03/24/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Viet Nghi Tran (@VietNghiTran_MD) Case Discussants: Dr. Philip Tran

Scribing (Jerome)

CC: consult: abnormal EKG, ST elevation w/out chest pain

HPI:
20 y/o/m, elevated CK level 10,000, A male admitted to inpatient psych facility. Pt is agitated and has hx of delusions. He was placed in restraints while in a nursing home. ROS: denies SOB, palpitations.

Given Ativan and IV Fluids in the ED for presumed rhabdo. Then admitted to ICU in 4 point restraints, and placed on precedex.

PMH:
Schizophrenia, PTSD (Child abuse)

Meds:
Risperidone, benadryl, thiorazine, and olanzapine

Fam Hx: N/A

Soc Hx: N/A

Health-Related Behaviors: **N/A**

Allergies: NKDA

Vitals: T: 36.4 BP: 145/71 **RR:** 16 **HR**: 125 **Sat: normal on RA**
Exam: Gen: A/o
Psych: 4 point restraints, agitated, no delusions on exam
Neck:
CV: no murmur, RRR, no extra, heart sounds
Pulm: CTA
Abd: Nt/ND
Neuro: involuntary hand and face movements
MSK: muscular build

Notable Labs & Imaging:

Hematology:
WBC: 9.78 Hgb: 11.6 Plt: 258

Chemistry
Cr: .99 BUN: 44 BMP: otherwise wnl
CRP: 5.28 ESR: 40→60→84 LDH: LFTs-wnl
CK- 9,588→downtrended with fluids→7k→5k–3k
Troponin: 0.02 (negative)--> serially negative
UDS: negative
UA: unremarkable

Imaging:
EKG: STE diffusely, 10 hr repeat EKG showed
CXR: Negative, no acute findings
TTE: prohibited due to agitation, despite max doses of precedex

Remaining hospital course:
Cards: wanted TTE, only met 1 out of 4 criteria (abnormal EKG)
Treated w/2-4 weeks high dose NSAID ibuprofen 800 TID (treats C/P if present) , and colchicine for 3 months (prevents recurrence).

Dx: Acute Pericarditis

Problem Representation:
A 20 year old male presented with agitation, delusion and elevated CK levels. EKG showed diffuse ST elevations and diagnosis of pericarditis was made.

Teaching Points (SEEME):

Approach to ST elevation:
We can think about drugs, medications, genetic conditions such as Brugada syndrome or inflammatory conditions. Diffuse St elevation can be seen in pericarditis and STEMI. Always compare with the older EKG. Family history is important at this point. Also past medical history of hypertension, smoking or chest pain is important. Always a urine drug screen should be done. Coronary abnormalities should be ruled out. Inflammation and ischemia of heart can affect conduction and lead to ST elevation.

Approach to Pericarditis:
Echocardiogram can help us rule out cardiac abnormalities. Always look for fever, pericardial rub and chest pain when considering pericarditis. Cardiac tamponade, subacute onset, anticoagulant history, acute trauma and high fever if present need admission in cases of pericarditis.

Approach to elevated CK:
Muscle breakdown can cause elevation in CK level. Rhabdomyolysis can be caused by certain medications such as haloperidol, it is important to discontinue the medications.

Treatment of pericarditis:
Chest pain if present is treated but in most cases it is self resolving. NSAIDS (high dose 2-4 weeks), colchicine (3 months) reduces the rate of recurrence. If chest pain and elevated troponin can be seen in peri endocarditis which requires longer treatment. Recurrent pericarditis can be treated similarly with 6 months of colchicine. Steroids are used if patient is on anticoagulants or has renal failure. If treatment fails with steroids interleukin-1 inhibitors can be used.