9/27/23 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: John Claudio Romero **Case Discussants**: Sharmin (@Sharminzi) and Jack Penner*

CC: 60 yo female with chest pain

HPI: the patient was in her usual state of health until a week ago, after which she started with episodes of moderate chest pain, mainly left sided, waxing and waning, accompanying her spikes of anxiety and occasionally associated with mild diaforesis. It was non radiating, but sometimes involved her entire chest. The pain was brought upon stressful condition, mildly relieved by rest and clonazepam.

PMH: anxiety, HTN

Meds: clonazepam

Fam Hx: dad died at 43 yo from cardiac disease

Soc Hx: stopped smoking 20 years ago

Health-Related Behaviors: **none**

Allergies: none

Vitals: T: 36.5ºC, **HR:** 105 **BP:** 180/90 **RR:** 26, **SpO2** 99% RA
Exam:
Gen: anxious, able to communicate, endorse right chest pain
HEENT: pupils ok, EOMs intact, non sinus tenderness
CV: normal RRR, no murmurs, rubs or gallops
Pulm: clear
Abd: soft, non tender, non distended, bowel movements wnl
Neuro: intact, no gross focal deficits; appropriate mood, affect and thought
Extremities/skin: no deformities. Strength ok. Skin intact.

Notable Labs & Imaging:
Hematology: WBC: 18.310
Chemistry: glucose: 180, Troponin: 11.000

EKG: sinus rhythm at 120 bpm, QRS axis normal, PR normal, ST depressions in I, aVL, II, V4-V6 and ST elevation in III and aVR -> **Cardiology consulted**: concerned for acute infarction given inferior STE -> **cath**: LAD 99% occlusion -> a drug-stent placed

Dx: acute myocardial infarction due to LAD occlusion

Problem Representation: 60 yo female with PMH of anxiety and HTN presents with one week of chest pain, found to have very elevated troponin and diffuse ST depression with ST elevation in III and aVR.

Teaching Points (Ximena):
-Algorithms help us reduce "the noise" when we have clinical presentations that might be subjective to clinicians' judgement or cognitive load →use those resources!
-Rule out life-threatening conditions related to chest pain
-Panic attack is mainly an exclusion diagnosis. However, it is important to discern the emotional involvement and distress that a patient might be going through vs conditions that can put a bigger strain on the heart.
-Past medical history guides the probability of patients to actually have an MI vs other non-life threatening conditions
-Tachycardia and tachypnea can present in the setting of MI or pulmonary disease.
-Family history of relatives passing away at a young age should also raise questions about cardiac risk factors
-In the setting of MI, it is helpful to know how controlled other metabolic comorbidities are (medication compliance)
-Diffuse elevations or changes on ECG can raise concerns of pericarditis
-In doubt, do an early consult to cardiology. It is helpful to involve them in case patient is going to the cath lab because they can provide great input over anticoagulant/antiplatelet therapy.
-Sending a patient to cath lab can be first diagnostic and then become therapeutic.
-Pearl: elevations in aVR can point to occlusions on the LAD.

Think about the interventions that we can make to support or rule out a diagnosis, and if we can't rule it out, keep testing until we can be more confident on the probability of a patient having that particular disease.