10/12/22 Morning Report with @CPSolvers

Case Presenter: Rafael Medina (@) Case Discussants: Madellena Conte (@MadellenaC) and Zaven (@sargsyanz)

CC: Chest pain for 1 day

HPI:

- 48yM w/ chest pain for 1 day
- Sharp, substernal, non-radiating
- Not worsened by position, activity or respiration
- Denies weight changes, fever, chills, night sweats, headache, blurry or double vision
- Endorses chest pain+palpitations
- Denies SOB, cough, hemoptysis, lightheadedness and dizziness

PMH:
ESRD
HTN
Anemia
Gout

Meds:
Aspirin
Carvedilol
Colchicine
Sevelamer

Fam Hx:

Soc Hx:

Health-Related Behaviors:

Allergies:

Vitals: T:99.1 F HR: 141 BP:84/58 RR:14 SpO_2:96% RA
Exam:
Gen: mad distress
HEENT:
CV: tachycardic, regular rhythm, distant heart sound, S1+S2 normal, no murmurs
Pulm: diminished breathsounds, no wheezing or rhonchi
Extremities/Skin: no edema

Notable Labs & Imaging:
Hematology:
WBC: Hgb: Plt:
CBK 37, Trop <0.1, D-dimer 2185
Chemistry:
Na: K: Cl: CO2: BUN: Cr: glucose: Ca: Phos: Mag:
AST: ALT: Alk-P: T. Bili: Albumin:

Imaging:
EKG:
CXR: pleural effusions, enlarged cardiac silhouette (waterbottle heart)
CT chest: pericardial effusion + pleural effusion

Final dx: Pericardial tamponade (collaps of R atrium+ventricle during diastole)

→ idiopathic or 2/2 uremic pericarditis (no single cause determined)

=> Tamponade has to be confirmed via diastolic collapse ~AMK

Problem Representation: A 48yM w/ one day of substernal, sharp, non-radiating chest pain and palpitations w/ a PMH of ESRD, HTN, Anemia and Gout. PE shows hypotension, tachycardia and diminished breath sounds. Labs notable for D-Dimers >2000.

Teaching Points (Yazmin):

- First consider life threatening causes **(4+4+2)**
- **Consider the history:** how did it start? Is is pleuritic? Irradiating? Are there triggers? (Strenuous exercise or alcohol consumption)
- Chest wall pain: Consider MSK pain, costochondritis, thoracic radiculopathy, Bornholm dx (pleurodynia), Tietze sx., Texidor twinge (precordial catch sx), Mondor dx.
- ESRD increases the risk of ACS: Coronary heart disease is a significant complication of chronic kidney disease and is the most common cause of death in this population. Patients on dialysis have a **10 to 30 times higher cardiovascular mortality risk than in the general population**.
- Increased D-Dimer → High sensitivity: deep vein thrombosis (DVT), pulmonary embolism (PE), and disseminated intravascular coagulation, aortic dissection.
- Wells criteria most important criteria is the lack of alternate dx.Is there another explanation?
- Look for potential causes of pericarditis: Infectious, MI, uremia, radiation, neoplasm or autoimmune.
- Confirm tamponade: search for **diastolic collapse.**
- **Uremic pericarditis is a complication of ESRD → fibrinous pericarditis that presents with chest pain worsened by inhalation.**