5/4/25 Morning Report with @CPSolvers

***"One life, so many dreams" Case Presenter**: Elena **Case Discussants**: Maddy and Julia*

Scribing (Ethan)

CC: 60 y/o M with 2 week of history SOB, chest pain and cough

HPI:

Usual health 2 weeks prior, then developed SOB that limit his ability to walk more than 50m. Chest pain was positional (not sure if worse lying down or leaning forward). In clinic, ECG showed A flutter (new), nl troponin, and CXR showed CAP and was empirically treated by PCP.

Admitted due to worsened SOB, pleuritic chest pain, and new developed night sweat

Patient was from South Africa

PMH:
HTN

Fam Hx:

PSH:

Meds:

Health-Related Behaviors:
Active smoker (30 PY)
Alcohol use disorder

Allergies:
NKA

Vitals: T: 38.3 **BP:** 90/70 **HR**: 112 **RR:** 37 **Sat: 92%** **Exam: Gen:**
HEENT:
CV: positive pulsus paradoxus, JVD
Pulm: nl
Abd: nl
MSK: cold extremities, livedo reticularis on b/l knee
GCS 15

Notable Labs & Imaging:

Hematology:
WBC: 27K with neutrophil predominant Hgb: nl Plt: nl MCV:

Chemistry
Cr: nl LFT: nl
VBG: slight low bicarb and low pCO2
Elevated trop
Ferritin: 18K

Imaging:
EKG: A flutter, low voltages
TTE: large pericardial effusion with tamponade physiology

Pericardial fluid: normal protein and albumin, ADA 47, LDH 2300, glucose slightly low

Blood culture and pericardial fluid culture: candida glabrata
CT Chest: pericardial effusion, connection of esophagus and pericardium
Endoscopy: esophageal orifice at 30 cm
Esophageal biopsy: SCC

Dx : Esophageal squamous cell carcinoma complicated with esophagopericardial fistula

Problem Representation: 60 y/o M with subacute pleuritic chest pain, SOB, new onset Aflutter, with findings of neutrophilia, candidal pericardial effusion and candidemia.

Teaching Points (Glen):

-CHEST PAIN: R/O life-threatening causes. E.g takotsubo cardiomyopathy, eso rupture, PE, MI, cardiac tamponade.
-EXERTIONAL SOB; think of cardiopulmonary system.
-POSITIONAL SOB: Could mean Inflammation of pleura and pericardium
-COUGH: Think of infectious causes
-TX OF CAP: DX should be acute and not subacute and with typical symptoms, also improvement to treatment. This suggests could be atypical.
-LOW BP & HIGH HR & RR: signs for shock and organ involvement with cold extremities.4 BUCKETS. Cardiogenic , obstructive, distributive and hypovolemic.
-ELEVATED JVP & PULSUS PARADOXUS: concern for tamponade. Has a beck triad of HoTN. JVP
-A FLUTTER; causes dyspnea as high HR reduces time for heart filling. Could be a compensation for heart dysfunction. Causes include valvulae dysfunction e.g IE and will be important to do blood cultures.
-CAUSES OF A.FIB AND FLUTTER: (PIRATES) Pulmonary, ischemia. RHD, anaemia, thyroid disease.
-ECG: sawtooth pattern indicating A. flutter.
-NEXT STEPS; Stabilise the patient, then do echo looking for pericardial fluid. Check labs for any inflammatory signs.,
-PERICARDIAL EFFUSION; confirmed by fluid in echo findings. Could be myocarditis esp combined with elevated troponin(ischemia).exudative vs transudative. More towards exudative and inflammatory(ADA, LDH, low glucose) and more likely TB. Will be important to send the fluid for AFB and cytology.
MX; pericardial drainage to improve vitals.
DIFFERENTIALS: Abnormal Connection(fistula) between esophagus and pericardium because cultures grew candida. Will be important to test pt for HIV(or compromised immune system). Checking for amylase can help.
SCC- Tends to invade adjacent structures early on unlike adenocarcinoma. Pt had risk factors inc alcohol and smoking.