04/17/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: (Ethan@@e_chiu17) Case Discussants: (Rabih@) and (David@)

Scribing (Nowrine)

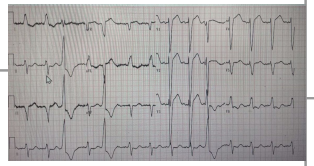
CC: 75 yo female **Shortness of breath on exertion** for 5 months.

HPI: Pt was under regular f/u for CAD and CHF at cardiology clinic, but for the past 5 months had increased frequency of dyspnea of exertion, relieved by rest.

PMH: 3 vessel CAD s/p PTCA and stent implantation 8 years back, CHF NYHA II 2017 LEEF 55%, RA, Gastritis of unknown etiology, dyslipidemia, R tibial fracture with operative fixation

Meds: Bumetanide, alprazolam, nebivolol, nitroglycerin, aspirin nicorandil, sulfasalazine, methocarbamol

Vitals: T: afebrile **BP:** 145/80 **RR:** 16 **HR**: 85 **Sat:** 97% on RA
Exam: CV: JVD **Pulm:** clear B/L
Abd: soft non tender 2+ Pitting edema bilaterally



Notable Labs & Imaging:

Hematology:
WBC: 4.8 Hgb: 12.8 Plt: 166
Chemistry: Na: 144 K: 2.6 Cr: 0.8 BUN: 18 ESR: 11 AST: 31 ALT: 25
Normal aPTT and PT. Normal high sensitive troponins.
EKG: Normal sinus rhythm, LBBB with frequent PVCs, slow progression in precordial leads, Q waves. Last EKG 5 years back normal. **Myocardial perfusion scan:** mixed cardiac ischemia **CXR:** mild interstitial infiltrates, borderline cardiomegaly

-> desaturation 92%, AMS overnight. Pt intubated. pH 6.9, PCO2 90, HCO3 21.7, PaO2 78.8, Lactate 25.7, BNP 2864. **Bedside ECHO**: anteroseptal hypokinesia **CXR:** pulmonary edema, **ECG**: 2:1 Atrial Flutter with LBBB
-> Amiodarone and Lasix, transferred to ICU. **Cath:** stenosis 95% at left main artery, new stent was placed. **TTE:** dilated LA and LV, LVEF 27%, thick interventricular septum, akinesia in apical anterior, anteroseptal segments of LV, mild TR and MR. transferred back after stabilized
-> recurrent fever 38-39°C, with multiple blood, sputum and urine Cx negative. UA bland. COVID and influenza negative. CRP 40. Soft murmur at RUSB, started on Tazocin+teicoplanin.
Repeat TTE: Moderate and functional MR and mild TR, negative for vegetations. PFO 0.2 cm. CT: Neg PE, Wedge shaped hypo-enhancement in bilateral kidney with left renal thickening, no fat stranding (susp pyelonephritis), B/L renal stones. Prominent lymph nodes at neck, axilla, mediastinum, porta hepatis and inguinal regions. Splenomegaly.
-> Decreasing WBCs to 2.2, Hgb drop to 8.5, Retic 0.7%, platelet drop to 81. PT and APTT prolonged both. FDP and D-dimer elevated, fibrinogen 230. Cr incr to 4
Hapto Normal, LDH 450 > 1200, Ferritin 1600s>12400(over a week). IL-2 >20,000. Repeat Blood cult negative. CMV and EBV negative.

Dx: HLH of unknown etiology

Problem Representation: 75 y F with SOB for 5 months, PMH of CAD and CHF. JVD (+) B/L Pitting edema (+). EKG: LBBB with PVC. Pt acutely develops AMS and desaturates.

Teaching Points (Julia):
HF + thoracic symptoms + JVD + LE edema -> acute decompensated HF

DOE: prioritize **cardiac** causes and issues at **alveolar capillary interface** w/ highest vulnerability to decrease in cardiac out
(+) **hypoxemia** → alveolar capillary membrane
(-) **No hypoxemia** → Obstructive cardiac disease (MS, HOCM) OR on coronary level

RBBB: wide QRS complex >120ms and RSR' in V1-V3 (delayed)
LBBB: R peak time prolonged
consequences→Risk for RV and LV disconnect (RCT) with higher degree of PVCs and delay (bundle block)

ADHF
(1) Arrhythmia(EKG) (2) ischemia (trop) (3) mech. issue (PAH 2/2 PE)

Aflutter trigger
a) Acute decom HF, atrial stretch,
b) PE: hint: CO2 ↑, resp. Acidosis (dead space↑ in PE & AMS (pop at risk: mech. ventilation)

FEVER = (dis)connected ?
→Thyroid (meds) → infection(hospital) → thrombus

Pancytopenia 5S
Space occupying, BM **S**uppression **S**ubstance **S**mear **S**plenomegaly

HLH overreaction to sth: exogenous, infections, cancer