7/8/25 Morning Report with @CPSolvers

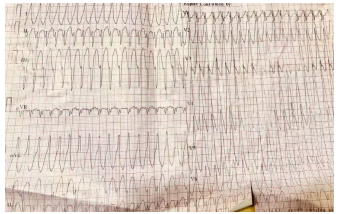
"One life, so many dreams" ***Case Presenter****: Eugene (@EugeneBondzie)* ***Case Discussants****: Ravi (@rav7ks) and Elena*

Scribing (Lera)

CC: 62 M with **transient LOC**

HPI: brought to ED because he passed out earlier today. Was walking when fell and became unresponsive. Return of consciousness in a minute, was confused after. On arrival reported ongoing **chest discomfort and palpitations,** also diaphoretic.

Week ago increased fatigue & **SOB on exertion.**



PMH:
HTN for 10 y
T2DM for 5 y

Meds:
Discontinued meds 1 y ago

Fam Hx: none

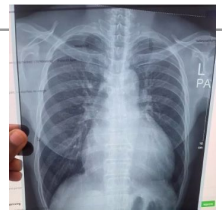
Social Hx: –

Health-Related Behaviors: no smoking or alcohol use.

Allergies: –

Vitals: T: 36.4 BP: 130/96 -> 129/90 **HR**: 140 (irregular) -> 63 bpm
RR: 24 **Sat:** 90% on RA -> 99% on O2 via nasal cannula
Exam: Gen: AO x 3, no signs of trauma, no icterus
CV: weak peripheral pulses, **JVD, systolic murmur radiating to the axilla**
Pulm: patent airway, no use of accessory muscles, bl basilar crepitation
Neuro: no focal neurological deficits **Abd**: normal
MSK: no peripheral edema, no cyanosis

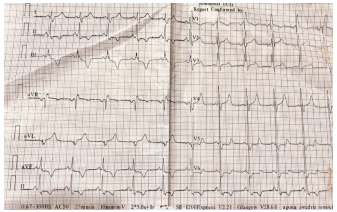
Notable Labs & Imaging:
EKG: sustained monomorphic VT
-> Electrically cardioverted -> sinus rhythm.



Echo: LA dilation, **posterior leaflet restriction** of the MV with moderate regurgitation.

Hematology: WBC: 8.9 (N 65%, L 29%) Hgb: 13.2 Plt: 204
Chemistry: Na: 138 K: 4.4 Cr: 1.1 BUN: 18 AST: 34 ALT: 29
Bili: 0.7 INR: 1.1 **Troponin I:** 3.4 TSH: nl **BNP**: 920

Imaging:
CXR: cardiomegaly
EKG: TWI in II, II, aVF , HATW V4-V5



Repeat troponin I: 7.8
-> primary PCI
Echo: dilated LA, moderate MR, Inferolateral hypokinesis, LVEF < 35%

Dx: acute inferolateral MI complicated by sustained monomorphic VT, HFrEF with moderate ischemia MR

Problem Representation: A 62 y/o gentleman with multiple CVD risk factors presented with LOC 2/2 sustained VT on a background of 1 week exertional SOB. EKG was consistent with inferolateral OMI.

Teaching Points (Vijay):
Transient LOC: Clarify passing out(LOC, Witness) - Cardio - neuro
**Not to forget infection/intrinsic as triggers
- Sugar, syncope, seizure
- Young: Vasovagal, cardiac(Bad gene), substance,
- Older: Cardio/Neuro

Not to miss complications of fall

ECG
1. **Wide complex regular** - VT vs SVT
   - History: CAD/Elderly age/comorbidities
   - AVD, Capture/fusion, Concordance, Morphology, new axis/extreme axis
2. Post Reversion: irBBB, TWI (L2,3,aVF) → Concerning for ischemia

Trigger for arrythmia - ischemia, structural, electrolytes, drug adherence
Murmur - MR → ?Silent ischemia→ Acute HF. *PML >AML* susceptible to ischemia (Single vs dual CAD supply)
Dynamic auscultation.
CXR: Enlargement → Pericardial effusion(To r/o tamponade) vs cardiac cause. *Beck triad* : Poor sensitivity
RUL opacity - mimic PNA in setting in acute MR
CATH even if troponin normal w/ such presentation !!