# 9/3/20 Morning Report with @CPSolvers

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**CC**: Syncope

**HPI**: 55 F developed dyspnea 4 months ago, initially while walking 4 blocks on level ground and then at rest. She also reported having developed lower limb swelling for which she was hospitalised and treated w/ diuretics.

Today she p/w syncope after walking 2 blocks with edema that was partly controlled by the medication she was prescribed.

**PMH**:
Hypothyroidism
Obesity

**Meds**:
Levothyroxine
Spironolactone
Furosemide

**Fam Hx**: None

**Soc Hx**: Housewife

**Health-Related Behaviors**:
Consumed 1-2 cigarettes/ day until 35 years

**Allergies**:
None

**Vitals**: **T**: 98.4 F **HR**: 75 **BP**: 95/60 **RR**: 24 **$SpO_2$**: 93% 4L
**Exam**:
**Gen**: Tired, appearing ill
**HEENT**: Normal
**CV**: Regular, diminished intensity, diastolic murmur pulmonic Area, systolic murmurs tricuspid area, S3+, JVD
**Pulm**: Decreased BS, crackles in basal area
**Abd:** Tender w/ shifting dullness +
**Neuro**: Awake, no FND
**Extremities/Skin**: Edema - B/l LL

**Notable Labs & Imaging**:
**Hematology**:
WBC: 4.8 Hgb: 12.7 Plt: 81
**Chemistry**:
Na: 137 K: 3.5 Cl: 95 CO2: 32 BUN: Cr: 0.9 glucose: 116 Ca:4.4 Corrected Ca 6.1
ALT: 34 Alk-P: 117 GGT 31T. Bili: Albumin: 2
CRP 13.9 Procalcitonin 0.11 lactate 1.9 Pro BNP 1045 BNP 438 Troponin T 0.014 CPK 21 LDH 518
**ABG:** pH 7.44 pCo 53.4 P02 46.7 -->65.3 SaO 80% Fi02 32% PaO2/Fi02 168.2
**Thyroid** normal
**Paracentesis:** bloody, albumin 0.9, Pr 3.7 RBC 27 WBC 200
Culture: Strep UA Alb 75
**Imaging**:
EKG: R ventricular strain pattern + RV hypertrophy signs, RBBB
CXR: Enlarged prox PA, enlarged R ventricle w/ mild pleural effusion
ECHO: R dilated cavities PA 77 mmHg, systolic dysfunction R ventricle, severe pericardial effusion
CT: No PE
Catheterisation: coronaries normal, coronary Artery P 55, L sided filling pressures <13, Pulm vascular resistance 15

**Problem Representation**:
A middle aged woman p/w acute syncope and chronic dyspnea w/ volume overload, hypotension and diminished heart sounds. Imaging and Labs were c/w a Dx of pericardial effusion and idiopathic pulmonary hypertension.

**Teaching Points (Sukriti)**:
- The dilemma of prioritising dyspnea (the more diagnostically fruitful condition) vs syncope (more morbid condition)
- Dyspnea: Anatomical approach, from outside to inside the chest + Base rate (heart, pulmonary).
- Filter the dyspnea through the Sx of Syncope: heart > lung
- What clues are we looking for? Time course, inflammation, features of presyncope and heart failure
- Looking at syncope from the lens of the physical exam: structural > rhythm abnormalities.
- The soft heart sounds suggest tamponade; presentations of which may vary w/ severity + time, look for pulsus exaggeratus!
- Valvular pathology -- Is it primary or secondary (functional)?
- CRP: Ignoring pertinent negatives is a source of diagnostic errors!
- An approach to hypocalcemia: 1. Hormones - Vit D, PTH 2. Chelation - PO4, Citrate, Albumin, Saponification (pancreatitis)
- Interpreting paracentesis: SAAG borderline, is this exudative (Clue: blood) or transudative (clue: Cardiac ascites-- total Pr >2.5 in context of portal HTN
- Dilated R. ventricle -- clue: tempo of pathology (acute) + severity of effusion
- Pericardial effusion -- idiopathic, uremia, autoimmune (lupus), cancer, hyperthyroidism