10/23/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Ravi (@rav7ks) Case Discussants: Rabih (@rabihmgeha) and Krithika (@krithikakripashankar5(IG))

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

Scribing (Magnus)

CC: 67M with progressive SOB and right-sided chest pain for 3 days

HPI: Increased frequency of intermittent pain, that radiates to epigastric region, right shoulder and chest. Worsens with exertion, deep breathing and oral intake, improves with nitro. Associated with nausea, and also endorses intermittent palpitations.
Tried laxatives and antacids with no relief.

ROS: No fever, cough or sputum production.

PMH:
CAD (PCI 1 yr ago)
HTN
HLD
DM2
Chronic constipation
Appendectomy

Meds:
ASA
Plavix
Atorvastatin
Insulin
Amlodipine
Lisinopril
Senna/colace

Fam Hx:
Father - constipation

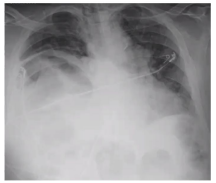
Social Hx:

Health-Related Behaviors:

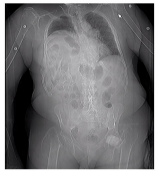
Allergies:

Vitals: T: 98 **HR:** 106 **BP:** 136/82 **RR:** 25 **Sat:** 97 -> 86 RA
Exam: Gen: Anxious, in pain
Pulm: Decreased breath sounds at right base
Abd: Distended, diffuse tender, bowel sounds present

Notable Labs & Imaging:
Hematology:
WBC: 11 Hgb: 15 Plt: nl
Chemistry:
Na: 141 K: 4 HCO3: 27 Cr: 1.9 BUN: 20

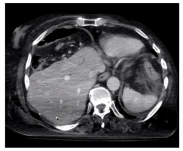


BNP and troponin x 2 negative
ABG hypoxemia, PaO2 55, PCO2 35
Lactate normal



Imaging:
EKG: Sinus tach, no ischemic changes
CXR: Marked elevation of the right hemidiaphragm with atelectasis at the right lung base and a lucent area underneath the diaphragm

CT: Dilation of the hepatic flexure with interposition of colon between liver and right hemidiaphragm consistent with Chilaiditi-sign.



Dx: Chilaiditi syndrome

Problem Representation: An elderly man with subacute right sided pleuritic chest pain + SOB, diffuse abdominal pain and distension and a CXR showing elevation of the right hemidiaphragm.

Teaching Points (Eugene)

Approach to Chest pain + SOB- Causes: Cardiac (e.g. MI), Respiratory, Structures in the mediastinum
Chest pain helps to explain cause of SOB i.e., cardiac cause. However heart usually doesn't cause RT sided pain. Also lungs don't hurt. What will hurt will be pleura, chest wall, pericardium.
Features supporting earlier hypothesis: Pain associated with deep breathing- pleuritic pain. Pleurisy can be a distractor
NB: Response to nitroglycerin not strongly associated with cardiac pain.
Approach to vitals and exams: Tachycardia is expected due to pain.
Decreased breath sound at lung base supports pleural hypothesis also together with abd. distension points to secondary pathology affecting the pleura (i.e., compression- from subdiaphragmatic pathology)
Abdominal distension + diffuse tenderness: Prioritize bowel obstruction (volvulus)
Other hypothesis to consider- chilaiditi syndrome. (interposition of bowel with diaphragm and liver or abdominal wall.

Investigations
CXR: showing blunting of right costophrenic angle with air under diaphragm. Subacute process could be fluid. Acute process could be diaphragmatic hernia, bowel perforation. CXR may not be enough to clench abdominal pathology extending to the lungs- Consider CT

Immediate management: Have NG tube ready (helps reduce intraluminal pressure), antibiotics, analgesics, oxygen support.