7/27/23 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Amanda (@Amandabarretof2) Case Discussants: Rabih (@Rabihmgeha) and Hui Ting (@Huitingruan)

CC: 50 year-old male presented to the family medicine clinic with 8/10 intensity pain in the left hemithorax for the past 6 days.

HPI: Localized pain which doesn't interfere with breathing, comes with paresthesia, and vesicles seen on the back about 72 hours ago.

Denies any fever, trauma, nausea, vomiting or SOB. Recently had pneumonia (wasn't treated properly)

PMH:
Hypertension, chicken pox

Meds: None

Fam Hx: None

Soc Hx: Smoker, drinks on weekends

Health-Related Behaviors: Anxious due to death of his mother

Allergies: None

Vitals: T: 37.9 **HR:** 98 **BP:** 130/70 **RR: SpO2** 93% on RA
Exam:
Gen: Palpable anterior and posterior cervical lymph nodes
Pulm: Crackles in lower right lung lobe
Extremities/skin: Vesicular lesions spreading in dermatomes T-1/2 - T4

Notable Labs & Imaging:

Biopsy: Results pending.

Management: Treated with Acyclovir for Zoster, crackles were treated with pneumoniae treatment. Immunology informed.
Patient returned a few days later with improvement of lesions and crackles.

Final diagnosis: Zoster reactivation with potential atelectasis

Problem Representation: 50 y/o male presented with a 6 day of left hemithorax pain accompanied with paresthesia and vesicles seen on the back. Exam was notable for hypoxia and palpable anterior and posterior lymph cervical lymph nodes, crackles in right lower lung lobe, & vesicular lesions in T1/2 - T4 dermatomes.

Teaching Points (Marino):
-Chest pain: rule out emergent causes with **4+2+2** mnemonic.
-**Chest pain approach:** cardiac, pulmonary, GI, MSK, skin and mediastinal.
- Take into consideration for how long the patient has had the pain and also the localization.
-Vesicles in the back in a patient with chest pain gives us a big clue to think about herpes/shingles.
-*Presence of SOB helps us to localize in the cardiopulmonary system. More narrow ddx in comparison to chest pain. Almost any presentation of SOB can be accompanied with chest pain, but not most of the causes of chest pain can cause SOB.*
-**Chest pain in the outpatient:** look for SOB and hypoxemia to try and rule out emergent causes. Scary diseases that cannot be ruled out by this: Pericardial/Pleural disease.
-Visceral/autonomic innervation is less specific and shows as more diffuse pain. Somatic pain is way more localized. Indicates that there is irritation of the chest/abdominal wall. Example: Appendicitis: first it is a vague pain, but after it irritates the peritoneum, the pain localizes to the RLQ. Pericardial/Pleural irritation (visceral part) causes somatic pain in the chest wall.
-Shingles can be triggered by stress, considering previous history of VZV infection in childhood.
-Crackles + hypoxemia: indicates lung involvement.
-VZV reactivation can include 2 contiguous dermatomes.