10/31/24 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Maddy Conte (@) **Case Discussants**: Dr Rabih Geha (@) and Oumaima(@)*

CC: Heartburn

HPI: 75Yo M with a history of GERD who presented to the ED due to 2 weeks of episodes of heartburn that worsens with activity. The patient drove himself to the ED because heartburn was not improving with his usual antacids. Before 2 weeks, was in his usual state of health, able to do activities around the house and go for a short walk w/o any heartburn. But in the last 2 weeks he has noticed episodes of heartburn after any activity.
The episodes last between 10-30 minutes and only resolve if he stops exerting himself.
He describes these episodes as "excruciating and debilitating." The location of heartburn is in the mid-chest with radiation down both of the arms and to the sub-sternal region.
He has tried Alka-Seltzer and omeprazole because he thought the pain was his GERD symptoms but it did not resolve the heartburn. Besides exertion, he cannot identify any triggers and has not noticed any relation of the pain to the food he eats. The only thing that relieves the heartburn is resting, not exerting himself and drinking cold water.
His GERD symptoms have been pre-existing for many years, present at rest and exertion, and related to certain trigger food. GERD pain usually resolves with antacid regimen. GERD pain is also burning but not only with exertion and does not restrict his ability to exert himself.
ROS: Notable for nausea, sweating, feeling of generalized weakness. No worsening of symptoms if he lays down, leans forward. No increasing lower extremity swelling. No fevers, SOB, vomiting, fainting, dizziness, syncope, weight loss/gain

PMH:
T2DM,HTN,HLD,CLL(2017),BARRETT'S ESOPHAGUS WITH GERD, AV STENOSIS

Meds:
METFORMIN
SITAGLIPTIN
OMEPRAZOLE

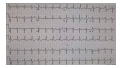
Fam Hx:

Soc Hx:
Retired,lives in Colorado with his wife. Prior tobacco use (quit 10 y ago, ½ PPD for 3o years)
Health-Related Behaviors:

No alcohol or ivdu

18Vitals: T:97.6 HR:85 BP: 127/65 **RR:18** 100% on RA
Exam:
Gen: In no distress

CV: No JVD, systolic murmur upper sternal border
Pulm: Clear b/l
Abd: Soft non-tender non distended
Extremities/skin: warm and mild +1 edema to bilateral ankles

Notable Labs & Imaging:
Hematology:
WBC:21.8 (lymphocyte predominant - stable) Hgb: wnl Plt: wnl
Chemistry: wnl
Na: K: Cl: HCO3: BUN: Cr:1.01 (baseline)
BNP: 866
Troponin 183 > 256 (2h)>520>655>666

Patient was given aspirin, heparin, and high intensity statin
Imaging:
EKG: ST 102,with RBBB,LAFB, and non specific T wave changes compared to baseline ECG from 4 months prior (<1 mm ST depression v3-v4), 2 hours later ST depression v2-v6, overnight resolution of T wave changes .
CXR: Interstitial marking on the lung bases, no effusions
Next day Cath was done, angio showed diffuse heavily calcified, multi vessel disease no stent were placed
Echocardiogram: Global hypokinesis of LV, no regional wall motion abnormalities, LVEF 30 %, moderate aortic stenosis
Echo 1.5 years ago: EF 65%, mild aortic stenosis
Proximal RCA with chronic total occlusion with collaterals
Dx: NSTEMI in the setting of multivessel CAD, New dx of HFrEF with AS

Problem Representation: A 75 Yo M , with a pmh of gerd presents with 2 weeks hx of heartburn that increases with exertion, that is associated with N,V,sweating. Labs showed uptrending Troponin and BNP, ECG showing non specific t wave changes.

Teaching Points:
GERD
Presentation: Can present as reflux or heartburn
Dx: Is often a "clinical (presumptive) diagnosis" without a gold standard EGD - curious if it was CAD all along

4 main cardiac diseases
HF (volume overloaded), arrhythmia (fast: palpitations, CP, dizziness; slow: CAD), **obstructive cardiac diseases** (like PE, aortic stenosis), **CAD**
- Obstructive cardiac disease is the most common mimicker of CAD

Heartburn/Angina
Many characteristics of CP we ask patients are non-specific
Red Flags: Angina inducible by exertion, age, underlying CAD, SOB, diaphoresis, N/V, family history, risk factors (smoking, HLD, HTN, diabetes)

ST elevation in aVR can be due to various things: diffuse CAD, left main coronary disease, severe PE, or hyperkalemia
Acute management of obstructive MI: Aspirin 325, Atorvastatin 80 mg, Heparin, P2Y12/ADP antagonist depending on intervention - PCI vs. CABG
Troponin (pharmacokinetics) will rise with latency so an increase might still be happening after revascularization
NSTEMI: intervention within 48-72h; however, cardiogenic shock, refractory CP (morphin less used, nitroglycerin is preferred), arrhythmia needs early intervention

The severity of the CAD inversely correlates with the clinical presentation because of chronic development of collaterals. Thus, most mild ACS is due to extensive CAD.