10/5/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Sydney & Emily* ***Case Discussants****: Maddy & Austin*

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

Scribing (Meghna):

CC: 61 y/o woman B/L LL edema, dyspnea on exertion

HPI: Worsening exertional dyspnea, intermittent chest pain over the past few months. Poor exercise tolerance (had to get on her hands and knees to go up the stairs). Progressive B/L leg swelling and breathing difficulty, which worsened on lying down (orthopnea). Referred to Cardiology by PCP and admitted through ED.

ROS: Constipation, fatigue, hair-loss, cold intolerance, dry eyes and mouth, chills, persistent tingling and burning on B/L LL. Denies fever, cough

PMH: Breast cancer treated in 1997
HTN, Hyperlipidemia, GERD, Anxiety

Meds:
Furosemide 20 mg
Famotidine 10 mg
Atorvastatin 40 mg
PRN for GERD

Fam Hx: NA

Social Hx: IV drug use (prior), current cannabis use

Health-Related Behaviors: No alcohol use

Allergies:
Denied

Vitals: T: 36 **HR**: 50 **BP**: 171/89 **RR**: 18 **Sat**: 97% **BMI**: -
Exam: Gen: Alert, oriented, comfortable at rest
HEENT: periorbital edema, dry oral mucosa, JVP mildly elevated
CV: Normal S1/S2 no murmurs or gallops
Pulm: B/L crackles +, non-laboured respirations
Abd: Epigastric tenderness +
Neuro: Intact sensation
Extremities/skin: Skin dry; B/L pitting edema till the knees
R LL: dorsalis pedis +
L LL: diminished pedal pulses

Notable Labs & Imaging:

Hematology:
WBC: 6 Hgb: 7.9 Plt: 273 MCV: 92

Chemistry:
Na: 139 K: 2.9 HCO3: 28 Ca: 8.4 Mg: 1.8 BUN: 22 Cr: 1.12 Glu: 91 PO4: 4.4 AST: 32 ALT: 15 ALP: T. Bili: 0.7 T. protein:
Alb: 2.9 Alk Phos: 135
Pro BNP: 1239 Anion gap: 6
Free T4: 0.53
Free T3: 1.6
TSH 115

Imaging:
EKG: Sinus bradycardia, sinus arrhythmia, 50 bpm
CXR: Cardiomegaly, small pleural effusions
Echo: LVEF 65-75%, hyperdynamic systolic function, LV hypertrophy, mod-large pericardial effusion

Dx: Hypothyroid Cardiomyopathy

Problem Representation: 65 y/o woman with a h/o breast cancer s/p chemo presented with progressive B/L LL edema and dyspnea on exertion with elevated JVP, pericardial and pleural effusions on imaging, and elevated TSH, low T3, T4.

Teaching Points (Daniel)

Approach to BLE edema
BLE edema - look up for signs of heart, kidney, and liver disease
Consider venous insufficiency due to high base rate
Prioritizing heart due to exertional dyspnea and orthopnea

Characterizing the HF
Hx to inform possible causes.
New onset HF vs existing HF
Acute vs chronic HF

Etiology
Ischemic most common cause of HF
other possible causes for this patient
medication/drug related
breast cancer - disease or treatment complications
ROS revealed additional finds - importance of considering both a unifying and non-unifying diagnosis

Possible causes of periorbital edema
Endocrine - hypothyroidism/Kidney disease
Angioedema and pseudo angioedema
Labs possibly pointing to signs of chronic illness - anemia, hypoalbuminemia

Hypothyroidism - can mimic HF
Make sure to check out recording on youtube. Presenters Sydney and Emily shared many amazing pearls on hypothyroidism!