



7/8/26 Morning Report with @CPSolvers



"One life, so many dreams" Case Presenter: Praveen Saran (@) Case Discussants: Abeer (@) & Ravi (@)
<https://clinicalproblemsolving.com/present-a-case/>

Scribing (Bayan)
CC: 70 yo male p/w sudden onset substernal chest pain at 1am
HPI: worsened with exertion for 30 minutes before presentation
a/w Gradual onset of palpitations

No hx of similar episodes

ROS: no cough, sob, diarrhea, abdominal pain, urinary symptoms
No travel
No sick contacts

PMH: T2DM

Meds:
Multivitamins
metformin

Fam Hx: none

Social Hx: school teacher (retired)
Vegan diet

Health-Related Behaviors: no alcohol, smoking or illicit drugs

Allergies: -

Vitals: T: afebrile HR: 140 BP: 90/60 RR: 20 Sat: 94% on RA BMI: 21
Exam: Gen: diaphoretic, in pain
CV: tachycardic, RR, S1+S2+no murmurs
Pulm: clear equal b/l air entry, no wheezing **Abdomen:** nl
Extremities/skin: b/l pitting edema up to mid shins, cold

Notable Labs & Imaging:

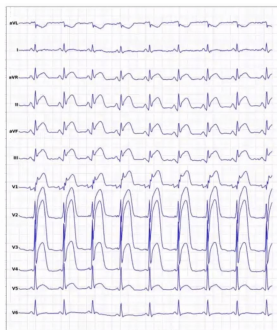
Hematology: WBC: 9.3 Hgb: 11.3 Plt: 273 MCV: 70
Chemistry: Na: 132 K: 3.2 Cl: HCO3: Cr: 1.7 BUN: 32.8 Glucose:
AST: 22 ALT: 27 Alk-P: 105 Bilir: 0.5 indirect 0.3 Albumin: 4.5 LDH: 4.5
Troponin 1.15 (N <0.004)

Imaging: EKG:

Clinical course:

started on ASA, Clopidogrel, Heparin
During transfer to Cardiac centre,
Pt went into VFib
ROSC after 11 minutes of ACLS & CPR
Pt intubated, on MV
Pt arrested again in cath lab
Found to have Proximal LAD occlusion > 90%
Primary PCI done and patient shifted to ICU on dual vasopressors
Echo: EF 20%, extensive LAD territory wall motion abnormalities.
Pt developed myoclonic jerks while in ICU raising suspicion for hypoxic brain injury. However, patient improved, was extubated, stabilised and discharged on GDMT and DAPT.
Repeat Echo 1 month later in outpatient f/u: EF 50%

Dx: ACS



Problem Representation: 70 year old male presenting with chest pain and palpitations, vitally unstable, EKG reveals OMI

Teaching Points (Preethi)

Approach to CP: serious ones to r/o: aortic dissection, PE, esophageal rupture, ACS
Risk factors of ACS: smoking, alcohol use, hyperlipidemia, Diabetes.

Tachycardia-> sinus tachycardia vs afib/flutter?. Longstanding Tachycardia induced cardiomyopathy can present as heart failure and/or cardiogenic shock

EKG, troponin, CXR, POCUS - initial investigations

Following with CBC, CMP, BNP

Edema b/L-> less likely to have a DVT but tachycardia, hypotension can be a PE.

Right sided congestion-> JVD, hepatic, perinephric system and LLE. Watch for end organ damage- liver, kidney/urine output, get a lactate.

POCUS-> look for cardiac tamponade, Mitral anterior leaflet approximation to septal wall, squeezing ability of LV.

Suspicion for ACS: initiate ASA load, clopidogrel, statin, heparin drip
EKG approach- ST elevations in lead 2, 3 Avf will have reciprocal changes in the lateral leads in Lead 1 and AvL. ST elevation in AvR -> severe left main or triple/multivessel disease. CODE STEMI with the above EKG. Call the cardiologist and facilitate activation of cath lab. Intensive care for inotropic support.
Highly suspicion of ACS at 4 AM during dawn due to high adrenergic response during this time.

Consequence of ACS-> V fib, ACLS protocol with defibrillation and ABC support with mechanical ventilation. Myoclonus post MI- suspicion for Lance-Adams Syndrome (LAS) that can occur after CPR or other events causing post-anoxic hypoxia.

Low EF-> initiate GDMT, repeat ECHO in 45 days, lifestest meanwhile if EF is <35%. Plan for ICD placement.