



8/28/24 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Kashayar (@) Case Discussants: Reza (@)

"Another Brick in the Wall"

CC: chest pain

HPI:

72 yo F w/ CAD (s/p CABG), DM c/b retinopathy, CKD (2/2 DM), HTN presenting with retrosternal chest pain

Pain with radiation to the back and left arm. Started this AM, had been experiencing intermittently throughout day. Cannot do daily activities as pain exacerbated by movement.

Has had similar pain with activity before, 3-4x a month, never this intense. Son passed away 2 nights prior. Dysuria for 1 week, no urgency/frequency. Sleeps with 3 pillows at home, no orthopnea, no PND.

On Day 2 of admission, developed cough, dyspnea

PMH

DM c/b retinopathy
CAD s/p CABG
CKD 2/2 DM
HTN

Meds:

Insulin
ASA
Does not know rest

Fam Hx:

Soc Hx:

Lives alone, 3 sons who are involved
Bakes bread in traditional furnaces

Health-Related Behaviors:

Smokes hookah, no cigarettes
No alcohol/other substances

Allergies: N/A

Vitals: Day 1 T: AF HR: 80 BP: 160/110 (both arms) RR: 15; 94% RA

Day 2: febrile, 70% on RA → 97% on 4L

Exam:

Gen: ill appearing

HEENT:

CV: S3, no murmurs. Intact pulses, symmetric

Pulm: CTAB

Abd: wnl, no thrills, no bruit

Neuro: AOx3

Extremities/skin: BLE edema, L>R

Notable Labs & Imaging:

Hematology:

WBC: 3.47(85% PMNs) Hgb: 13.1 w/ MCV 88 Plt: 114

Chemistry:

Na: 133 K: 4.4 Cl: HCO3: BUN: 105 (nml 17-43) Cr: 1.65 (unknown bl)

glucose: 180

Troponin (HS): 0.009 → 0.027 (1 hr)

UA w/ trace protein, glucose

COVID-19 PCR +

Imaging:

EKG: Day 1: no ST segment changes

Day 2: a flutter, no ST changes

CXR: elevated R hemidiaphragm

POCUS: nml WOB, no paradoxical movement of diaphragm, no aortic abnormality

CTA chest: no aortic abnormalities, no PE, no parenchymal findings

Echocardiogram: LVEF 40%, no LVH, base mid-inferior akinesis, abnormal septal motion, mild diastolic dysfunction, mild LAE, mild RV dysfunction, no valvulopathies, PASP 35, no pericardial effusions

Dx: HFmrEF w/ covid, afib/flutter

Problem Representation:

72yo F w/ extensive cardiac hx p/w acute chest pain fth AHRF, HFmrEF w/ aflutter, covid

Teaching Points (Gerardo)::

Chest pain, key: tempo and quality of the pain.

Not to miss causes of chest pain: ACS, AD, PE.

Stress induced cardiomyopathy (Takotsubo): DDx for chest pain in critically stressed patients

CTA is a useful tool for assessing different emergent causes of chest pain: AD, PE

Afib & Aflutter: upregulation of the SNA (compensatory mechanisms due to a disturbance)

Hypoxemia:

1. True vs false, radiographic positive or negative
2. Radiographic negative hypoxemia: shunt or problems in the vessels

Echocardiogram in the setting of image negative chest pain: low LVEF with regional wall motion abnormalities

- Most common cause of low LVEF: CAD
- Systemic inflammation + low LVEF = could be myocarditis by COVID-19

Cardiac MRI with gadolinium and cardiac angiography could be useful for assessing possible ischemia and inflammation due to myocarditis or ACS