# 03/13/24 Morning Report with @CPSolvers

*"One life, so many dreams" Case Presenter: Avi Singh Case Discussants: Jack Penner and Sharmin Shekarchian (@Sharminzi)*

**CC**: pressure like chest pain ("elephant sitting on chest")

**HPI**: A 45 year old female came with concern of **alcohol withdrawal**, had symptoms of headache tremor, palpitations, tactile hallucinations; the symptoms resolved. Patient was put on Barbiturate taper. Inpatient<1day; the patient suddenly developed continuous pressure on chest, **radiating to jaw**, no history of similar episode in the past; at that time; HR-127
She had multiple episodes of renal colic in the past
**ROS**: RUQ pain, left flank pain, multiple episodes of vomiting in last 2 days

**PMH**: HIV
AV Endocarditis 2/2 enterococcus faecalis with mechanical valve
AUD
s/p CCY
s/p SMA aneurysm repair

**Meds**:
ART
Warfarin
ASA

**Fam Hx**:
N/A

**Soc Hx and Health-Related Behaviors**: : 23 pack years smoking marijuana

**Allergies**: NA

**Vitals**: **T:wnl HR:** 127 **BP:115/90 RR:wnl**
**Exam: Gen:** wnl
**HEENT:** wnl
**CV:** mechanical sound (mech valve)
**Pulm: wnl**
**Abd:** L flank tenderness (similar with prior episodes of renal colic), RUQ tenderness. Umbilical hernia
**Neuro:** fine tremors
**Extremities/skin:** wnl

**Notable Labs & Imaging**:
**Hematology**:
Hgb: 10.3 | WBC:8.9 wnl| CD4:174(<200)

**Chemistry**:
Na: 127 | K: 3.2 | LDL: 154,
AST:493 | ALT:129 | Alk-P: 641 ;
hs Troponin: 2131 → 4000 → 6000(within a day); PT/INR:1

**Imaging**:
EKG: new Q wave changes; nothing very acute → repeat stable (Serial ecgs: no st elevation)
CTPE: not significant
Echocardiogram: EF: 45-50%, **apical hypokinesis, mass/thrombus on the mechanical valve**
Left heart cath:- occlusion in LAD and diagonals; **no CAD**
Discontinued aspirin and continued heparin.
PCI not done because trops trended downwards.

**Dx: Medication (Warfarin) non-compliance induced acute MI (Type 2)**

**Problem Representation**: A 45 year old lady with PMH of Enterococcal endocarditis and mechanical aortic valve who was initially admitted for alcohol withdrawal suddenly developed acute pressure like chest pain with rising Troponin levels and no evidence of CAD

**Teaching Points (Harry)**:
-Chest pain approach: can't miss of 4+2+2: cardiac - ACS, aortic dissection, tamponade, stress cardiomyopathy. Pulm -PE, PTX. GI - esophageal rupture, esophageal impaction.
-ACS: remember, females tend to present with "atypical" symptoms including N/V more frequently than males
-ACS: infarcts can lead to HF → venous congestion → hepatic congestion
-ACS initial mgmt: anti-platelet (at least ASA) + heparin, statin; some wait to add on 2nd antiplatelet agent until cath
-Stress cardiomyopathy: think of this when pt is young with ACS-like symptoms without traditional cardiac risk factors in the setting of high stress setting (including etoh w/d)
-Folks with HIV are inflamed → increased risk of plaque formation
-Clinical reasoning pearl: don't anchor on the patient's initial presenting syndrome if a new symptom develops during the course
-Aortic dissection: as progresses, can have travelling pain
-Causes of epicardial artery occlusion/ACS: plaque rupture, dissection (spontaneous aka SCAD), embolic (e.g septic emboli from endocarditis or mechanical valve); latter two do not need antiplatelet/statin
-Mgmt: remember warfarin has many drug-drug interactions that can affect therapeutic dosing/INR