10/23/21 Morning Report with @CPSolvers

***Case Presenter**: Sinai Hospital of Baltimore Residents (@SinaiBmoreIMRes) **Case Discussants**: CPS Family <3*

CC: Chest pain and dysphagia
HPI: 53 yo man with history of AV fistula with left upper extremity swelling. Presents for an elective brachiocephalic venogram but was referred to the ED because of dysphagia and chest pain for several days. Chest pain is substernal 7/10, irradiating to his arm to his left neck and jaw. Dysphagia started 4 days ago as inability to tolerate his PO meds and reports food gets "stuck" in his chest.

Past Medical History: SLE secondary to lupus nephritis. Kidney transplant x3. Hx of DVTs and GERD. ERCP w/ sphincterotomy. EGD w/ dilation. Nissen fundoplication. Recurrent esophageal strictures. Incisional hernia repair. Nephrectomy, pericardial window, splenectomy.
Meds: Prednisone, tacrolimus, azathioprine, amlodipine, gabapentin, pantoprazole, Coreg, Eliquis .

Family History: Mom and aunt LES and heart disease. Maternal grandmother has CKD.

Health Related Behaviours: No EtOH or tobacco.

Vitals: **T**:36.6 **HR**: 78 **BP**: 138/95 **RR**: **SpO_2**: 100 on 2 lt LNC.
Exam:
Gen: Appeared anxious
CV: Regular rate and rhythm w/o rubs, gallops or murmurs.
Pulm: Clear b/l.
Abd: +BS, NT, Non distended.
Extremities/Skin: Left AV fistula. + peripheral pulses, no edema. No rashes or lesions.

Notable Labs & Imaging:
Hematology: WBC: 7.76 Hgb: 10.5 Plt: 361

Chemistry:
Na: 139 K: 4.2 Cl: 107 CO2: 23 BUN: 17 Cr:1.3 glucose: 76 Ca: 8.1
Troponins were normal. Coagulation panel was normal.

Imaging:
EKG: Normal sinus rhythm with first degree AV block.

Evolution: Hypertensive >180 SBP. Started metoprolol w/ PRN labetalol IV. Appeared anxious and started IV Phenergan. Later woke up with 10/10 chest pain which felt different relieved with leaning forwards and radiated through the back.
EKG: new T wave inversion V4-V6. Troponin elevation. Patient was supposed to undergo EGD, but it was cancelled due to chest pain.
Echo: EF 70% w/o pericardial effusion, trace Ao insufficiency. No wall motion abnormalities.
CT Chest: Anterior aortic wall rupture and pseudoaneurysm just distal to sinotubular junction w/ hemopericardium and hemomediastinum. No lobar or segmental PE.

Final Dx: Aortic Dissection.

Problem Representation:
ENG: 53M w/ history of AV fistula p/w edema on LUE, chest pain and dysphagia.
ESP: Paciente masculino de mediana edad con antecedente de trasplante renal y fístula AV en HD se presenta con disfagia, dolor de pecho y edema de MSI.
POR: Um homem de 53 anos com história de fistula AV, transplante renal e cirurgias previas gastrointestinais que se apresenta com edema de MSE, disfagia e dor toracica.

Teaching Points (Maria/Kirtan):

- **Sinai Hospital of Baltimore**= Amazing and diverse group of people who enjoy seafood (crab cakes!) and ice cream.
- **Fistulas:** Congenital or acquired. Always consider infection, vascular steal syndrome and high output heart failure.
- **Dysphagia:** Although we tend to think of the esophagus, also consider other mediastinal structures especially with extraesophageal symptoms. Compression from surrounding structures like great vessels → aneurysm, Lymph nodes → LAD/lymphoma, thymus, venous congestion/thrombosis, or mediastinal inflammation/occupation, heart → left atrium enlargement.
- **Kidney transplant patients:** think comorbidities, immunosuppression, PTLD, secondary amyloidosis
- **SLE** - Always keep in mind possible complications like APLA, valvular lesions, libman sacks endocarditis, and effects of immunosuppressive meds
- **Chest Pain 4+2+2 (emergent causes)**: 4- ACS, aortic dissection, tamponade, Takotsubo. 2 - PE, pneumothorax. 2 - esophageal rupture or impaction. If sinister and EKG and troponins don't answer the question → move quickly to CT chest w/contrast.
  - ST changes without ST elevation: NSTEMI - ACS, increased demand, pericarditis
  - Acute aortic insufficiency: valvular (endocarditis), post-valvular (Ao dissection)
- **Aortic insufficiency:** might present itself subacutely!!!!!