6/25/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Anmol Case Discussants: Sharmin and Seeme

Scribing (David)

CC: 50 yo male with chest pain for one day

HPI: chest pain radiating to shoulder and back, with diaphoresis.
No similar episodes in the past.

PMH: none

Meds: none

Fam Hx:

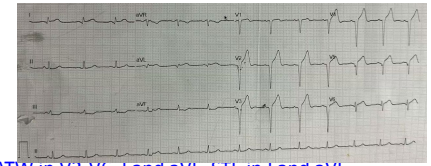
Social Hx: no recent travels.

Health-Related Behaviors: no smoke, no alcohol

Allergies: none

Vitals: BP: 180/80 **HR**: 78 **RR:** 20 **SpO2:** 97% RA
Exam: Gen: conscious, oriented, rest normal
CV: normal

Notable Labs & Imaging:
Hematology: WBC: 10.900 (neutrophil predominant), Hgb: 14.6, MCV 89.6, Plt: nl
Chemistry
Na: 140 K: 4.7 Cl 107, Cr 0.9 BUN 25 Ca 9.3 Mg:1.73, total protein 6.7, albumin normal, AST: 288 ALT: 76 ALP: 54 Bili: 1.64 (conjugated 0.18)
Trop: 0.487, BNP 57 (normal)
ESR: 15
UA normal
Total cholesterol 176



Imaging:
EKG: normal SR, Q waves in V2-V5, HATW in V2-V6, I and aVL, STE in I and aVL, reciprocal STD in inferior leads
Echo: regional wall motion abnormality, EF 30%
Cath lab: proximal LAD 100% occlusion (thought to be chronically occluded?)
Patient discharged on DAPT, statins, spironolactone.

2 days after discharge: throat pain with dysphagia and loss of speech
BP 170/70, HR 80, SpO 96% RA, afebrile. Conscious, oriented. Pupils normal, No JVD, no icterus. CV, pulm, abdomen and extremities unremarkable. Patient unable to speak, but responded moving his head.
Labs: CBC unchanged, lytes normal, Br 0.81, AST 44, ALT 65, CK-MB normal, BNP 245.
2nd ECG: STE in V2-V6 with TWI in V2-V6, I and aVL.
Brain MRI: acute infarct in MCA territory.
Echo: similar but large LV apical clot.

Dx: ACS complicated by LV clot leading to acute MCA stroke

Problem Representation: 50 y/M with one day of CP, Elevated BP on examination. Elevated troponin and transaminases. ECG showing signs of ACS. Pt discharged on antiplatelets and anticoagulant. Later presented with dysphagia and dysphagia. MRI shown an infarct in MCA as a complication of Left ventricular clot.

Teaching Points (Glen):
-Differentials for CP radiating to shoulder: CVS; ACS, aortic dissection, tamponade, PULM embolism, pneumothorax, ESO: rupture and vessel obstruction.
-Proceed with ECG and troponin. Good to trend it and trace trend.
-Widen the differential to below chest with normal exam and elevated transaminases. Could be acute liver injury or from the heart.
-Elevated BP and CP for 1 day could be aortic dissection, pulm embolism or chronic uncontrolled BP. Elevated pulse pressure usually means aortic dissection but less likely.
-Pain could also be referred from some organ.
-ECG with hyperacute T waves. ST elevated at anterolateral side could mean ACS(STEMI). Differentials are dissection, takotsubo.
-Manage with aspirin and antiplatelets waiting for a cath lab. Consider echo.
-Dysphagia and dysphonia could be iatrogenic or intrinsic abnormality e.g HIV or a chronic abnormality. Stroke as a differential(CT/MRI of head will help).
-Approach dysphagia by 3 brackets. Oropharyngeal, esophageal(inc pill induced esophagitis) and functional.
-Proximal LAD could have been managed surgically instead of medically.
-T wave inversions, anterolateral ST elevations in ECG could be a thrombus or reperfusion injury.Important to repeat the echo and consider MRI.
-Stroke could be from complication of MI(as embolic or ischemic with low EF), or independent.