3/19/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Manaswini* ***Case Discussants****: Rabih (@rabihmgeha) & Eugene (@EugeneBondzie)*

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

Scribing (Eyron)

CC: 29/M p/w BP 60/40 with rapid, thready pulse

HPI: Reported chest pain, palpitations, and fatigue that started 20 minutes PTA. Sudden onset chest pain while vacuuming, described as pressure, not relieved by rest, associated with discomfort and rapid, pounding heartbeat and dizziness.

ROS:
Denies syncope. Denies prior similar episodes. Denies headache, edema.

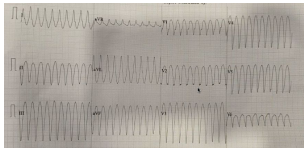
PMH:
None

Meds:
None

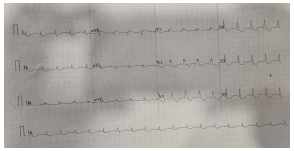
Social Hx:
Works as domestic worker

Allergies:
None

Vitals: T: **HR**: **BP**: 60/40 **RR**: 22 **Sat**: 97 on RA **BMI**:
Exam: Gen: conscious, a&o | **CV**: S1, S2 normal, no murmur
Pulm|**Abd**: nl: | **Extremities/skin**: warm, no edema or rash



EKG 1



EKG 2

EKG 1: monomorphic, concordant negative waves from V1-V6 suggestive of VT
Given Amiodarone, did not revert, given another dose of Amiodarone, still hypotensive to 66/42
Synchronized cardioversion done -> reverted back to sinus rhythm with Recurrence of VT requiring repeat cardioversion, Lignocaine, and Metoprolol
Persistent hypotension -> started on norepinephrine
Patient was cardioverted for the 4th time and was given Esmolol
EKG 2: ST with first degree AV block with RSR' in V1-V2, terminally positive deflection in V1, notching in II and III
Hematology: CBC: nl | **Chemistry**: Na: nl K: 4.2 Ca: nl Mg: nl Trop nl
Imaging: CXR: nl
Beside Echo: RA and RV dilation with RV wall motion abnormality, LA was normal.
Formal Echo: RA and RV dilation, RV dysfunction, mild free wall dyskinesia, RVOT reduced contractility. LV globally hypokinetic with moderate systolic dysfunction, EF 36%
cMRI: Dilated RV, small outpouchings and dyskinesis in the RV wall. Thinning with akinesis of the mid inferolateral segment.

Dx: Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)

Problem Representation:
29 y/o male presenting with chest pain, palpitations found to be hypotensive with recurrent ventricular tachycardia. Echo revealed RA and RV dilation with RV dysfunction with reduced contractility of the RVOT. cMRI revealed RV dilation, small outpouchings and dyskinesis in the RV wall and thinning with akinesis of the mid inferolateral segment c/w ARVC

Teaching Points (Saketh)

Measurement of Limb BP: What is under perfused = patient's arm or body ?

Approach to Hypotension

a **focal problem in a bad location** (e.g Pericardium/ PE) or a **focal problem that secondarily generalizes** (e..g Pneumonia -> Septic Shock)

Approach to Rapid Wide Complex Tachycardia

a) There is a focus of abnormal activity in the ventricles (No impulse being transmitted via His Purkinje system)
b) Unhealthy His Purkinje (unlikely in a young patients)

Management Pearls to fix arrhythmia

-Pulseless from Arrhythmia: Unsynchronized Shock
-Not Pulseless but not stable: Synchronized Cardioversion
-Stable from Arrhythmia: Medications
Empirical Tx of VT: Antiarrhythmics + Shock + Modulation of Sympathetic Tone

Classification of VT

1) **Monomorphic** - i.e focal seizure: think about focal structural abnormality
2) **Polymorphic** - i.e generalized seizure: think about electrolytes, QT prolonging meds.

Young Patient + Arrhythmia + Right Heart Disease - Think about ARVC
EKG: Highly Specific Feature - Epsilon Wave