11/27/24 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Amanpreet Singh (@) **Case Discussants**: Youssef (@saklawiMD), Mark (@Mark_Heslin)*

CC: Chest pain and dyspnea

HPI: 63 year old female presents with chest pain and breathlessness with exertion for 3 days. Chest pain was sudden and compressive in nature. Dyspnea initially was on exertion, progressed to at rest.

ROS (-): Palpitations, sweating, chest pressure, anxiety.

PMH:
HTN
T2DM

Meds:
Antihypertensives
Antidiabetics

Fam Hx:

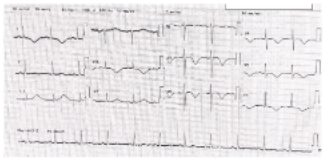
Soc Hx:

Health-Related Behaviors:
No alcohol, smoking

Allergies:
NKA

Vitals: T: afebrile BP: 220/128 **RR:** 34 **Sat:** 98% on RA **HR:** 124
BMI 28.4
Exam: Gen: Alert oriented, respiratory distress.
HEENT: macroglossia
CV: Palpation and auscultation were normal, normal JVP, no edema
Pulm: Bl rales
Abd: nl
Neuro: nl

Notable Labs & Imaging:
VBG: No acidosis, K 3.1.
UA: Normal.
Troponin I: Positive.
Pro BNP: 3460
TSH: 75 (0.4-4)
T4 and T3: reduced.



Imaging:
EKG: Sinus tachycardia, QT prolongation 570 ms.
Chest X Ray: Normal, bilateral base atelectasis.
Echo transthoracic: Ejection fraction 28%, hypokinesis of the LAD territory, 18-23mm LV thrombus. RA pressure: 10 mmHg.
Coronary cath: Normal epicardial coronary arteries.

Dx: Atypical Takotsubo cardiomyopathy in the setting of severe hypothyroidism.

Follow up: the patient was started on hypothyroidism treatment with improvement.

Problem Representation: 63yo F p/w acute progressive chest pain, dyspnea and hypertensive emergency. Exam was remarkable for macroglossia and pulmonary rales. Labs showed elevated proBNP, troponin and TSH. Echo showed decreased EF, LV thrombus. Coronary cath was normal.

Teaching Points (Parisa):
Acute→4(ACS+dissection+tamponade+takeshobo)+2(PE+PTX)+2(rupture+impaction)→Subacute chest pain→PE+ACS+tamponade
Risk stratifying → Heart score→ACS multiple RF/ECG/presentation→ **PMH** is the key; risk factors of hyperlipidemia; HTN; tobacco use is the key
Characteristic of chest pain→ pleuritic chest pain (PE); radiates to back (dissection); absence of characteristic does not help
Qualify past medical history: how HTN/DM is controlled; complication of diabetic kidney disease
Mng: HTN emergency→ the presence of AKI and elevated troponin we could consider starting nitro drip; The presence of exertional dyspnea increase the likelihood of bilateral rales flash pulmonary edema → Bipap + C-x ray (fluffy opacity) → drip + high dose lasix (should be responsive)
Amyloidosis→AA (inflammation);AL(MM light chain; SPEP/light chain); ATTR elderly; spinal stenosis → do not present acutely; does not present acutely; diastolic dysfunction.
Macroglossia→ amyloidosis; hypothyroidism
Secondary HTN→Thyrotoxicosis (TSH); drug intoxication (cocaine)
Patients w/ hypokalemia + history of arrhythmia are at risk of having arrhythmias; **Uncontrolled HTN** looking for any sign of hypoaldosteronism (primary; secondary d/t renal stenosis) /hypothyroidism
Mimics of ACS: MINOCA; embolic spontaneous coronary artery; takotsubo; myocarditis
MINOCA→ regional wall abnormalities; structurally normal coronary on angio
Myxedema coma: hypotensive; encephalopathic; hyponatremic
Takotsubo cardiomyopathy → left ventricular dysfunction; apical ballooning; atypical presentation→ presence of LV thrombus