02/06/21 Morning Report with @CPSolvers

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CC: Chest pain/Dolor Toracico Agudo/Dor torácica

HPI: 62yF, chest pain for past 8 hours. Oppressive character, localized to middle of chest, no irradiation associated with N/V, sweating + dyspnea.

ROS: Epigastric pain for last 15d, an episode of headache, fine tremor in hands and chronic lower back pain.

Past Medical History: Hypertension, Diabetes type 2, Acute coronary syndrome (ACS) in 2019 - drug eluting stent in L descending artery. Cervical intraepithelial neoplasia.

Meds: Omeprazole, losartan, amlodipine, propranolol, prazosin, ASA, atorvastatin, clopidogrel, insulin, glargine

Family History: Mother died after an ACS older than 65yo.

Social History:

Health Related Behaviours: No tobacco, alcohol or drug use.

Allergies: None

Vitals: **T**:afebrile **HR**:100 **BP**:190/100 both arms, unknown in lower extremities → 150/90 w/meds **RR**:20 **SpO_2**: 97% RA
Gen: ill appearing, pale sclera and pale skin.
HEENT and **CV** and **Pulm**: Normal
Abd: Mild pain with palpation on right upper quadrant (RUQ). No mass or visceromegaly.
Neuro and **Extremities/Skin**: Normal

Notable Labs & Imaging:
Hematology: Hgb:10 MCV: 80

Chemistry: BUN:37 Cr:1.5 glucose: 98 Liver enzymes normal. TSH: 5.13 T4 level:11

Imaging:
EKG: sinus rhythm, regular. Normal axis. T wave inversion V3- V6, no ST elevation.
CT Thorax + Abdomen w/Contrast: No PE, no lung parenchyma disease. Isolated mass on R adrenal mass 48+52mm in close contact w/R kidney w/50HU. No lymphadenopathy.

Cardio workup:
Troponin: 0.0.48 (slightly elevated) → was started on heparin and taken to cath lab.
Cath lab: 10% stenosis of L descending artery.
TTE: Hypertrophy of LV, LVEF 60%, no segmental dysmotility.

Cortisol and aldosterone: nl. Renin activity increased. Serum epinephrine: nl. Serum norepinephrine elevated. 24h urine metanephrines: 152 mcg (nl), normetanephrines increased. Chromogranin elevated.

Final DX: Pheochromocytoma.

Problem Representation: ENG: 62yF p/w acute chest pain, subacute epigastric pain, headache and fine tremor in the setting of high cardiovascular risk factors. Workup revealed type 2 ACS and adrenal mass w/ elevated metanephrine levels.
ESP: Mujer de 62a con múltiples factores de riesgo para enfermedad cardiovascular se presenta con síndrome coronario agudo, dolor epigástrico 15 días previo a presentación, tremor fino en reposo y cefalea. Evaluación revela un SCA tipo 2, masa adrenal y niveles elevados de metanefrinas.
POR: Paciente F 62a com dor torácica aguda e dor epigástrica subaguda c/ riscos CV elevados. Exames indicaram massa adrenal com níveis elevados metanefrina.
FRE: Femme agée de 62 ans, antecédent de coronaropathie, diabete, hypertension, qui se présente a l'hospital pour une douleur thoracique retrosternale, oprpressive avec tremblement de repos, notion de doleur abdominale les 15 derniers jours, douleur a la palpation de l'abdomen et presence d'une hypertension massive.

Teaching Points (Sukriti):
Investigating the Sx: Chest pain
Rule out the sinister causes -- 4 + 2 + 2
Localisation to thorax: Mechanical pathology- block/break
4 (ACS, dissection, tamponade, takotsubo cardiomyopathy) + 2 (PE, pneumothorax) + 2 (Esophageal rupture & impaction)
Prominent syndrome complex outside the thorax: Aortic dissection > ACS + cardiogenic shock, PE + malignancy
Acute Tremor: Toxins -- on (intoxication) / off (withdrawal), hyperthyroidism
Collecting clues:
STEMI on EKG**:** ST elevation >1 mm on >2 continuous leads w/ reciprocal T wave depression/ new LBBB
Without clues suggestive of ACS on initial evaluation (use H+P, EKG, Troponin, CXR) -- **Use a CT chest w/ contrast** to identify signs suggestive of other sinister causes of chest pain
ACS w/o evidence of obstruction catheterisation: Clot dissolves, Vessel (vasospasm, dissection, external compression, fistulas), microvascular, MINOCA
Anemia - gastric pathology >
Framing a hypothesis: Chest pain + Tremor + Hypertension + Kidney injury + epigastric pain = Aortic dissection >> Sinister causes of chest pain > Systemic causes
MINOCA - Dx of exclusion
Adrenal Incidentaloma + acute chest pain syndrome = >> Pheochromocytoma