



04/18/24 Morning Report with @CPSolvers



“One life, so many dreams” Case Presenter: Parisa (@parisabediii) Case Discussants: Rabih (@rabihmgeha) and Maddy (@MadellenaC)

CC: 84 yo M presented to MICU and incubated after PEA, following aspiration event

HPI: The pt presented with weakness with fall and change in speech after swallowing a fishbone 5 days ago, along with severe dysphagia, esophageal dysmotility, candidate to PEG tube placement.

He recently had a klebsiella UTI complicated with bacteremia and received ceftriaxone. He had an aspiration and then developed a cardiac arrest. ROS: not available

PMH: CVA, ESRD, bilateral renal transplantation (2014, 2019), AF, s/p biventricular pacemaker, HTN, HLD, HEREF, Type2DM, PAD (s/p bilateral femoral arteries angioplasty), prostate cancer after radiation therapy

Med: Amlodipine, aspirin, atorvastatin, edoxaban, lisinopril, folic acid, guaifenesin, hydralazine, prednisone, tacrolimus

Fam Hx: Cardiac disease in mother
Cancer history in brother

Health-Related Behaviors: Smoking history 30 years

Vitals: T: 36.3 HR: 65 BP: 127/68 RR: 28 SpO2 100% (intubated)

Gen: unresponsive

HEENT: fixed pupils, unreactive, moist oral mucosa

CV: normal rate rhythm, no murmur, no edema

Pulm: bl coarse breath sound

Abd: nontender, positive bowel sounds, no costovertebral angle tenderness

Neuro: unresponsive to voice commands or deep sternal rubs, doesn't withdraw under pain stimulation in extremities

Notable Labs & Imaging:

Hematology:

WBC: 2k Hgb:11 Plt: 106

Chemistry:

Na: 142 K: 4.1 Cl: HCO3:18.5 BUN: Cr: 1.39 (bs 0.7) Ca:10.3 Mag: 2.2 P 2.1 Lactate 5.6 PT 19.1, INR 1.6, troponin 654, ABG: PH7.39, Pco2 31, pO2 87, HCO3 19 on FiO2 of 70%, A-a gradient 359, Anion gap 8

Imaging:

CXR: bl infiltration, pacemaker in place, incubated (ET tube in the right main bronchus)

EGD: Gastric ulcer found and managed with clip, edoxaban discontinued and was on PPI inhibitors

POCUS: right ventricular dilation and strain

->The pt is unstable to have VQ scan, CTPE deferred due to AKI

Echo: normal EF, RV dilation and dysfunction suggestive of PE

US: extensive low extremity deep venous thrombosis

->The pt was treated with IVC filter and hemodialysis

Dx: DVT and pulmonary embolism

Problem Representation: An 84 yo M with PMH of renal transplantation, CVA, PAD, prostate cancer presented with weakness and dysphagia. He had a PEA arrest after an aspiration; later found to be unresponsive and had to be intubated.

Teaching Points (Kuchal):

1. Cardiac Arrest: 6H/4Ts; Microscopic Causes: POCUS not helpful, like acidemia.: and Macroscopic causes where POCUS is helpful in diagnosing (like in Pneumothorax, Tamponade)

2. PEA: Pulseless Electrical Activity. non shockable. Electromechanical Dissociation; patient on Beta Blockers, CCB. (# amazing schema available on CPSolvers.com)

3. Phase I: connect the patient to monitors: assess if its Shockable/non shockable; CPR done; For Rhythms not responsive to Shocks, Amiodarone is given;

Phase II: Empiric treatment of plausible causes; eg in this patient treat for Hyperkalemia, given this patient's ESRD;

Phase III: POCUS,

Phase IV: Labs for SE, Hb.

Phase V: empiric dose of tPA for PE not visible on POCUS

4. Bulbar symptoms, with history of cancer, r/o paraneoplastic syndrome

5. Intracranial injury: Post code: due to medication, Intra code: due to the resuscitation process Pre code: due to the pre existing condition like CVA,, aspiration.

6. 30% patients with Aspiration: X Ray doesn't reveal anything prominent; Sensitivity for acute aspiration is low.

7. Mild abnormality in electrolytes, lactate in post code might be due to the cardiac arrest itself or to rule out if its cause for the arrest.

8. RV strain/dilatation: High concern for Pulmonary Embolism. High Pulmonary Pressure might also be due to Hypoxia???

9. In case of PE in patients with active GI bleed empiric tPA vs : Mechanical Thrombectomy to be considered, IVC filter to prevent further clots.