12/25/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Anmol (@anugrewal19)* ***Case Discussants****: Ravi(@rav7ks) & Rabih (@rabihmgeha)*

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

Scribing (CPS Fam <3)

CC: **DOE for 1 month** and generalized weakness

HPI: 52 y old M with SOB on exertion associated with retrosternal CP + high troponin -> managed as ACS. Placed on inotropes -> the course was complicated by bradycardia & cardiac arrest. ROSC achieved -> intubation.

ROS: **Dysphagia** with food regurgitation for 15 days

PMH: none

Meds: none

Fam Hx: none

Social Hx: lives in a suburban area, no animal exposures.

Health-Related Behaviors: non smoker

Allergies: none

Vitals: T: 98.4 **HR**: 103 **BP**: 100/60 **RR**: 17 **Sat**: 100% on SIMV

Exam: HEENT: PERRL, no JVD, but anterior neck swelling noted, no icterus

CV, **Pulm**, **Abd**, **Neuro**, **Extremities/skin**: nl

Notable Labs & Imaging:

ABG: pH 7.48, PaO2 223, CO2 42, HCO3 31, lactate 1 *[on Fi02: 100, PEEP:5]*

Hematology: WBC: 11.3 (N 86%) Hgb: 13.4 Plt: 161 MCV: 80.8

Chemistry: Na: 144 K: 3.44 Cl: 100 Cr: 0.5 BUN: 19 Ca: 8.4

LFTs: nl Albumin: 3.3 Total Protein: 5.8 **ESR**: 35 Uric acid: 1.7

UA: WBCs **UCx**: E coli > 100K CFU,

Total cholesterol: nl **Coags**: nl **ID screen**: HIV, HBV, HCV neg

Troponin: positive (0.144) **EKG**: sinus tachy **Echo**: nl LV size, EF 60%

Coronary angio: nl coronary arteries

EGD: small gastric polyp with erosive gastropathy -> Bx: hyperplastic polyp

T3: 63.1 [low] **T4**: 6.99 [nl] **TSH**: 0.21 [low] -> *nl on repeat*

US thyroid: thickened isthmus + hyperechoic mass with cystic changes and punctate calcifications, bl submandibular LAD

FNA: hemorrhagic smear -> follicular epithelial cells with mild nuclear enlargement

CT w/ con: heterogeneously enhancing **thyroid soft tissue mass** compressing the trachea with LAD and heterogeneously enhancing **anterior mediastinal mass,** no bony erosions.

AChR ABs: 14.89 [positive] **Thymus micro:** c/w thymoma B2.

Thyroid micro: papillary thyroid carcinoma.

-> started on IVIG + steroids for presumed myasthenic crisis [UTI as potential trigger]

Dx: myasthenic crisis with papillary thyroid carcinoma.

Problem Representation: 52 y old M presented with generalized weakness, SOB and cardiac arrest associated with anterior neck swelling and anterior mediastinal swelling.

Teaching Points (Siva)

Heart-muscle(intrinsic muscle or vascular)

Dysphagia -oropharyngeal and esophageal. Ba swallow(cant do as our pt is intubated).

Food regurg-MC seen in oropharyngeal.Isolated presentation rare, commonly systemic sx are seen.(accompanying neurological sx).

Ant neck masses in a subacute presentation -abscesses,LN,thyroid.

Mechanical obs-solids ,Neurological obs -solids+liquids.

LA enlargement -esophageal compression.

Isolated cardiac or cardiac with subtle systemic signs ?

Dysphagia + cardiac disease=rare combo

Cardiogenic shock -we expect low EF.(not having cardiac disease print on echo directs us to - is it resolved fast ?or no shock in the first place.

Strike fast and resolve fast -arrhythmia,severe vasovagal.

Thyroid mass-dysphagia,retrosternal chest pain,brady

Mediastinal infiltration-compress vagal nerve-intermittent brady /severe brady cardiogenic shock.

Cystic mass -malignancy ??

Thyroid mass ,lymphadenopathy →FNA→biopsy ?

No biopsy for thymoma(radio dx and surgical removal).

Thymoma(benign) doesn't cause LYMPHadenopathy, not a invasive disease.

Not able to wean off-poor mental status?.check inspiratory effort.Hypoxia→bradycardia .B/l phrenic nerve palsy due to this mass.

UTI can trigger MG crisis. Fluoroquinolones can trigger MG crisis.

MG can be sneaky.