8/27/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Suna Yoo Case Discussants: Sharmin and Zakariyya G.

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

Scribing (David)

CC: headache

HPI: 37 yo male with throbbing headache and nausea that started some hours ago when he woke up.
He walked to the ED.
Also described mild shortness of breath.
Headache got worse in the last hours, but didn't bother him to walk. Was 7/10. He tried acetaminophen but didn't work.

ROS: No palpitations. No chest pain.

Evolution: Was started on nicardipine drip. Light-headed when lowering the BP.
Later started on ACEI.

PMH:
HTN (run out of anti-HTN meds some weeks ago)

Meds:
amlodipine 10 mg + hydralazine 10 mg (not taking them)

Fam Hx: younger brother with ESRD in the 20s s/p kidney Tx in the 30s

Social Hx:

Health-Related Behaviors:

Vitals: HR: 130 **BP:** 210/120 **Sat: BMI:** normal
Exam:
Pulm: clear, no crackles
Abd: nausea without vomiting
Neuro: no weakness
Extremities/skin: no edema

Notable Labs & Imaging:

Hematology: CBC: nl

Chemistry:
Na: 135 K: 2.9 Cl: 97 HCO3: nl Cr: 8 (1.5 3 years ago), TSH nl
Troponin: 4 (high) -> downtrended
Urine toxicology panel: negative
Urine lytes: Na+ 90, K+ 14, Cl- 97
Urine protein 113 mg/dl
Aldosterone level: 19 (mildly high), PRA 16 (0.6-4.3), aldosterone/renine 1.2 (not supportive of hyperaldosteronism)
24h urine metanephrines: 363 (< 92), 24h urine normetanephrines high
Serum metanephrines 1681 (< 205)

Imaging:
EKG: LVH
Non contrast CT: no signs of bleeding or acute intracranial pathology.
Renal ultrasound: normal sized, bilateral parenchymal disease, minimal stenosis of the renal arteries.
CT abdomen: mild hyperplasia of the right adrenal gland.
MRI of the skull base: mass concerning for paraganglioma in the cervical spine.
Genetic panel: patient and brothers - positive for *SDH-C* mutation

Dx: Paraganglioma due to SDH mutation, with secondary hypertension

Problem Representation: 37 year old male with PMH of HTN and one brother with ESRD presents with headache and marked hypertension. Labs showed moderate hypokalemia, mild renin and aldosterone increase and high urine and serum metanephrines. CT showed cervical paraganglioma and genetic panel, SDH mutation

Teaching Points (Hans):
Headache acute and throbbing w/ nausea: r/o emergencies ruptured vessels (aneurysm, sinus venous thrombosis), HTN emergency, urgency end organ. Systemic disease vs confined to the head.
Secondary HTN: End-organ damage our pt is 37 y/o and possibly not a candidate for essential HTN. Medication withdrawal, other substances. (Pheochromocytoma, hyperaldosteronism, FMD (F>M))
ESDR with low K: use of diuretics, Hyperaldo, GI loss (vomiting). Look at kidney size for additional clues.

Paroxysmal Sympathetic Hyperactivity (PSH): r/o seizures, withdrawal (pt stopped meds) autonomic dysreflexia, pheochromocytoma (episodic) (adrenal, paraganglioma, MEN), ICP, thyroid storm (look at body T, HR, tachypnea),

Patient had SDH gene mutation