05/29/21 Rapid Morning Report with @CPSolvers Family

CASE 1 - Vale Roldan (@ValeRoldan23)

Problem Representation: 34yF on active labor w/PMHx relevant for HTN, and 2 previous abortions p/w hemodynamic inestability + an elevated DDimer.

History:
-34yF, 40w pregnant. Active labor w/intense chest pain + diaphoresis + dyspnea.
- PMHx: 1st trim- hyperemesis + HTN during pregnancy (21w), 2 previous abortions.

Labs/imaging:
- Hypotensive, 89 % SaO2
-WBC 15 (N >66, Bands 1%), Hb 6.
- GSA pH:7.32, Lactic:3.2, PaCo2:42 PaO2:89
-D Dimer: 1000. PT 4.2, PTT 110 (high)
- Creatinine 0.39, Albumin 3
- Angio CT: **Aortic dissection.**

Teaching points (Sukriti):
Fernand says "think 4 + 2 + 2 to r/o emergent causes"
In **Pregnancy** -- Prioritize **vascular** pathology: Hemorrhage vs Thrombosis -- Lumen (Preclampsia, PE), Wall (Dissection, Vasospasm, aneurysm), Other (Amniotic fluid)
Anemia + coagulopathy = MAHA
- Pregnancy Limited -- HELLP, amniotic embolism vs DIC, TTP, HUS, APLS

Aortic Dissection -> Shock
Distributive, Ext to coronaries - cardiogenic shock; hemopericardium - obstructive; Ext spinal A - neurogenic shock

CASE 2 - Gurleen Kaur (@Gurleen_Kaur96)

Problem Representation: 75yM w/ lumbar spinal stenosis and a recent aortic valve replacement p/w sudden worsening of back pain, urinary incontinence a new systolic murmur and a ischemic stroke.

History:
-75yM w/ lumbar spinal stenosis. P/w sudden worsening of back pain after a fall. History of fecal incontinence due to IBS. New urinary incontinence. No numbness or tingling.
-PMHx: Recently diagnosed w/Covid. RA - prednisone (recently increased dose), OA, aortic valve replacement - warfarin, AFib.

Labs/imaging:
- Vitals nl. Systolic murmur. Tenderness of paraspinal muscles. Neuro exam nl. CBC nl. BMP nl. PT 36.2, INR 3.2
- CT scan: severe degenerative changes + lumbar stenosis. No osteomyelitis. MRI: L3-L4 herniation, hyperintense L4-L5 discs.
- Day 2: somnolence, hypoxic, GSC diminished. New ST segment elevations w/ high troponin and new wall motion anl. Had VTac. Procal 14, CRP 135, INR 6, increased WBC. Lactic ac. 1.42
New CT scan: infarct of R parietal lobe.
- Blood Culture: Corynebacterium striatum Echo: LVEF 50-60% + vegetation. **Final Dx: Endocarditis + Discitis**

Teaching points:
Back pain: Mechanical MSK > Primary neuro Retroperitoneal dz
Kushal says "Given the red flags, Its impt to consider TM & Cauda equina"
- New murmur + Prosthetic valve = > Endocarditis

Thrombosis -- **What** (Inflamm < pus) & **Where** (multifocal emboli < heart)
Endocarditis + back pain = Vert osteomyelitis, epidural abscess > spinal cord infarction
CP: Endocarditis -> Vertebral osteomyelitis may be **missed on imaging early in the course of the disease**

CASE 3 - Gabriel Talledo (@gabrieltalledop)

Problem Representation: 60yM from Andes w/ previous cholecystectomy p/w direct hyperbilirubinemia and a hyperechogenic mass w/no acoustic shadow on USG.

History:
-60yM from Andes. PMHx cholecystectomy and DM2. P/w 1 month of progressive malaise, jaundice and weight loss (10kg)

Labs/imaging:
-PE: Vitals nl. Mucosal and conjunctival icterus. No cirrhotic stigmata. Rest of PE normal.
-WBC: nl. ESR: 30. AST 113, ALT 196, Alk P 1870, Lipase and amylase nl. TB: high; DB: 5.4
-USG: common bile duct dilation w/ hyperechogenic mass w/ no acoustic shadow and double wall sign
- **Final DX: Ascaris Lumbricoides**

Teaching points:
Rafa says "Thinking fast, I think of PSC" Kara would say "All aboard the Jaundice thought train!"
Direct vs Indirect Bilirubin -- 1st Branching point
- Findings on imaging -- 2nd branching point
- Image +: Extra hepatic -- Lumen (Parasite, stone, sludge), Wall, Ext compression

Parasite in the GB lumen --> Stone & stricture