6/20/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Anmolpreet (@anugrewal19) Case Discussants: Rabih (@rabihmgeha) and Reza (@DxRxEdu)

Scribing (@ZakariyyaE)

CC: 78 y/o F , 1/7 hx of multiple episodes of vomiting and loose stool

HPI:
Watery, no blood or mucous,
No fevers
Diffuse abdominal pain , no SOB
Hemodynamically unstable at peripheral hospital, stabilized and referred to Anmol's center

PMH:
HPT, CAD [Dx 3/12 (medical Mx
LV dysfunction EF 40-42 %)]
Intubated recently for ?dyspnea > tertiary centre

Meds: DAPT (Aspirin + Clopidogrel)
Ramipril
Atorvastatin 40 mg nocte
Metoprolol
Spironolactone 12.5mg dly

Fam Hx:
None

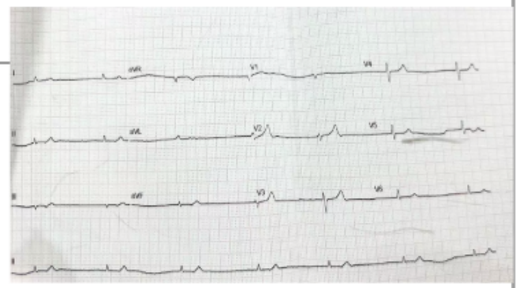
Social Hx:

None

Health-Related Behaviors:
None

Allergies:
None

Vitals: T: BP: HR: RR: Sat: BMI:
Exam: Gen: BP 100/60 , HR 40, RR 25 , O2 97% NPO2, afebrile
HEENT: AO x3 , pallor (conjunctival)
CV: no JVD , S1, S2, no murmurs
Pulm: unremarkable, GAEB
Abd: Soft, mild diffuse tenderness , no rebound , no distension
Neuro: PEARL, AOx3, no focal neurology
MSK: NAD



Notable Labs & Imaging:
Hematology:
WBC: Hgb: Plt: MCV:
11.4, 10.7 , 6000 , 98

ABG:
pH 7.37, PCO2 24, NA 123, K +7, Glu 103, Lac 1.09 , HCO3 30
Chemistry
Na: 125 K: confirmed ? Cr: 3.52 BUN: 83 Ca:9.4 Ph: Mg: 1.5 Glu: Cl:
CRP: ESR: LDH: AST: 19 ALT: 25 ALP: normal Bili: normal
T chol 96
Amylase 90
UA : normal
TropT : 0.036
BNP : 405
Imaging:
EKG: Junxional , bradycardia, borderline broad QRS, low voltage QRS
CXR:

Dx: BRASH syndrome.

Problem Representation: A 78 y/o female with Hx of CVD presented with acute gastroenteritis and hemodynamic instability. Was found to have bradycardia and AKI, complicated by hyperK and BRASH syndrome.

Teaching Points (Saketh):

1) Nausea + Vomiting + Diarrhea: Pan GI involvement likely.
High Degree of N/V+DIarrhea required to cause Hypotension.
N/V >> Abdominal Pain (Unlikely to be Gastroenteritis)
Immunocompromised Status - Increased likelihood of Acute GE
2) Age>50 + Abdominal Pain/N&V - Should consider MI - Needs an EKG (though Diarrhea makes it unlikely)
Drugs (Metoprolol, Diuretics and ACEis) - low threshold for hypotension.
3) Medication history (B blockers) - makes a patient more vulnerable to a host of complications (electrolyte derangements, compromised perfusion)
Check Potassium ASAP - **Low threshold for Ca Gluconate**
EKG interpretation - No strial Activity (Junctional Rhythm)
Wide QRS, and bradycardia -> ?Hyperkalemia
Low Voltage precordial leads:
- **Quick Exam + BMI**
- **Pleural vs Pericardial Disease**

4) HyperK Management - Serum Potassium (Very Low fraction of Total K in the body)
- K Removal (Non Specific Measures): Blind Removal (Lasix) and Shifting K+ -> intracellular (Storing K in cells using Insulin + D50 is a powerful move but also need to think about hypoglycemia.
- Consider a lower dose of insulin when you don't have a Cr/KFT.
- Always give Ca when administering K+ intracellular shifting agents
- **Always focus on treating the underlying cause !**

5) HyperK -> Most likely culprit is Kidney unless proven otherwise -> Check Creatinine (if normal, Cystatin C is another option).
6) BRASH - Bradycardia, renal failure, AV block, Shock and HyperK:
- Make sure to do a thorough workup for cause of HyperK and AV Block/Bradycardia - to avoid unnecessary interventions.
- Rebound HyperK if we don't fix the underlying cause.