3/20/23 Morning Report with @CPSolvers

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CC: SOB

HPI: 25 y/o female immigrated from China 2 days of SOB. Started in the afternoon
Vague chest pain, not positional.
It is confused w/ the medical terms.
More talked w/ her SOB progressed in the last few days. She had covid in the last month, but didn't have this symptoms.
Occasional cough, trough sensation.
No nausea, vomiting, diarrhea, fever, chills, night sweats
It was Sat 78% w/ NC → 94%

PMH:
China had a bug bite

Meds:
None

Fam Hx:
Mother had diabetes

Soc Hx:
Alone in US, learning english

Health-Related Behaviors:
Never smoked (tobacco or vape), used drugs, don't drink alcohol

Allergies: Denied

Vitals: T: afebrile **HR: BP:** 160/75 **RR:** 18 **SpO2** 99% 4 L **BMI:** 25
Exam:
Gen: No acute distress
HEENT: NCAT, no oropharynx without signs of erythema
CV: Tachycardic, no murmur
Pulm: Diffuse and expiratory wheezing, increased work of breathing without use of accessory muscle use
Abd: Soft, NTND, normoactive BS
Neuro: CN2-12 intact, no focal deficits
Extremities/skin: 2x2 lesion over L scapula w/ scab

Notable Labs & Imaging:
Hematology:
WBC: 13.6 (Neutrophil predominant) Hgb: 16.6 Plt: 334
Chemistry:
Na:141 K:3.8 Cl:105 CO2: 24 BUN:13 Cr:1.1 glucose:83 Ca:9.1 Phos 1.2 AST:28
ALT:21 Alk-P:66 T. Bili: Albumin: 4.5 Lactate 2.7 Protein: 8.4
ABG 7.30/ 43/72/21. D dimer negative, troponin negative

Imaging:
EKG: Sinus tachycardia w/ RVH
CXR: Diffuse mild BL interstitial opacities, no focal consolidation
CT: Nondiagnostic for PE. GGO in RLL. Tangle of vessels: possible vascular malformation in the lingula w/ feeding vessels above and below the diaphragm
Blood cultures: 2/4 Staph Epi
-Patient said that she was maybe exposure to something but not sure what.
Pulmonary: Congenital AVM not likely to be causing the symptoms. Treatment w/ solumedrol, supplemental O2 2L, Lactate 1.0, Sat 95% RA, improvement of all dyspnea like symptoms after 24 hours.
No fever.

Diagnosis: Chemical Pneumonitis

Problem Representation: Younger woman immigrated from china w/ 2 days of SOB, progressed in the last few days. She had covid in the last month, but without symptoms.

Teaching Points (Yaz):

SOB: Heme (Malignancy) vs. Cardiac vs. Lung

- Hypoxia = lung origin

When the px refers a "subjective" issue take the objective data from PE: Hoarseness, Stridor, Retraction of chest
Time of progression can help in the ddx: an acute process can orient us to more emergent dx such as PE, while a subacute process can be pneumonia
Be careful on H&P: SH, PMH, etc. can orient us to the dx.

Approach to ddx w/labs & imaging

- Increased Hb: First think is it Hemoconcentration?
- Leukocytosis + Tachy = acute and progressive → first rule out PE
- Look for patterns in the lung imaging: infectious, infiltrative, interstitial, etc.
- GGO: edema, pus, cells, blood or protein

RVH = is this due to AVM or is this an acute on chronic issue?
(May need to repeat imaging to determine ddx) [Most AVMs are detected as an incidental finding, with the exception of congenital AVM]

Always look for **occupational/environmental exposure** → Ask the px about their perspective of the etiology
May need to re-formulate questions and establish good rapport with px through translator/interpreter, consider information lost in translation.
In px whose first language is not english always have the interpreter to explain the medical processes.
Confirmation bias: the tx may work but not for the right reasons.

Steroids tx depend on the type of pneumonitis → first confirm the exposure