



6/8/26 Mainstream Monday with @CPSolvers



"One life, so many dreams" Case Presenter: Eugene (@EugeneBondzie) Case Discussants: Youssef (@saklawiMD) & Magnus
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Javier)
CC: 56 years old man with recurrent episodes of **palpitations for 4 months** with bilateral lower limb **edema**.
HPI:
 56 ys old man with a history of 4 months of intermittent palpitations not related with exercise, not associated with other symptoms (chest pain, syncope), progressive and then 3-4 weeks prior to presentation developed **lower extremity edema and abdominal fullness**, Difficult sleeping at night due to **dry cough**
ROS:
 No fever, no productive cough, no wheeze, no hemoptysis, no weight loss, no night sweats. No polyuria, polydipsia, heat intolerance, or tremors.

PMH: hypertension,
Meds:
 Amlodipine, non consistent

Fam Hx:
Social Hx: alcohol 10 years, heavy and regular
Allergies:

Vitals T: 36.6 °C Pulse: 92 bpm, regular RR: 16 /min BP: 119/92 mmHg
Weight: 59.1 kg
Exam: **Gen:** Middle-aged man, not in acute distress at rest. Not pale, anicteric, afebrile. **Bilateral pitting pedal edema up to ankle present**.
CV: apex beat at 5th intercostal space, JVP not elevated
Pulm: nl
Abd: non significant, non ascites
Extremities/skin: bl pitting edema up to the ankles

Notable Labs & Imaging:
Hematology: Hb: 14.8 g/dl WBC: 6.2 ×10⁹/L Platelets: 210 ×10⁹/L
Chemistry: Urea: 3.4 mmol/L Cr: 0.74 mg/dL Sodium: 138 mmol/L Potassium: 4.0 mmol/L Chloride: 104 mmol/L Bicarbonate: 24 mmol/L GFR: 120 mL/min
Liver Function Tests: **AST:** 90 U/L **ALT:** 69 U/L **GGT:** 860 U/L (markedly elevated)
 ALP: mildly elevated Bilirubin: normal Albumin: 4.1
Thyroid Function: TSH: 1.89 mIU/L fT3: 3.92 pmol/L fT4: 13.6 pmol/L
Abdominal Ultrasound: Fatty liver grade 2–3, No hepatomegaly
Other studies: **proBNP:**482, Total cholesterol: 7.51 mmol/L LDL: 5.70 mmol/L HDL: 1.42 mmol/L Triglycerides: 0.85 mmol/L
 HBsAg: negative HCV Ab: negative HIV: negative

Imaging:
 EKG: sinus rhythm, Left ventricular hypertrophy, T inversions in lateral leads
 CXR: minimal bilateral pleural effusion
 Echo: lv dilated, EF 38%, Diastolic dysfunction, Left atrium: Dilated (4.5 cm) Right atrium: Dilated Right ventricle: Dilated IVC: Dilated with reduced collapse PSAP 40-50
 Holter: frequent premature ventricular complexes
 Final diagnosis: Alcohol induced dilated cardiomyopathy with reduced ejection fraction

Problem Representation: A 56-year-old man with a 10-year history of heavy alcohol abuse and inconsistent hypertension treatment presents with a 4-month progression from paroxysmal palpitations to subacute congestive heart failure (manifested by pedal edema and worsening nocturnal dry cough), without overt signs of systemic volume overload on current examination.

Teaching Points (Hans)

Palpitations + edema makes think more about cardiac cause.
Arrhythmia + HF:

- Sequence of events? Arrhythmia -> HF // HF -> arrhythmia // X [eg ischemia] -> HF & arrhythmia
- sympathetic overtone (anxiety)

Palpitations LE edema, orthopnea:
 point to volume overload. HF, (look at signs of HF, look at pt he overused ETOH a possible cause for AFIB, however, the liver is usually first involved then the heart)
 LE edema side effect of amlodipine

Echo: EF 38%
 ProBNP: 482
 Holter: frequent premature ventricular complexes