9/9/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Ravi (@rav7ks)* ***Case Discussants****: Vale (@valeroldan23) and John (@)*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Gillian & Lera)

CC: 58M with **chest pain** 9/10, constant, substernal, crushing, non-radiating **+ SOB**

HPI:

Cough for 10 days with yellow phlegm

Came back from cruise 10 days ago. Tested positive for COVID on home test Went to urgent care and got Doxycycline for possible bronchitis.

ROS (+): Intermittent dysphagia, weight loss 12 lbs for past month.
No N/V, abdominal pain, PND, orthopnea, leg swelling, abdominal pain.

PMH: HTN, HLD

Meds:
Amlodipine
HCTZ
Atorvastatin

Fam Hx: none

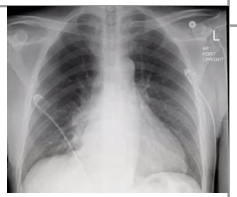
Social Hx: smokes 1 cigar per week for past 5 years, 2 beer / day x 10 yrs; no other substance use

Health-Related Behaviors: 9-10k steps per day

Vitals: T: 37.2 **HR:** 203 **BP:** 94/37 **RR:** 20 **Sat:** 99% on RA
Exam: Gen: looks critically ill **CV:** irregularly irregular pulse, chest tenderness
Pulm: decreased breath sounds esp. right side, labored breathing
Abd, Neuro, Extremities/skin: normal

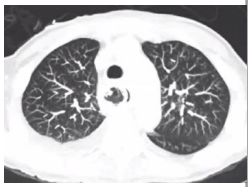
Notable Labs & Imaging:

Hematology:
WBC: 23k (86% neutrophils) Hgb: 11 Plt: nl
Chemistry: nl **Troponin**: 14→ 15 → 1760

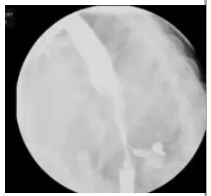


Imaging:
EKG: Afib with RVR addressed with diltiazem (after improved BP) + amiodarone drip -> **Subsequent EKG**: diffuse ST elevations, no PR depression. No reciprocal ST depressions

CXR: slight prominence of hilar region, mild right infrahilar opacification, no pneumothorax, no air in mediastinum
Echo: Mild LVH; EF > 75%, small pericardial effusion anterior to RV, mild inferior wall motion abnormality
Cardiac Cath: clean, no targets for PCI



CT Chest: thick distal esophageal wall, extensive right LL pneumonia, small pleural effusion, no PE
Barium Esophagram: Large irregular mass of distal esophagus, extravasation of contrast into region of right LL
Mass Bx: poorly differentiated SCC



Dx: Esophageal SCC complicated by Esophageal-Pulmonary Fistula and right LL pneumonia.

Problem Representation: 58M with cigar + alcohol use presenting with 10 days of substernal chest pain, SOB, cough, and dysphagia w/ weight loss; found to have afib w/ RVR, neutrophilic leukocytosis, elevated troponin, diffuse ST elevations, and distal esophageal mass with pneumonia on imaging.

Teaching Points (Eugene):

-Chest Pain: Localizing: Heart-MI, Tamponade; Lung: PE; Pneumothorax; Oesophagus
-SOB: Localizing: Lungs, Heart
-Description of chest pain points to likely ACS
-Important to rule out life threatening causes
-Associated positive symptoms: COVID- recent infection can precipitate prothrombotic state; Dysphagia: guiding to oropharyngeal or esophageal process, plus weight loss-: thinking malignancy
Vitals & Exams: irregular fast heart rate, a sign of impending doom. Cause could be AFib, A flutter. Resp. Distress: Pneumothorax, effusion, esophageal rupture
Labs: Diffuse ST elevations- Pericarditis, myocarditis; Elevated Troponins: Ischemia
CT scan of chest: opacification in distal esophageal lumen. Need imaging with contrast in the esophageal lumen + Biopsy.
Cancer+Fistula: Patient immunocompromised, prone to infections, fistula possible cause of mediastinitis explaining clinical picture.