6/29/22 Morning Report with @CPSolvers

***Case Presenter**: Ravi Singh (@ravi7ks) **Case Discussants**: Madellena (@MadellenaC) and Kirtan (@Kirtanpatolia)*

CC: tachycardia

HPI: Medicine team responded to a rapid response initiated due to tachycardia
Bedside, patient was in the 160s, BP was low (120/80) , RR-40S, and 02 high 90% on RA
25yoM with no PMH presented after being stabbed in L infra-clavicular region 4 days prior. Had a 3 cm wound and decreased lung sounds on L requiring emergent CT placement in the ED
Had been tachy in the 120's - now worsened to 160-170s and a/w tachypnea and restlessness

PMH: none

Meds: none

Fam Hx: none

Health-Related Behaviors:

Allergies: none

Vitals: **T**: **37.1** **HR**: **160** **BP**: 110-120s/80-90s **RR**: **40** **SpO_2**: 100 on 2L NC

Exam:

Gen: alert and oriented slightly confused. Anxious and restless but able to follow commands

HEENT:

CV: rapid HR with regular S1 and S2 - no murmurs. No JVD and pulmonary edema. Pulses intact in all extremities . Anterior wound dressing present without erythema and drainage.

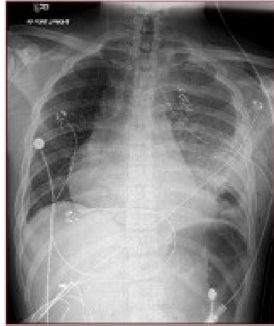
Pulm: increased work of breathing, decreased lung sounds in the L lung normal breath sounds in R lung

Abd: soft, NT/ND, normal BS

Neuro: alert, oriented, normal sensory, normal motor function, no focal deficits, CNs grossly intact

Notable Labs & Imaging:

Hematology:
WBC: 27 Hgb: 8.9 MCV 70 Plt: 537



Chemistry:
Na: 132 K: 4.2 Cl: CO2: 23 BUN: nl Cr:nl
AST: ALT: Alk-P: T. Bili: Albumin:
Lactate 4.7 PT 16.2 INR 1.3

Imaging:
CXR: deviation of trachea to the R side, increased cardiac silhouette (cardiomegaly), widened mediastinum.
EKG: ST-elevations V3-V4; ECHO with EF=65% and normal V size and motion.
Remained tachycardic but stable - chest pain with increased levels of troponin
CXR: left PTX
Pericardial effusion - fluid positive for Staph - L thoracostomy tube
Complete decortication due to empyema

Problem Representation: 25 year old with no PMH presents after L-infraclavicular stabbing with tachycardia, reduced lung sounds, and enlarged cardiac silhouette on CXR.

Teaching Points (Ravi):

- Make sure if sinus tachycardia or other arrhythmia ? How wide is the QRS complex
- Need to make sure patient is stable
- Implement ACLS ! If pt AMS, ACS ? Workup- do we need pads, defibb etc
- Tachycardia- - think if primary or secondary
- Numerous processes that can lead to tachycardia
- Volume losses ? etc Anemia Endocrinological disturbances
- Primary- cardiac processes
- Resp rate stands out- Is this pt unstable- need to intervene (Airway) → respiratory failure
- Pulm exam- increased work of breathing. Decreased lung sounds ? fluid, air in pleural space. PTX ? Pleural effusion ?
- Chest tube - has there been any changes ?
- Tachypnea- PCO2 should be low. If normal patient can decompensate rapidly.
- Tachy ? Bleeding now a concern. Pulm contusion ?
- HemoPTX, Hemopericardium ? Possibility of arrhythmias being triggered. Lastly possible infection can be entertinaned Mediastinitis.
- WBC ? infection and thrombocytosis due to bleeding or anemia or stress.
- EKG: ST elevation— ? Ischemia What can cause STE ? ACS, or AD or aortic rupture, Dissection can involve right coronary vessels, myo or pericarditis w/wout tamponade.
- Elev. TPI can be due to trauma or irritation to myocardium. PE Can also be entertained.