9/4/26 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Kwame(@)* ***Case Discussants****: Rabih(@) & Gillian(@)*

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

Scribing (Lukas):

CC: 57 yo male p/w lower abdominal pain, occasional palpitations and chest discomfort for 2 weeks in the ED

HPI: Healthy until a week ago.
Epigastric pain radiating to the umbilical pain scale 3/10. Gradually increasing.

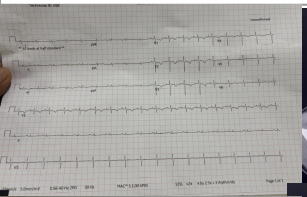
ROS (+): non productive cough (worsening), nausea, SOB

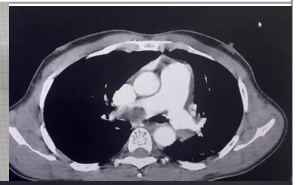
ROS (-): orthopnea, paroxysmal dyspnea, fever, weight loss, melena, diarrhea

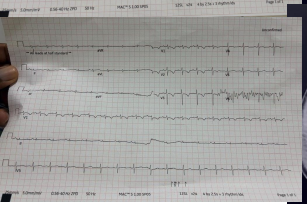
Fam Hx: - **Social Hx:** Saw mill operator (wood contact)

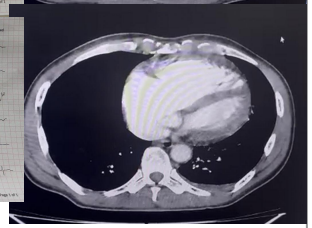
Health-Related Behaviors:

-Stopped smoking 5 years ago, Unprotected sexual activity, Socially drinking









Vitals: T: 36,3°C **HR**: 106 **BP**: 120/89 **RR**: 15 **Sat**: 99% **BMI**: 20,27

Exam: Gen: looks anxious, no icterus, **HEENT**: unremarkable **CV**: tachycardic, **Pulm**: wnl **Abd**: tenderness in epigastric/umbilical area **Neuro**: unremarkable, **Extremities/skin**: diaphoresis

Notable Labs & Imaging:

Hematology:

WBC: 3,8 Hgb: 12,2 Plt: 68,5 MCV: 89

Chemistry:

Na: 134 K: 4,9 Cl: 101 HCO3: 29 Ca: 8,6 Mg: 1,6 Cr: 1 Glu: AST: 223 ALT: 360 ALP: 136 GGT: 306 T. Bili: 0,8 directBili: 0,2 Alb: 3,8 TProtein: 7,0 ESR: 45 CRP: 3,4 (<1,0) LDH: 100 U/L Troponin I: 0,5 microgram/l (< 0,04), Troponin T: 0,2 (<0,01) HbA1c: 5,88 BNP: 340 (elevated)

HIV: neg HBV: neg HCV: neg Hpylori stool antigen: reactive

Ultrasound: Mild chronic renal parenchymal disease. No sonographic Murphy sign but pericholecystic fluid and biliary dilatation. Diffuse gallbladder wall thickening without gallstones → suspected chronic acalculous cholecystopathy

ECG: T-wave inversions in V1-4, poor wave progression, low voltage

CXR: Cardiomegaly, no pulmonary pathology

Course: vitals dramatically changed: BP 94/60; heartrate 121, SpO2: 87%

CTPA: bilateral pulmonary embolism extending into the bilateral interlobar pulmonary arteries. Enlarged pulmonary artery consistent with right heart strain. Wedge shaped area of GGI and consolidation in the left lower lobe suggestive of pulmonary infarction.

Course: ICU transfer, thrombolysis introduced.

Dx: Pulmonary embolism

Problem Representation: 57 yo male p/w subacute epigastric pain, palpitations and CP to the ED with T-wave inversions in the anterior leads developed developing worsening cardiovascular state turns out to have bilateral PE of unknown origin

Teaching Points (Varsha)

Time course: Subacute syndrome - most concerning, slowly progressing to something chronic? Vs Chronic syndrome - well compensated to live with it Vs Acute- maybe an external factor/ environment trigger

SOB - **dysfunction** → focal factor vs **discomfort** -nausea/cough

Lack of PMHX - disconnected from care vs unrecognised chronic disease vs new onset illness in a previously healthy person

Diaphoresis and tachycardia - physiological process associated with tachycardia/ pathological sympathetic excess

- Thyrotoxicosis, hypoglycemia, medications, pheochromocytoma
- Severning a purpose - dissipation of heat, response to a problem somewhere else (sepsis, shock),

GI and CVS symptoms: Living in the abdomen/chest Vs radiating from one to the other Vs sitting at the surface/diffuse process

CBC abnormality - is it reflecting a primary abnormality Vs a reactive process

CBC abnormality + liver abnormality - something affecting the reticuloendothelial system - infections (tick borne, Viral) /Infiltrative process

Liver abnormality:

- focal injury: acute causes: biliary obstruction and hepatic vein obstruction (elevated AST ALT)
  - If there is RV stress → hepatic venous hypertension?
- Diffuse liver injury - activation of immune system (external:hepatitis, mono vs Internal: autoimmune hepatitis) vs medication/ toxin (internal - Wilson's vs external ingestion or exposure)

EKG: T wave inversion in anterior lead - anterior vessel: LAD disease Vs anterior chamber disease: RV

T wave inversion in anterior lead and inferior lead → prioritize RV disease (++ tachycardia) → RV strain

Cardiogenic shock - diseased myocardium (low LVEF) → ECHO VS electrical asynchrony → EKG VS focal obstruction in a specific compartment (pericardium, LVOT, Pulmonary artery) → normal myocardium on ECHO → CT