



6/30/25 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: (Ravi@rav7ks) Case Discussants: (Mark@Twitter: @Mark_Heslin) and (Noah@noahnakajima)

Scribing (Elena)
CC: Chest pain
HPI: 58M, chest pain: constant, substernal, crushing, no radiating, 9/10

Was on a **cruise**, tested positive for Covid
Persistent symptoms -> Doxy empirically (3d prior) w/o improvement

ROS (+): SOB (10 days), cough, yellow sputum, Dysphagia, weight loss 10-12 pounds (during past 30d)
ROS (-): PND, orthopnea, swelling LE, N/V, abdominal pain, no immobilisation

PMH:
 HTN
 HLD
 Hernia surgery 5y prior

Meds:
 HCT
 Aml0
 Atorvastatin

Fam Hx:
 Not relevant

Health-Related Behaviors:
 1 cigars/week (for last 5 years)
 2 beers/day
 No illicit substance use
 Regular diet
 Walk 9000 steps

Vitals: T: 37.2 BP: 94/37 HR: 203 RR: 20 Sat: 99%

Exam: Gen: Ill appearing
CV: Irregular irregular, tender chest, no murmurs
Pulm: Decreased breath sounds, tachypnea, no edema
Abd: Benign, non tender

Notable Labs & Imaging:
Hematology:
 Chem nl
 WBC: 23 (neutrophil 86.9) Hgb: 11 Plt: 382
 Trop 14 -> 15 -> 1570 -> 1760

Imaging:
 EKG: Tachycardic Afib
 2nd EKG: Diffuse ST-E and ST-D

Cardiac cath: SCAD (apical, left inferior), wall motion abnormality, LVEF 55%
TTE: mild LVH, normal RV, small effusion, no tamponade

Dx: Advanced squamous cell carcinoma, necrotizing pneumonia due to esophageal-pulmonary fistula, SCAD

Problem Representation:
 58 yo male presenting for 10 days of dyspnea, dysphagia found to have Afib w/ RVR & STEMI 2/2 SCAD, subsequently found to have esophageal SCC w/ pulmonary fistula.

Teaching Points (Krithika):
 4+3+2 approach for chest pain
 Cardiac- ACS, MI, TAMPONADE, CARDIOMYOPATHY,
 Respi- Pneumothorax, PE
 GI-Esophageal spasms, rupture
 Chest xray, ECG, Trop I, D-dimer- imp- aortic dissection, PE
 Past history, onset, what they were doing at the time
 Post inflammatory phase- post COVID
 Respiratory cause-pneumonia- with pleuritic chest pain
 Others-Pharyngitis, pericarditis, myocarditis, Takotsubo, Doxycycline can cause oesophagitis
 Dysphagia- motility(solids) vs obstructive(solids and liquids)
 Atrial fibrillation is generally compensatory
 Amiodarone can cause momentary hypotension
 CT scan of neck and chest- due to dysphagia/high TC
 2D ECHO- to r/o RWMA- ACS
 NSTEMI should be taken to Cath immediately if- Unstable ventricular arrhythmia, refractory chest pain
 In a large pericardial effusion- nitrates/any preload reducing agents- dangerous
 SCAD- is generally an endpoint diagnosis
 SCAD- can be associated with pregnancy, connective tissue disorders like Ehler danlos, autoimmune conditions, also a/w Takotsubo