hypovolemic, arrhythmia, shunting)
  - Decreased resistance (increased parasympathetic tone- vasovagal, vagal stimulation / decreased sympathetic - meds, dysautonomia)
- .Unintentional weight loss:
  - inflammatory -mediated (Imade)
  - Malabsorption
  - Decreased PO intake
- Upper lobe lung mass:
  - Infection (TB, fungal dz)
  - Malignancy (primary lung cancer >>> metastatic dz, lymphoma)
  - Autoimmune (GPA, Sarcoid, IgG4-related dz)
- Cancer-Syncope Overlap
  - Most common structural causes: PE, pericardial effusion
  - Localized mass effect: vagal nerve irritation, subclavian artery steal syndrome