3/1/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Sarah B (@sarahkblaine)* ***Case Discussants****: Kirtan (@KirtanPatolia) & John (@calicocapybara)*

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

Scribing (Saketh)

CC: 32 y/o M with 2 weeks of progressive cough and chest pain

HPI: 2 weeks prior, went to Utah. Had positional Chest Pain and dry cough. Treated for viral pericarditis. Given ibuprofen, pantoprazole and colchicine and given return precautions. Chest pain worsened despite therapy - developed Dyspnea on exertion.

ROS: No fever, chills, SOB, orthopnea, joint pains, nausea, vomiting, diarrhea

PMH:
RA (RF +ve, CCP -ve)
GERD

Meds:
Colchicine
Ibuprofen
Pantoprazole
HCQ

Fam Hx:
RA: Grandmother
CAD: Father

Social Hx:
-Married, monogamous
-Recent Travel to Utah

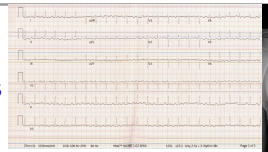
Health-Related Behaviors:

Allergies:

Vitals: T: 37.3 **HR**: 116 **BP**: 110/61 **RR**: 32 **Sat**: 96% RA **BMI**:

Exam: Gen: No acute distress
HEENT: No oral ulcers, anicteric sclera
CV: Tachycardic, no rubs, equal pulses bilaterally
Pulm: crackles over left upper and middle lung fields (L>R). Decreased air movement over B/L lower lung fields.
Abd: Normal
Neuro: Normal
Extremities/skin: No rashes, joints without effusions. No Lower extremity edema

Notable Labs & Imaging:





Hematology:
WBC: 12.6 (N diff) Hgb: 11.4 Hct 35.5
Plt: 549

Chemistry:
Na/K/Cl/HCO3: Normal BUN/Cr: Normal, AST: 31 ALT: 47
Alk-P: 91 CPK: N
ESR:55, CRP:203.4, TSH: 2.43,
UA: Normal, HIV/Hep A/B/C: -ve
Flu/Covid/RSV/Respiratory Multiplex Panel/Bacterial and fungal sputum culture: Negative

Imaging:
EKG: Sinus tachycardia, diffuse T wave inversions
CXR: Small pericardial effusion. Small Pleural effusions (L>R) with compressive atelectasis
CTPE:No PE, B/L Pleural Effusion
TTE: EF 55%, LV - septal bounce (borderline for constrictive physiology), pericardial thickening, small pericardial effusion (no concern for tamponade), large left pleural effusion
Thoracentesis: 850ml Removed, 2460 nucleated cells, cloudy, LDH 341
Additional Labs:
C3: 278, C4: 70, ANA: +ve (1:1280, speckled), RF/CCP: -ve, RNP IgG: 7.4 Smith: 6.1, Anti chromatin: High

Rheum consulted: Started on high dose steroids. Continued on steroid taper and HCQ. Responded well. Never met full diagnostic criteria for SLE.

Dx: Undifferentiated Connective Tissue Disorder

Problem Representation: 32-year-old man with h/o RA presenting with subacute progressive chest pain, dry cough, and exertional dyspnea following recent travel, found to have systemic inflammation, sinus tachycardia, and imaging demonstrating small pericardial effusion with pericardial thickening plus large left-predominant pleural effusion, without infectious etiology, consistent with a serositis-predominant inflammatory process.

Teaching Points (Krishna)

Chest pain:
Use the 4+2+2 for No-miss diagnosis for Chest pain 4 Cardiac causes (ACS, Aortic dissection, Tamponade, Takotsubo), 2 Pulmonary causes (Pulmonary embolism, Pneumothorax), and 2 Esophageal cause(rupture/impaction).

Cough:
Use the anatomic approach - URTI causes vs LRTI causes
Always think of your neighbours= Thoracic causes

Classic Pericarditis:
Pleuritic CP+ Biomarkers + EKG + Imaging(effusion); MCC: Idiopathic; (?extra articular RA, young male with RA; Other autoimmune disease cause) [additionally confirm how RA was diagnosed for this pt]

Pericarditis WITH dyspnea :
compression (progressive effusion)/ pericardium AND lung parenchymal involvement(in the broader autoimmune context).
- Pay attention to physical examination- Tachycardia, Tachypnea
Pleural effusions can be reactive to pericardial effusion

Etiology of pericarditis:
- Viral= Influenza, EBV, CMV(immunocompromised), Fungal (LAD on CT), Bacterial (more fulminant and sick patient); Atypical bacterial (Coxiella sps) Tick-borne (lyme)
- Autoimmune: SLE, RA, Adult- onset Still's (Fever is typical) [CRP, Thrombocytosis fit autoimmune]
- ANA high titre; Anti-Sm, U1-RNP =MCTD/SLE