01/31/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Zakariyya(@pouroverguy) Case Discussants: Rabih(@rabihmgeha) , Reza (@DxRxEdu)

CC: 39Y/F presented with abdominal pain, loss of appetite. ORS didn't help the patient. EKG was obtained for concerning Tachycardia.

HPI:
EKG: ST elevation in lateral leads, ST depression V1-V4, Tall R waves in V1-V2, Right axis deviation.

SOB, Chest pain 3 days ago, on inspiration > expiration, LMWH was begun.

PMH: No known comorbidities.

Meds: None

Fam Hx:Not significant.

Soc Hx:None

Health-Related Behaviors: **No smoking/ alcohol use**

Allergies:none

Vitals: T: 36c BP: 140/103 mmHg **RR:** 30**HR**: 150bpm**Sat: 91@RA**
Exam: Gen: Mild distress,
HEENT: No pallor, LAD, no edema
Neck: Kussmaul sign +
CV: Palpable impulse in 2nd ICS, nl capillary time, apex not displaced, Loud S2.
Pulm: Distress, accessory muscle use, trace wheezes in left axilla, clear to auscultation.
Abd&Neuro: Normal

Hematology:
WBC: 6.26Hgb: 13.5 Plt: 219

Chemistry
Na: nlK:nl Cr: below the normal,BUN,Ca,Ph,Mg,Glu,Cl,HCO3: Nl
CRP:39 ESR: LDH: 825AST:271 ALT: 118ALP:239, T. Bili: 12GGT: 420, Alb&TP: Nl
D-dimer: 2(0.25) , lipase: Nl,
Trop: <3.
HIV: negative, CA- 125: 96, CEA: 5.8, CA: 19.9, TB PCR: negative.

Imaging:
EKG:ST elevation in lateral leads, ST depression V1-V4, Tall R waves in V1-V2, Right axis deviation.
CTPA: No filling defects, normal pulmonary trunk, normal pulm/aorta **Numerous pulmonary nodules, tree in bud appearance**, no wedge shaped opacities, **left hilar lymphadenopathy, partially imaged hypodensity in V/VI liver segments.**
CT abdomen: **Numerous hypodensity throughout liver segments, suspected to be primary rather than metastatic.**

Hepatitis B surface: Positive.
AFP: 60, 500

Dx: Hepatocellular carcinoma 2/2 Hepatitis B with pulmonary metastasis.

Problem Representation: 39Y/F presenting acute h/o tachycardia, EKG suspicious of possible Right ventricular strain, found to have numerous pulmonary and hepatic nodules Dx as **Hepatocellular carcinoma 2/2 Hepatitis B with pulmonary metastasis**

Teaching Points(Anmolpreet):

I] Loading dose for ACS: Tab Disprin 325 mg, Tab Clopidogrel 600 mg, Tab Atorvastatin 80 mg, inj Enoxaparin
Careful study of ECG is important. Sometimes, ST segment depressions can represent posterior wall MI.

II] JVP: we have to the keep the patient at 45 degrees angle.
JVP and Carotid:- JVP varies with respiration & Carotid does not.
JVP is not pulsatile, Carotid is.
When we breathe in, creating a negative intrathoracic force, blood rushes into right heart, JVP should go down.
But if it does not, it's called Kussmaul sign: something restricting the blood from entering RV.:- Acute RVMI, pericardial effusion, restrictive/infiltrative cardiomyopathy

III] Treatment of Pulmonary embolism: risk stratify⟶ low-risk; intermediate-risk! Heparin has not much role in this.

IV] Liver mass: cirrhosis, metastatic (multiple masses) / primary cancer(a large mass)
HCC is the most common cause of primary hepatocellular tumor, but has high AFP negativity
Multiple nodules in lung makes us think about tumor thrombi.

V] Patient can get HCC from Hepatitis B without cirrhosis!