5/28/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Shivani (@)* ***Case Discussants****:Rabih (@rabihmgeha) & Sana (@)*

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

Scribing (Eugene)

CC: 76 yr M old with cough and dyspnea on exertion for 4 weeks

HPI:

Recently returned from trip to Japan [met someone with "violent cough"].

Empiric doxy prescribed

ROS: **(+)** Hemoptysis, weight loss over 4 weeks, exertional fatigue

Sputum and weight loss, fatigue

, no orthopnea or chest pain,

PMH:

HIV [CD4 count 490, Undetectable load]

HFrEF [EF 30-35%]

HTN

Afib not on AC- watchman device

Squamous cell CA-skin

Meds:

Acyclovir + Dovato

Aspirin

Plavix

Statin

Entresto

Jardiance

Fam Hx:

Social Hx: avid traveler, recent trip to Japan + Jordan

Health-Related Behaviors: smoking Hx

Not sexually active

Allergies:

Vitals: T: 98.2 **HR**: 107 **BP**: 127/101 **RR**: 18 **Sat**: 98%

Exam: Gen: unremarkable

HEENT:no pharyngitis **CV**: nl **Pulm**: CTAB

Current exam:

T: 97.5 **HR**: 80 **BP**: 138/75 **RR**: 18 **Sat**: 100%

Gen: No LAD

Lungs: CTAB

CV: RRR, no murmurs, no JVD / LE edema

Notable Labs & Imaging:

Hematology:

WBC:6.3 Hgb:12. Plt: 233 MCV: 78

Chemistry:

Na: 139 K: 4 Cl: 105 HCO3: 25 Cr: 0.97 BUN: 21

Glucose: 103 **Ca**: 10.5 AST: 17 ALT: 13

Troponin-9.4 BNP- 250 d-dimer- 5.48

Imaging:

CXR: normal

CTA: multifocal b/l pulmonary emboli with right heart strain

Dx: Provoked PE

Problem Representation: Elderly M presenting with subacute dyspnea on exertion, background of a recent long haul flight and a hx of SCC of skin.

Teaching Points (Evan)

-Cough + resp symptoms for more chronic period >> think lung parenchyma. Cough - irritated lung

-Both upper and lower resp tract involved point more towards pulmonary then cardiac cause

-Cough/upper resp can be noise or can be key symptom

-Weight loss points towards more system process, few diseases with focal cause for weight loss

-Improvement with doxycycline - disease can vary in intensity taken into account with body's own healing properties

-Hard to work backwards from this benign lab/exam findings to chief complaint

-Weight loss (if verified) and 4 week timeframe with no improvement help push investigation further

-Extremely high D-Dimer leads towards more systemic. D Dimer has really good negative predictive value

-PE is in the top missed diagnoses in the US

-Exam and history disconnect - can't reproduce patients symptoms and not getting full picture - limits ddx

-Exertional dyspnea - additional vascular disease ddx

-L atrial appendage in afib is where clots come from but these cant lead to PE. MC PE is from leg clot

-VTE is advanced complication from disease and non modifiable RF. Age and genetics also contribute. Look for signal with cancer or something we can treat.