9/22/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: Sukriti (@sukritibanthiya) Case Discussants: Steve Pan (@stephenpanmd)

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

Scribing (Lera)

CC: 35F with palpitations.

HPI: Presents in HF clinic due to new HFrEF Dx. Increased frequency **palpitations and chest discomfort** *("fullness in chest", lasting minutes)* for few months -> now every day palpitations *("heart rate racing")*, associated with lightheadedness, but no LOC.

Monitor in the past: nl results. Now: **sustained VT episodes.** Referred to EP specialist. ECG: sinus rhythm, 2 mm ST elevation in V2 -> ER. LH cath: nl.

ROS: hip pain (OA?). No neuropathy / tendinopathy / Afib / orthopnea / PND.

PMH: new HFrEF
Scoliosis with spinal fusion
Herniated disks -> radiculopathy

Meds:
OCP
Metoprolol succinate 25 mg

Fam Hx: grandmother Dx with HF at 59 y, both brothers healthy

2 children, pregnancies nl, 2nd complicated by gestational DM

Social Hx: social worker

Health-Related Behaviors: drinks socially, quit since Sx started, no smoking

Vitals: HR: 80 **BP:** 115/71 **RR:** nl **Sat:** nl
Exam: Gen: well, nourished **HEENT:** no JVD
CV: normal **Pulm:** CTAB **Abdomen:** soft, non tender, symmetric
Neuro: no focal deficits **Extremities/skin:** no LE edema

Notable Labs & Imaging:

Hematology: WBC: 5.74 Hgb: 12.8 Plt: 340

Chemistry: Na: 140 K: 4.1 HCO3: 22 Cr: 0.5
Hs troponin: normal (11-14) **proBNP**: 174
Lipid panel: normal *(LDL: 70, total cholesterol: 161, HDL: 73, TG: 94)*
TSH: normal **UDS**: normal **ACE**: normal

Imaging:
EKG: sinus rhythm, 2 mm STE in V2 *(baseline)*
CXR: no active cardiopulmonary pathology
Echo: normal LV wall thickness and systolic function (EF 60-65%), focal area of dyskinesis around IV septum (prior VSD?) with no evidence of shunt, no valvular pathology

Cardiac MRI: **segmental akinesis with bulging and delayed enhancement** (33%) representing scar / infarct involving anteroseptal mid-LV, LV & RV reduced systolic function *(LV EF 47%)*

PET-CT: cardiac sarcoidosis evidence
-> started on steroids, underwent VT ablation

Dx: cardiac sarcoidosis

Problem Representation: A 35 y/o female with recent new HFrEF Dx presented with chest discomfort & worsening palpitations due to sustained VT episodes. Cardiac MRI was suspicious for cardiac sarcoidosis, confirmed by PET-CT.

Teaching Points (Shriya + Deb):

- **HF** → young patient can compensate vs. old patient
In a young patient is when we worried the most.
DDx: Non ischemic cardiomyopathy: Infiltrative, familial, sarcoid, myocarditis.
Autoimmune causes like SLE and scleroderma are associated with myocarditis.
Ischemic (low differential, rare in a young patient)
- His purkinje fibre VT in young pt can be a cause of cardiomyopathy.
- **PMH:** OA can be associated with obesity in a young patient.
Ask about respiratory disease, wondering about Sarcoidosis
GI symptoms: Diarrhea, blood stool and constipations can be very concern.
- **Red flags:** Troponin + → myocardial injury (eg, giant cell). It is a marker of what this could be, and how fast we should act.
ACE level + (a small level can be really helpful!) → cardiac sarcoid
CRP, ESR →to check inflammation.
IL2 Receptor can indicate cardiac sarcoid.
- **Cardiac MRI:** Transmural or near transmural in the MRI → think about Sarcoid, the number 1,2 or 3 cause are sarcoid.
Other causes: Viral (from a long time, because of the scar), Giant cell (you need to rule out giant cell by biopsy).
- Cardiac PET scan can be a diagnostic test for the biopsy unreachable regions for cardiac sarcoidosis.
- ICD done for almost all patients with cardiac sarcoid with not much evidence for other treatments .
- **Empiric therapy:** It is an option if the patient is really ill. Normally is better to avoid to give steroids too early.
- Normal Echo does not rule out Cardiac Sarcoidosis.