



2/23/26 Mainstream Monday with @CPSolvers

“One life, so many dreams” Case Presenter: Eyron (@) Case Discussants: Lera (@LNovotnaya) & Youssef (@SaklawiMD)
<https://clinicalproblemsolving.com/present-a-case/>



Scribing (Seeme)
CC: 38/M coming in for sudden onset chest pain
HPI: 2 hours prior to arrival, the patient noted sudden onset of chest pain, parasternal, nonradiating, described as heaviness, rated at 10/10 in severity. He was playing games at a casino. He denies headache, nausea, vomiting, abdominal pain, difficulty breathing, or any other complaint. 1 hour prior to arrival, he went to an urgent care where he was given Pantoprazole and Pepto Bismol without relief of symptoms. Since symptoms persist, he proceeded to the ED for further evaluation.

PMH:
HTN
DLD

Meds:
Telmisartan
Carvedilol
Atorvastatin
(Not compliant)

Fam Hx:
-
Social Hx:
Works at casino
Health-Related Behaviors: exposed to secondhand smoke

Allergies: NKDA



Vitals: T: nl HR: 72 BP: 180/100 RR:21 Sat: 100%on RA BMI:
Exam: Gen: nl
HEENT: nl **CV:** normal heart sounds
Pulm: no crackles **Abd:** nl **Neuro:** nl
Extremities/skin: nl

Notable Labs & Imaging:

Hematology:

WBC: 15240 N85 L11 M4 Hgb: 16.5 Plt: 239 MCV:83

Chemistry:

Na: 141 K: 2.7 Cl: nl HCO3: nl Cr:nl BUN: 13 Glucose: nl Ca:1.12
Mg:1.7 AST: 54 ALT:112 ALK-P: 73 Bili: 0.84 CB:0.34 UB:0.5 Total
Protein:7.96 lipase:31 HS Trop I 5.5

Noted BP elevations (SBP 200s) given nicardipine drip and total 3 mg nicardipine push. Loaded with aspirin (80 mg 4 tabs) clopidogrel (80 mg 4 tabs) and atorvastatin 80 mg.

Imaging:

Chest X-ray: nl

EKG: ST elevation in V2 and V3

WAB CT: aortic dissection in thoracic aorta

CT angio:A subtle crescentic hyperdensity is seen along the wall of ascending aorta to the aortic arch-probable intramural hematoma. A dissecting intimal flap is detected with suggestive entry tear at the proximal thoracic descending aorta while exit tear at abdominal aorta renal artery level - Stanford B aortic dissection

Dx: Aortic Dissection

Problem Representation: 38 y old M presented with sudden onset, parasternal, non radiating , described as heaviness and rated at 10/10 in severity. Patient had BP of 180/100 and hypokalemia. CT angio showed presence Stanford B aortic dissection.

Teaching Points (Saketh)

1) “Sudden Onset” Chest Pain: Most morbid cause - ACS (EKG + Troponin)

- Enquire about similar episodes in the past, quality, radiation, comorbidities.
- Young patient with complaints: Think Bad Genes, Bad Luck and Bad habits.
- Pain on palpation has a poor likelihood ratio for ruling out ACS.

2) EKG: Captures what happens in the moment Likelihood of EKG + higher in patients with current episode of pain as opposed to intermittent pain.

Reciprocal Changes:A focal myocardial injury generates an electrical vector directed toward the injured region therefore, leads viewing the opposite wall record a negative deflection, producing reciprocal ST-segment changes.

3) High BP + HypoKalemia = Sympathetic Activation

- Sympathetic Surge (2 main buckets): Aldosterone excess or Catecholamine excess.
- Acute Aortic Dissection: Start patient on B Blockers +/- Nitroprusside to decrease stress on the vessel wall. Involve Vascular Surgery.
- 80% of Patients with an AD have mediastinal widening on CXR. 20% CXR Negative.