# 04/24/25 Morning Report with @CPSolvers

*"One life, so many dreams" **Case Presenter**: Maddy (@MadellenaC) **Case Discussants**: Rabih (@rabihmgeha) and Tansue(@drtansue)*

Scribing (Eugene & Nowrine)
**CC:** 67 y F brought in by EMS - chest pain for last 30 hours

**HPI:** Pain started day before at 8am. She was standing on a chair in her kitchen trying to grab something on a high shelf in her kitchen when she developed sudden substernal chest pain. She also has numbness in her right arm. The severe substernal chest pain lasted for about an hour and then she felt chest tightness which persisted at work. No prior history with difficulty walking. At ED- chest tightness still present.
**ROS:**(+) diaphoresis, flushing sensation (-) fever chills, sick contact

**PMH**: hyperlipidemia, HTN, hypothyroidism

**Meds**: Atorvastatin , Lisinopril, Levothyroxine, Took aspirin before visiting hospital

**Fam Hx:** No relevant history

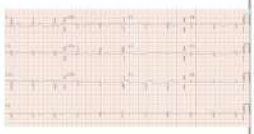
**Soc Hx**:wildlife refuge in colorado worker.

**Health-Related Behaviors**: No tobacco or alcohol

**Allergies**: NKDA

**Vitals: T:** afebrile **BP:** 140/70 **RR:** **HR**:70 **Sat:**
**Exam: Gen:** well-appearing, otherwise nl exam
**HEENT:** Within normal limits
**Neck:** Normal
**CV:** Normal S1 and S2
**Pulm:** Clear breath sounds b/l
**Abd:** No tenderness
**Neuro:** Non focal exam
**MSK:** Normal

**Notable Labs & Imaging:**

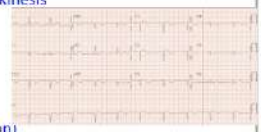


Troponin: 13,000
A1C: 5.1, LDL 80

**Imaging**:
EKG: ST elevation in anterior leads.

Cath: Focal Subacute distal LAD occlusion with left to left collaterals in apical distal LAD, unable to stent. Given unfractionated heparin and Ticagrelor in lab.

ECHO: 67% EF, apical akinesis, septal hypokinesis
No aneurysm or effusion



Telemetry: frequent PVCs
Rx: Beta blocker
(frequent PVCs and lack of revascularization)

**Dx Late presenting Transmural apical MI**

**Problem Representation**: 67 y F with substernal chest pain and numbness for last 30 hrs. No previous history. Troponin 13,000 and EKG findings (+)

**Teaching Points (Julia):** **Chest pain:**
**4 cardiac** (ACS, tamponade, aortic dissection, tako subo)
**+ 2 lung** (pneumothorax, PE)
**+ 2 esophageal** (rupture, impaction)

Becks triade in cardiac tamponade
-> I) hypotension II) muffled heart sounds III) JVD

**ACS pillows** (1) story (Prior history CAD) (2)EKG (3)Troponin (4) Echo (focal wall motion abnormalities in vascular territory (5) rule out alternative cause!!
*Chest pain on exertion* (progressive CAD) BEFORE they present w/chest pain at rest
-> Medication ST elevation: always: ASS, Atorvastatin, Enxaparin
- hold P2Y12 inhibitor: 7 days half life (cave bypass delay)

EKG and time course
**Q waves** and **poor R wave progression** in anterior leads -> old anterior MI
ST elevation a) (h / days) vs repolarization issues vs LV aneurysm

Stable pat. w/no reciprocal ST-depressions -> **DD anterior ST-elevations:**
- **PE** (T wave inversions in inferior wave)
- **Takotsubo cardiomyopathy** (apical wall motion abnormalities),- prolonged QTc, aVR depressions possible,

Trop x EF product **= high** -> ACS; **low** -> Takotsubo
ACS: Trop disprop. high EF high => product high
Takitsubo EF low, Trop rel low vs

Arteriosklerosis starts in the vessel's intima w/fatty macrophages plaques -> eventually develop to a flow limiting CAD
A) Previous episodes: NSTEMI 9:1 (Long standing flow limiting CAD-> collaterals protect)
B) First time presenter: STEMI (Recent plaque is most vulnerable to rupture since no protective fibrous cap has yet built)