1/7/26 Morning Report with @CPSolvers

"One life, so many dreams" **Case Presenter**: *Ravi (@rav7ks)* **Case Discussants**: *Zaven (@sargsyanz) & Steph (@)*

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

Scribing (CPS Fam <3)

CC: 33F with **L sided CP** radiating to L shoulder, progressive dyspnea on exertion and fatigue.

HPI: Initially was hospitalized in outside facility when developed DRESS due to sulfasalazine. Discharged with resolution of Sx on 2 week steroid taper after.

Now presents 2-3 weeks later with current Sx, associated with **fever** and diaphoresis. CP worse when supine, better with leaning forward. Rash recurred. New LE edema.

PMH:
DRESS
Psoriatic Arthritis

Meds:
Sulfasalazine [*discontinued*]
Prednisone [*60 mg -> taper*]
NSAIDs PRN

Fam Hx: none

Social Hx: none

Health-Related Behaviors: none

Allergies: none previously

Vitals: T: 100 **HR**: 120 **BP**: 100/60 **RR**: 20 **Sat**: 86%
Exam: Gen: dyspneic at rest, tachypneic, diaphoretic
CV: JVD to the mandible
Pulm: b/l bibasilar crackles
Extremities/skin: bl pitting edema, diffuse morbilliform rash

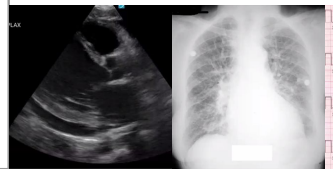
Notable Labs & Imaging:
Hematology: **WBC**: 20.4 [**AEC:** 2K, 1.5% atypical lymph] **Plt**: 84
Chemistry: Na: 126 **Cr**: 1.76 **BUN**: 38
AST: 250 **ALT**: 320 Bili: nl **hsTrop**: 6.81 **BNP**: 5K **CRP**: 18

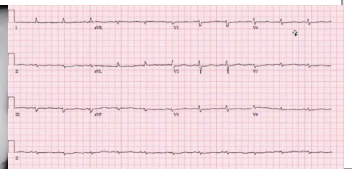
CXR: bl perihilar opacities, patchy air space densities
EKG: low voltage, sinus rhythm, ST changes
Echo: mild pericardial effusion, **LVEF 10-15%,** global hypokinesia
Cath: clear CA, high L sided filling pressures

-> dobutamine assisted diuresis + high dose steroid + cyclosporin initiated -> EF recovered to 40%.

Cardiac MRI: Diffuse myocardial edema with late gadolinium enhancement of the mid myocardium and subepicardium of the basal, lateral and septal and inferior walls.
Cardiac biopsy: Dense eosinophilic infiltration.

Dx: acute necrotizing eosinophilic myocarditis [ANEM].





Problem Representation: A 33 y/o lady with Hx of recent DRESS on steroid taper presented with subacute fever, chest pain and DOE. Workup consistent with HFrEF, labs notable for moderate eosinophilia. Cardiac MRI confirmed myocarditis. Given the Hx of DRESS, Dx of ANEM was made.

Teaching Points :

Left sided chest pain: directs us to pulmonary causes away from GI and cardiac pathology (age 37) (Inflammation, metastases viral sx, pneumonia, musculoskeletal)

Drug reaction w/ eosinophilia: Type 4 with rash and organ involvement (here positional pain mentioned)
To Allopurinol, ABx etc versus resurgence of past autoimmune diseases.
Vitals show signature of dress labs hypereosinophilia and lymphocytosis:
Look for organ damage due to DRESS (liver and kidney) LFTS & UA for pyuria
Approach to CXR:
cardiac space enlarged - pericardial effusion or ventricular enlargement?
Approach to EKG:
ST changes - indicative of myocardial process (ischemic or inflammatory)
Echo: Reduced EF w/ first mitral leaflet not touching the septum characteristic of LV failure.(eosinophilic myocarditis?) consider corticosteroids.
Cardiac biopsy revealed a eosinophilic myocarditis. 2/2 to DRESS.